FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Pomaville, Director
Public Health Department

David Cardona, M.D.
At-large

David S. Hodge, M.D.
At-large

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Ed Hill, Director
Public Health Department

Harold Nikoghosian
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Brian Smullin
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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 12, 2021

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 18, 2021
1:30 pm to 3:30 pm

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

Teleconference: 605-313-4819
Participant Code: 270393

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 18, 2021
1:30pm - 3:30pm

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

Teleconference: 605-313-4819
Participant Code: 270393

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B	**Madera County At-Large Seat Nomination(s)** • BL 21-003 Madera County At-Large Seat Nomination(s) • Application – P. Soares *Recommended Action: Approve appointment*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C Attachment 4.D	**Consent Agenda:** • Commission Minutes dated 2/18/2021 • Finance Committee Minutes dated 11/19/2020 • QI/UM Committee Minutes dated 11/19/2020 • Public Policy Committee Minutes dated 12/2/2020 *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5. Action	Attachment 5.A Attachment 5.B	**Reappoint Moss Adams as Independent Auditors** • BL 21-004 • Audit and Non-Attest Services Proposal *Recommended Action: Approve reappointment of Moss Adams*	D. Maychen, CFO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 6 & 7* ***One vote will be taken for combined items 6 & 7***	
6 Action	Attachment 6.A Attachment 6.B	**2021 Quality Improvement** • 2021 Program Description • 2021 Work Plan	P. Marabella, MD, CMO
7 Action	Attachment 7.A Attachment 7.B	**2021 Utilization Management & Case Management** • 2021 Case Management Program Description • 2021 UMCM Work Plan *Action: Approve 2021 Quality Improvement Program Description, 2021 Quality Improvement Work Plan, 2021 Case*	P. Marabella, MD, CMO

		Management Program Description, and the 2021 Utilization Management Case Management Work Plan.	
8. Action		**Standing Reports**	
		Finance Report	
	Attachment 8.A	• Financials as of January 31, 2021	D. Maychen, CFO
		Compliance	
	Attachment 8.B	• Compliance Report	M.B. Corrado, CCO
		Medical Management	
	Attachment 8.C	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 8.D	• Key Indicator Report	
	Attachment 8.E	• Credentialing Sub-Committee Quarterly Report	
	Attachment 8.F	• Peer Review Sub-Committee Quarterly	
		Operations	
	Attachment 8.G	• Operations Report	J. Nkansah, COO
		Executive Report	
	Attachment 8.H	• Executive Dashboard	G. Hund, CEO
		Action: Accept Standing Reports	
9.		**Closed Session:** *(a separate confidential call-in number will be provided to Commissioners the morning of the meeting)*	
		The Board of Directors will go into closed session to discuss the following item(s)	
		1. Public Employee Appointment, Employment, Evaluation, or Discipline	
Action	*No attachment*	A. Staffing – Action	
Action	*No attachment*	B. Staffing - Action	
		Per Government Code Section 54957(b)(1)	
10.		**Final Comments from Commission Members and Staff**	
11.		**Announcements**	
12.		**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.*	

13.	**Adjourn**	D. Hodge, MD, Chair

Supporting documents will be posted on our website 72 hours prior to the meeting.
If you have any questions, please notify the Clerk to the Commission at: Churley@calvivahealth.org

If special accommodations are needed to participate in this meeting, please contact
Cheryl Hurley at 559-540-7842 during regular business hours (M-F 8:00 a.m. – 5:00 p.m.)

Next Meeting scheduled for May 20, 2021 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

Attachments 3.A – 3B

- BL 21-003 Madera County At-Large
- Application: P. Soares

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Pomaville, Director
Public Health Department

David Cardona, M.D.
At-large

David S. Hodge, M.D.
At-large

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Ed Hill, Director
Public Health Department

Harold Nikoghosian- At-large

Madera County

David Rogers
Board of Supervisors

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

DATE: March 18, 2021

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Commission Appointed – Madera County At-Large Seat

BL #: 21-003
Agenda Item 3
Attachment 3.A

BACKGROUND:

Under the terms of the Joint Exercise of Powers Agreement (JPA) between the Counties of Fresno, Kings and Madera (Section 6.B.2) and the Bylaws of the Fresno-Kings-Madera Regional Health Authority Commission (Section 2.3.4), the Commission shall appoint three (3) At-Large commissioners (one person representing each county). The appointees must be a resident of or employed in the county they are representing.

Qualified applicants shall represent the general public, beneficiaries, physicians; hospitals, clinics and other non-physician health care provider. Individuals considering Commission at-large positions should have a commitment to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances, delivers high quality care and is financially viable.

DISCUSSION:

The Commission Appointed Madera County At-Large position is up for reappointment as of March 2021.

Mr. Soares has expressed his interest to continue serving in his current position.

This appointment is for a three (3) year term.

RECOMMENDED ACTION:

Review application and reappoint Madera County At-Large Commissioner for a three year term.

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY
COMMISSION AT-LARGE APPOINTEE
APPLICATION FORM

Three Commission appointed positions have been designed as follows: one resident from Fresno County, one resident from Kings County and one resident from Madera County. Qualified applicants shall represent the general public, beneficiaries, physicians; hospitals, clinics and other non-physician health care provider. Individuals considering Commission at-large positions should have a commitment to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances, delivers high quality care and is financially viable.

Name of Applicant: Paulo A. Soares
Home Address: [redacted] City: [redacted] Zip: [redacted]
Current Employer: Camarena Health
Business Address: 730 N. I Street #202 City: Madera Zip: 93637
Home Phone: [redacted] Work Phone: 559-664-4089 E-mail Address: psoares@camarenahealth.org

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List past or present County appointments, as well as any other public service appointments, or elected positions held (please list dates served):

N/A

List past or present affiliations with private and/or public health plans.
Current appointment as Commissioner to the Cal Viva Commission

What experience or special knowledge can you bring to the Regional Health Authority?

As CEO of Camarena Health, the largest provider of primary care services in Madera County, I can provide a reliable perspective on the needs of Cal Viva beneficiaries as well as the needs/concerns of providers in Madera County. Camarena Health is responsible for the care of approximately 15,000 Cal Viva members.

List community organizations to which you belong:

CASA of Fresno/Madera Counties, Madera Rotary, American Heart Association - Board Chair, Central Valley Health Network, Central California Partnership for Health - Board Chair

Convictions and penalties- Have you ever been convicted of a felony? If yes, give date(s), Location(s) and penalties. (Convictions are evaluated for each position and are not necessarily disqualifying.)

None

List any affiliation you or your spouse has with public service agencies:

None

Provide a minimum of three references and their contact information that the commission Nominating Committee may contact:

1. Name Kerry Hydash
   Affiliation Family Healthcare Network - CEO
   Contact Phone Number 559-972-4097
2. Name Justin Preas
   Affiliation United Health Centers
   Contact Phone Number 559-304-9727
3. Name Edgar Jiminez
   Affiliation Camarena Health - Board Chair
   Contact Phone Number 559-363-9512

Please Note: Commission appointees are required to submit California Form 700 for filing with the Fair Political Practices Commission.

I HAVE READ THE "FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY COMMISSION POLICY" REGARDING CONFLICT OF INTEREST FOR COMMISSION APPOINTEES AND AGREE TO ABIDE BY THE POLICIES AND PRODEDURES AT ALL TIMES WHILE AN APPOINTED MEMBER. AT PRESENT, TO THE BEST OF MY KNOWLEDGE, NO CONFLICT OF INTEREST EXISTS IN MY SERVING ON THIS COMMITTEE.

(Signature)

12/11/2020
(Date)

COMPLETE FORM AND RETURN TO:

Clerk to the Commission
Fresno-Kings-Madera Regional Health Authority
7625 N. Palm Avenue, Suite 109
Fresno, CA 93711

Applications will be kept on file for a year.

Item #4

Attachment 4.A

Commission Minutes
Dated 2/18/2021

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
February 18, 2021

Meeting Location:
Teleconference Meeting due
to COVID-19 Executive Order
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

	Commission Members		
✓●	**Sara Bosse**, Director, Madera Co. Dept. of Public Health	✓●	**Aftab Naz**, Madera County At-large Appointee
✓●	**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
✓●	**Joyce Fields-Keene,** Fresno County At-large Appointee	✓●	**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	✓●	**David Rogers**, Madera County Board of Supervisors
✓●	**Ed Hill**, Director, Kings County Dept. of Public Health	✓●	**Brian Smullin**, Valley Children's Hospital Appointee
✓●	**David Hodge**, M.D., Chair, Fresno County At-large Appointee	✓●	**Paulo Soares**, Commission At-large Appointee, Madera County
	Kerry Hydash, Commission At-large Appointee, Kings County		
	Commission Staff		
✓	**Gregory Hund**, Chief Executive Officer (CEO)	✓	**Amy Schneider**, R.N., Director of Medical Management
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Mary Lourdes Leone**, Director of Compliance
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Cheryl Hurley**, Commission Clerk
✓●	**Mary Beth Corrado**, Chief Compliance Officer (CCO)		
✓	**Jeff Nkansah**, Chief Operations Officer (COO)		
	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 1:30 pm. A quorum was present via conference call in lieu of gathering in public per executive order signed	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of Commissioners' physical attendance at the public location or by teleconferencing.	
#2 Roll Call Cheryl Hurley, Clerk to the Commission	A roll call was taken for the current Commission Members.	*A roll call was taken*
#3 Appointment/Reappointment of Board of Supervisors Commissioners Action David Hodge, MD, Chairman	Fresno County has re-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.	***Motion:*** *Ratify reappointment of County BOS Commissioners* *14 – 0 – 0 – 3* *(Frye / Fields-Keene)*
#4 Consent Agenda Commission Minutes 11/19/2020 a) Finance Committee Minutes 10/15/2020 b) QIUM Committee Minutes dated 10/15/2020 c) PPC Minutes dated 9/2/2020 d) Compliance Report Action D. Hodge, MD, Chair	All consent items were presented and accepted as read.	***Motion****: Approve Consent Agenda* *14 – 0 – 0 – 3* *(Neves / Nikoghosian)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#5 Annual Administration Information David Hodge, MD, Chairman	Dr. Hodge reminded the Commission the Form 700 is due on an annual basis, due this year on 4/1/21. Commissioners will receive notification from the Commission Clerk via email. Anyone due for an updated Ethics Certification will be notified.	***No Motion taken***
#6 Funding Request Action D. Hodge, MD, Chair	The two funding requests received are no longer needed. Health Net has agreed to cover the Plan's cost for the e-Consult request. The second funding request to assist county health departments with the cost of COVID-19 vaccinations will now be covered by federal dollars coming to all three service counties. *Dr. Naz arrived at 1:39 pm*	***No Motion taken***
#7 Community Support Program – Ad-Hoc Committee Selection Action David Hodge, MD, Chairman	A new ad-hoc committee is needed for the Community Support Program. Dr. Hodge has asked any Commissioners interested to email him directly.	***No Motion: Dr. Hodge will select Ad-Hoc Committee members outside of Commission meeting.***
#8 2020 Annual Quality Improvement Work Plan Evaluation Action David Hodge, MD, Chairman	Dr. Marabella presented the 2020 Annual Quality Improvement Work Plan Evaluation. The planned activities and Quality Improvement focus for 2020 included the following: • Access, Availability and Service: o Improve Access to Care: ▪ Provider Appointment Availability Survey assessment. ▪ Revised Corrective Action Plans (CAPs) with targeted PPG approach. Seven (7) CAPs submitted for non-compliant PPGs. Two (2) CAPs outstanding for non-compliant PPGs.	*See #9 for Action Taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Education packets sent to non-compliant FFS and Direct Network providers. ▪ Ten (10) Provider Trainer Webinars conducted. ▪ Provider Office Wait Time data continues to reflect that providers meet the overall goal of 30 minutes or less for scheduled appointments in all three counties in Q4 2020. • Quality and Safety of Care: All three counties met or exceeded the DHCS Minimum Performance Level (MPL) in four of the six Default Enrollment Measures; The six measures are: o Childhood Immunization Combo 3 (Performance Improvement Project put on hold due to COVID-19) o Well Child Visits 3-6 years o Prenatal Care HbA1c Testing (Only Fresno County fell below the MPL for HbA1c testing.) o Controlling High Blood Pressure o Cervical Cancer Screening • Performance Improvement Projects (PIPs): The two PIPs initiated in 2020 were: o Childhood Immunizations (CIS-10) o Breast Cancer Screening Disparity Project Due to COVID-19 restrictions, both projects were closed by DHCS on June 30, 2020. • Other 2020 QI Activities:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o Chlamydia Screening in Madera County was initiated in 2020 and continues	
#9 2020 Annual Utilization Management Case Management Work Plan Evaluation; and 2021 UM Program Description Action David Hodge, MD, Chairman	Dr. Marabella presented the Annual Utilization Management Case Management Work Plan Evaluation. Utilization Management & Case Management focused on the following areas for 2020: • Compliance with Regulatory & Accreditation Requirements: o Licensure and credentialing requirements maintained. o Program documents and policies were updated to incorporate new regulatory requirements into practice. o DHCS Medi-Cal Managed Care Division Medical Director meetings attended by Medical Directors and CVH CMO. • Monitoring the UM Process: o Met all standards with the exception of Timeliness of Processing Authorization Requests for Q1 and Q2. A formal Corrective Action Plan was closed in Q3 2020. o Comparison of 2018 through 2020 demonstrates a significant increase in the volume of cases. • Monitoring Utilization Metrics: o UM Metrics for Monitoring Utilization was the one area that did not meet the objectives. This was due to an inability to accurately capture the data for specific DRGs and other barriers encountered, associated with the COVID-19 pandemic. o Care management initiatives for all members continued in 2020	**Motion:** Approve the 2020 Annual Quality Improvement Work Plan Evaluation and 2020 Annual Utilization Management Case Management Work Plan Evaluation; and 2021 UM Program Description *15 – 0 – 0 – 2* *(Naz / Griffin)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Monitoring Coordination with Other Programs and Vendor Oversight:
	  o All metrics met goal.
	• Monitoring Activities for Special Populations:
	  o CCS, SPD, CBAS, and Mental Health tracking and monitoring is ongoing.
	  o All monitoring activities met goals.
	
	• Utilization Management Program Description Changes include:
	  o Updated HN Mission and Purpose.
	  o Removed reference to Home Health from prior authorization information.
	  o Removed MHN from inpatient management.
	  o Updated Utilization Decision Criteria references.
	  o Re-ordered some sections, updated leadership titles, and made other minor updates.	

#10-14 • **10**. 2020 Annual Compliance Evaluation • **11**. 2021 Compliance Program Description • **12**. 2021 Code of Conduct • **13**. 2021 Anti-Fraud Plan • **14**. 2021 Privacy and Security Plan	MB Corrado reported on the Annual Compliance Evaluation, the Compliance Program Description and the Anti-Fraud Plan. No updates on the Code of Conduct and Privacy and Security Plan were needed. **<u>2020 Annual Compliance Evaluation</u>** 2020 DHCS Regulatory Oversite includes: • February 2020 DHCS Annual Audit – CAP issued 6/30/2020, in process. • DHCS 2018-2019 Performance Evaluation – final report issued 7/6/2020.	**Motion:** Approve 2020 Annual Compliance Evaluation, 2021 Compliance Program Description, 2021 Code of Conduct, 2021 Anti-Fraud Plan, and 2021 Privacy & Security Plan. *15-0-0-2 (Fields-Keene / Frye)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action David Hodge, MD, Chairman	• 2020 DHCS Annual Network Certification – CAP responses submitted 12/28/2020. • DHCS Contract Amendments – Four MC contract amendments were executed; DHCS has renewed the Plan's MC contract through 12/31/21. • COVID-19 – The Plan reported provider site closures, positive COVID-19 tests and hospitalization on a daily basis. 2020 DMHC Oversite includes: • Measurement Year (MY) 2019 Timely Access Report (TAR) – the annual MY2019 TAR was filed in May 2020 – currently in review. • February 2019 (Triennial) DMHC Audit – Final report issued 2/5/20 with deficiencies in four areas; two previously corrected. CAP for remaining two findings in process. 18-month follow-up desk-level audit to begin 3/1/21. Fraud, Waste, and Abuse Reporting: • 14 cases of potential fraud/abuse were reported to DHCS – 12 were provider-related; 2 were member related. • Most cases involved provider billing practices, providers billing the highest-level E & M codes for new and established patients, and provider prescribing practices. Privacy and Security Oversight: • New HIPAA risk analysis completed using HIPAA One. Nine privacy risks and 10 security risks identified. All privacy risks and 9 of the 10 security risks have been addressed. Privacy & Security Incidents/Breaches:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• 31 privacy and security incidents were reported to DHCS; 4 incidents occurred within CalViva Heath, 27 involved the Plan's Administrator Health Net. DHCS Notice of New Benefits, Waivers or Programs: • Due to the 2020 Public Health Emergency (PHE), DHCS received CMS approval to extend Section 1115(a) Waiver Program by 12 months. • CalViva Health and DHCS approved two provider applicants covering three Behavioral Health Integration (BHI) Incentive Programs for implementation. Due to the COVID-19 PHE, the start date and time period was delayed and changed to January 1, 2021 through December 31, 2022. • Conduct transition activities related to the carve-out of outpatient pharmacy benefits to Medi-Cal Rx program. In late November, 2020, DHCS deferred the pharmacy benefit transition from 1/1/2021 until 4/1/2021. Delegation Oversight: • Completed audits of Health Net services in 2020. • Monthly Management Oversight meetings. • Review monthly/quarterly performance metrics & key indicator data. • Joint Workgroups • On-going oversight of PPGs, specialty plans, and vendors. Trainings: • Employees passed all mandatory trainings. • Two new hires completed training.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member and Provider Communications: • 73 member communications were reviewed and approved in 2020. • 2020 Annual Mailing was sent • Reviewed and approved 34 informational letter templates and 17 forms for provider use. • 234 Provider Updates sent to providers. Provider Relations: • Completed 3,113 provider "touches" and 257 training visits in all three service counties. • Outreach activities modified due to COVID-19. No in-person training visits beyond March 2020. Appeals and Grievance Resolution: • Turn-Around Time was above 99% compliance. Independent Medical Reviews (IMRs) and State Hearings: • Total number increased for 2020 was 142 compared to 121 cases in 2019. Looking ahead for 2021: • Increased regulatory oversight and performance monitoring activity. o Declarations of the COVID-19 public health emergency will continue to be renewed and have ongoing impacts on Plan activities. o Prep for CalAIM program re-launches effective in 2022. o Preparation for Medi-Cal Rx "go-live" 4/1/21. o New COVID-19 related reporting.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o More focus on provider network adequacy and certification requirements. o Timely Access. o Clinical Quality Improvement (MCAS measures). **2021 Compliance Program Description** • Minor edit to reflect current practice where CCO prepared the Annual Compliance Program Evaluation. • Added Operations as an internal stakeholder. • Annual review, editorial changes. **2021 Code of Conduct** • No changes needed. **2021 Anti-Fraud Plan** • Edited section II to include the EOC/Member Handbook reference. • Added language section II regarding quarterly member service verification. • Minor clarifications to section II. • Annual review, editorial changes. **2021 Privacy and Security** • No changes needed.	
#15 Standing Reports • **Finance Report** Daniel Maychen, CFO	**Finance** **Financials as of December 31, 2020**: Total current assets were approximately $353M; total current liabilities were approximately $255.7M. Current ratio is 1.38. TNE as of	***Motion**: Standing Reports Approved* *15 – 0 – 0 – 2* *(Soares / Fields-Keene)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	December 31, 2020 was approximately $107.4M, which is approximately 679% above the minimum DMHC required TNE amount. For the first six (6) months of FY 2021 actual premium capitation income recorded was approximately $647.7M which is approximately $1.8M below budgeted amounts, primarily due to MCO tax being less than what was projected. In relation to revenue, the Plan experienced an MCO tax loss for the first six (6) months of FY 2021 of approximately $4.5M. This is a result of how DHCS calculates the MCO tax revenue rate, noting that DHCS' enrollment projection is a key component of that revenue rate calculation. Furthermore, there was a 25K member difference per month in what DHCS had projected (relating to the time-period of July 1, 2020 – December 31, 2020) in comparison to CalViva's actual membership, which created the MCO tax revenue shortage. DHCS has taken into consideration concerns of the Plan, as well as other plans, regarding the MCO tax loss and effective January 2021, they increased the MCO tax revenue rate. Assuming that enrollment is consistent with the current enrollment figure of 376,700 as of January 2021 (or higher), the increase for the MCO tax revenue amount beginning January 2021 is sufficient to cover the MCO tax expenses through June 2021. In addition, the increase in MCO tax revenue rate would be sufficient enough to cover the losses the Plan experienced for the first six months of FY 2021 assuming enrollment is consistent or better with January 2021 enrollment numbers. The Plan is projecting the $4.5M loss would be erased by the end of June 2021. In reference to the pharmacy carve out, communication from DHCS was received on 2/17/21 that they will be delaying the pharmacy carve out again and no new implementation date was provided. In addition, no further information on the delay will be provided until May 2021. The impact	*A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	of this on the Plan's current year financials is a larger difference between Actual vs. Budgeted revenue amounts, noting the actual amount will be higher. The two trade associations that the Plan is associated with wrote a letter to the State prior to the second delay stating if there is a second delay that it be moved to 1/1/2022 which would provide the State ample time to ensure a more seamless transition occurs. During an LHPC board meeting with CEOs of the local health plans, it was unanimous that they support not initiating the pharmacy carveout until 1/1/2022 due to the purchase of Magellan by Centene which presented a conflict of interest and cited other administrative issues. Total cost of medical care expense recorded is approximately $544.3M which is approximately $2.5M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense was $411K more than budgeted primarily due to enrollment being higher than projected. All other expense line items are in line or below what is budgeted. For the first six (6) months of fiscal year 2021, there is an approximate net loss of $1.3M, which is approximately $4.4M less than what was budgeted due to MCO tax loss of $4.5M. If accounting for increase in MCO tax revenue (assuming relatively similar enrollment as of January 2021 through the end of June 2021) total projected Net Income is approximately $7.6M which is in comparison to approximately $5.3M budgeted. **<u>Medical Management</u>**	
• **Medical Management** P. Marabella, MD, CMO	**Appeals and Grievances Dashboard**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Marabella presented the Appeals & Grievances Dashboard through year end 2020. The total number of grievances through year end 2020 is noted to be lower than year end 2019. The highest volume of grievances reported were in the "Exempt" grievance type, followed by "Quality of Service" grievance type. The volume of "Quality of Care" grievances decreased in 2020 when compared with 2019 volumes. The majority of Exempt Grievances fell under the category of "PCP Assignment/Transfer – Health Plan Assignment – Change Request". The total number of Appeals Received through year end 2020 increased when compared with year end 2019, with the majority falling under Pre-Service Appeals. The Uphold and Overturn ratio has improved. **Key Indicator Report** Dr. Marabella presented the Key Indicator Report year end 2020. Overall membership for 2020 increased.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In-hospital utilization rates decreased in all areas for year end 2020 compared to 2019. The lower ER Visits may be related to the COVID-19 pandemic and the aversion to the emergency department. Case Management results for YTD 2020 demonstrated positive trends in all areas. **QIUM Quarterly Report** Dr. Marabella provided the QI/UM Qtr. 4, 2020 update. Two QI/UM meetings were held in Quarter 4; one in October and one in November. The October meeting was reported on at the November Commission meeting. This report covered the November meeting. The following general documents approved at this meeting were: • Pharmacy Formulary & Provider Updates. • Public Health & County Relations Policies & Procedures. The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard, Potential Quality Issues (PQI) Report, MHN Performance Indicator Report for Behavioral Health, Facility Site and Medical Record Review & PARS, and Initial Health Assessment Quarterly Audit Report. Additional Quality Improvement reports included: County Relations Quarterly Report, CCS Report, and the Provider Preventable Conditions Report. Two Access Related reports presented were the Provider Office Wait Time and Specialty Referral Report.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The Utilization Management & Case Management reports reviewed were the Key Indicator Report, the UM Concurrent Review Report, the UM IRR Report, and the Case Management & CCM Report. Pharmacy reports reviewed included Pharmacy Call Report, Operation Metrics, Top 30 Medication Prior Authorizations, and the Inter-rater Reliability Report. All reports met standards. HEDIS® Activity: In Q4, HEDIS® related activities focused on analyzing the results for RY2020 under the new Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. The areas CalViva reported results below the 50th percentile MPL were: • Antidepressant Medication Management, for both the Acute Phase and the Continuation Phase, for all three counties. • Adolescent Well-Care Visits for Fresno County. • Breast Cancer Screening for Fresno County. • Chlamydia Screening for Madera County. • Childhood Immunizations – Combo 10 for Fresno and Kings counties. • Well-Child Visits in the first 15 months of life for Fresno and Kings counties. The two Performance Improvement Projects (PIPs) for RY 2020 consisted of: • Childhood Immunizations – Combo 10	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Breast Cancer Screening Disparity Project On November 2nd CalViva submitted notification to DHCS of intent to re-establish Performance Improvement Projects (PIPs) for these two measures. Each MCP is also required to develop one PDSA rapid cycle improvement project from the MCAS measures. For the Plan's PDSA project, Medical Management submitted the initial plan for improvement for Chlamydia Screening in Madera County. This plan was accepted by DHCS and intervention implementation is underway. New this year, each Plan is required to report on what is called the "COVID-19 Quality Improvement Plan (QIP)". This is a selection of 3 or more improvement strategies that demonstrate how the Plan has/will adapt to improve the health/wellness of its members during the COVID 19 Emergency. These interventions are to be associated with preventive services, chronic illness and/or behavioral health. The initial CalViva COVID-19 QIP report was submitted to DHCS on October 21st, 2020 and has been accepted by DHCS. The 3 improvement strategies include: **1.** Antidepressant Medication Management (AMM) Member Outreach effort by Behavioral Health Case Managers in Kings and Madera counties to encourage medication adherence. **2.** Adolescent Well-Care Visits addressed through a MemberConnections Outreach intervention for families in Fresno County.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Operations** J. Nkansah, COO	**3.** Pharmacy Outreach effort to encourage medication adherence for patients on blood pressure medications and/or anti-diabetic agents in Fresno County. **<u>Operations Report</u>** For IT Communications and Systems to date there are no issues or concerns. J. Nkansah also informed the Commission about two prominent breaches/hacks involving two prominent IT companies: SolarWinds and SonicWall. Neither the SolarWinds breach or the SonicWall hack has impacted CalViva Health in any way. Continued monitoring is ongoing. For Privacy and Security, a Risk Analysis is completed annually and will be conducted again in 2021 with a new HIPAA One auditor. The Notice of Privacy Practices (NPP) mailing to members is on hold due to the Pharmacy Carveout delay; future mailing date is unknown at this time. The NPP is incorporated within the Member Handbook / Evidence of Coverage ("EOC") which is mailed to members. The Pharmacy Carveout delay has impacted the mailing date of the 2021 EOC. For the Member Call Center, the Transportation Call Center service level compliance goal was met in November and December 2020 thus raising the service level percentage in Q4 2020 to just below the 80% goal metric. The newly redesigned CalViva Website was demoed to members of the Public Policy Committee, which included enrolled CalViva members and representatives of community-based organizations in December of 2020. Positive feedback was received and	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** G. Hund, CEO	the new design of the website is now live as of December 28, 2020. Analytics are being tracked. With reference to Provider Network Activities, the 2020 DHCS Annual Network Certification corrective action plan was related to a failure to meet time and distance standards for certain provider types. In 2020, DHCS changed the metric and standard from time *and* distance, however, in 2021, they are changing it back to time *or* distance. Quarter 3 2020 numbers are available for Claims Processing and Provider Disputes. Goal was met in most areas. **Executive Report** Membership as of the end of January 2021 increased to 376,770 members. Market share continues to trend down at a slow rate. An analysis was completed with results showing CVH members are not moving to ABC; ABC is capturing new members through Choice. Future discussions with Health Net are scheduled to discuss a plan to turn the market share trend line upward. The Annual Report was emailed to all Commissioners, with a hard copy sent via US Mail. Marketing RFIs were received on 2/8/21 and after careful review by the Marketing Committee, JSA will continue on as the Plan's ad agency.	
#16 Closed Session **A.** Government Code section 54957(b)(1) – Public Employee	Jason Epperson, General Counsel, reported out of Closed Session. Commissioners discussed those items agendized for closed session discussion. Specifically, #16.A Public Employee Appointment, Employment, Evaluation, or Discipline pursuant to Government Code	***6.A No Motion; Information only*** ***6.B Motion****:* *15 – 0 – 0 – 2* *(Naz / Nikoghosian)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Appointment, Employment, Evaluation, or Discipline – Staffing (*Information Only*) **B.** Government Code section 54957(b)(1) – Public Employee Appointment, Employment, Evaluation, or Discipline – Staffing (*Confidential – Action Required*)	section 54957(b)(1). An ad-hoc committee will be appointed to construct a contract for the new CEO; members of the ad-hoc committee will be reported at the March meeting. Closed Session concluded at 3:14 pm. *Sara Bosse departed at end of Closed Session* *Ed Hill departed at end of Closed Session* *Paulo Soares departed at end of Closed Session*	*A roll call was taken*
#17 Final Comments from Commission Members and Staff	None.	
#18 Announcements	CalViva Health's 10 Year Anniversary is March 1, 2021.	
#19 Public Comment	None.	
#20 Adjourn	The meeting was adjourned at 3:18 pm The next Commission meeting is scheduled for March 18, 2021 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #4

Attachment 4.B

Finance Committee Minutes
dated 11/19/2020

CalViva Health
Finance
Committee Meeting Minutes

November 19, 2020

Meeting Location
Teleconference Meeting due
to COVID-19 Executive Order
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Office Manager
✓	Gregory Hund, CEO	✓	Jiaqi Liu, Accounting Manager
✓•	Paulo Soares		
✓•	Joe Neves		
	Harold Nikoghosian		
✓•	David Rogers		
✓•	John Frye		
		✓	Present
		*	Arrived late/Left Early
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:30 am. A quorum was present via conference call in lieu of gathering in public per executive order signed by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of Commissioners' physical attendance at the public location or by teleconferencing.	A roll call was taken.

#2 Finance Committee Minutes dated October 15, 2020 Attachment 2.A Action D. Maychen, Chair	The minutes from the October 15, 2020 Finance meeting were approved as read.	Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Hund / Frye)* A roll call was taken.
#3 Financial Statements as of September 30, 2020 Action D. Maychen, Chair	Total current assets were approximately $283.8M; total current liabilities were approximately $186.6M. Current ratio is 1.52. TNE as of September 30, 2020 was approximately $107.4M, which is approximately 724% above the minimum DMHC required TNE amount. For July 2020 through September 2020 actual premium capitation income recorded was approximately $320.5M which is approximately $4.25M below budgeted amounts, primarily due to MCO tax being less than what was projected, and rates being less than budgeted. The MCO tax loss is decreasing due to an increase in enrollment; however, is still creating a material loss to the Plan. From July 2020 to September 2020, the Plan has incurred an approximate $2.5M MCO tax loss. Furthermore, assuming enrollment remains relatively consistent, the projected tax loss of approximately $4.3M for the period of July 2020 through December 2020 is expected. DHCS has acknowledged and are keeping track of the MCO tax loss the Plans are experiencing, and are currently assessing potential solutions; the timing of any adjustments is yet to be determined. In addition, DHCS is in the process of creating their MCO tax revenue rate for the period of January 2021 through June 2021; those rates should be received late December 2020. Total cost of medical care expense recorded is	Motion*: Approve Financials as of September 30, 2020* *6 – 0 – 0 – 1* *(Frye / Soares)* A roll call was taken.

	approximately $269.2M which is approximately $1.7M less than budgeted due to rates being less than projected. All other expense line items are in line or below what is budgeted. For the first three months of fiscal year 2021, there is an approximate net loss of $1.3M, noting Net Income is approximately $2.5M less than budgeted, primarily due to the MCO tax loss.	
#5 Announcements	The implementation of the Medi-Cal pharmacy services transition slated for January 1, 2021 has been delayed to April 1, 2021. DHCS confirmed the pharmacy component will be added back to the Plan's rates as of January 2021 through March 2021. This will cause revenue rates to be higher than what was budgeted. Gross revenue impact will be approximately $54M, and net income impact will be approximately $800K in additional net income to CVH. A large national organization has expressed interest in leasing the vacant space available in the building which will potentially require approximately $400K of TI's. Response to their RFP will be given the week of November 23, 2020.	
#6 Adjourn	Meeting was adjourned at 11:50 am	

Submitted by: Cheryl Hurley
Cheryl Hurley, Clerk to the Commission

Dated: Feb. 18, 2021

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 2/18/2021

Item #4

Attachment 4.C

QIUM Committee Minutes
dated 11/19/2020

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

November 19th, 2020

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	✓	**Mary Lourdes Leone**, Director of Compliance
✓•	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers	✓	**Ashelee Alvarado**, Medical Management Specialist
✓*•	**Raul Ayala, MD, Adventist Health**, Kings County	✓	**Lori Norman**, Compliance Manager
✓•	**Joel Ramirez, M.D.,** Camarena Health Madera County	✓	**Hyasha Anderson**, Medical Management Coordinator
✓•	**Rajeev Verma, M.D.,** UCSF Fresno Medical Center	✓	**Mary Martinez**, Medical Management Nurse Analyst
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA (**Alternate**)		
	Guests/Speakers		

✓ = In attendance
* = Arrived late/left early
• = Attended via Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D, Chair	The meeting was called to order at 10:32 am. A quorum was present.	
#2 **Approve Consent Agenda** - Committee Minutes: October 15th, 2020 - Provider Preventable Conditions (Q3) - Standing Referrals	The October 15th, 2020 QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. An update was provided on the MediCalRx transition (pharmacy function) which has been delayed to 04/01/2021 due to state focus on COVID issues over recent months. Also, CalViva will have a DMHC 18-month Follow-up Audit on 03/01/2021. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member.	Motion: Approve Consent Agenda (Foster/Ayala) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Report (Q3) - Appeals & Grievances Inter-Rater Reliability Report (Q3) - Appeals & Grievances Classification Audit Report (Q3) - Customer Contact Center DMHC Expedited Grievance Report (Q3) - California Children's Service Report (Q3) - Pharmacy Provider Update (Q3) - Compliance Update (Attachments A-I) Action Patrick Marabella, M.D Chair	Dr. Ayala arrived at 10:35 am.	
#3 **QI Business** - Appeals & Grievances Dashboard (September) - Appeals & Grievances Executive Summary (Q3) - Appeals & Grievances Quarterly Member	Dr. Marabella presented the Appeals & Grievances Dashboard through the end of Q3 2020. ➢ The total number of grievances through Q3 has remained relatively consistent with Q2, but is noted to be lower than Q1 2020 and previous quarters. ➢ The majority of grievances were due to Exempt grievances followed by Quality-of-Service issues. ➢ Quality of Care grievances have decreased from both Q1 and Q2 2020.	Motion: Approve - Appeals & Grievances Dashboard (September) - Appeals & Grievances Executive Summary (Q3) - Appeals & Grievances Quarterly Member Report (Q3) - Quarterly A&G Member

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Report (Q3) - Quarterly A&G Member Letter Monitoring Report (Q3) (Attachment J-M) Action Patrick Marabella, M.D, Chair	The Exempt grievances for Q3 have remained consistent with Q2 2020. The two categories stated as "PCP Assignment/Transfer" that were labeled incorrectly have been modified to better reflect the issues. The total number of Appeals Received as of the end of Q3 2020 has demonstrated variation quarter to quarter with increased volumes compared to the prior year. Opportunities to further evaluate these appeals and educate providers have been identified, and training has been conducted.	Letter Monitoring Report (Q3) (Verma/Ramirez) 6-0-0-2
#3 **QI Business** - Potential Quality Issues Report (Q3) (Attachment N) Action Patrick Marabella, M.D, Chair	<u>Potential Quality Issues (PQI) Report</u> 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 issues originate during the provision of care or services when the omission or commission of care interventions results in potential harm to the member. PQI issues may be identified during the Utilization Management, Care Management, Appeal and Grievance review processes or other activities such as the Provider Preventable Conditions reporting process, which includes Health Care Acquired Conditions (HCAC) or Other Preventable Provider Conditions (OPPCs). PQI reviews are separated into three types: member generated, non-member generated, or identified through peer review activities. ➢ Non-member initiated PQI category cases are lower for Q3 2020 when compared to the last three Quarters. None (0) of these cases were generated from Provider Preventable Conditions (PPCs). ➢ Member generated PQI raw numbers have also decreased when compared to the previous three Quarters. ➢ There were eight (8) peer review cases processed during this reporting period. Follow up has been initiated when appropriate. PQI and PPC cases will continue to be tracked, monitored and reported.	Motion: Approve - Potential Quality Issues Report (Q3) (Ramirez/Foster) 6-0-0-2
#3 **QI Business** - MHN Performance Indicator Report for Behavioral Health	The MHN Performance Indicator Report for Behavioral Health Services (Q3 2020) was presented. 15 out of the 15 metrics met or exceeded their targets. ➢ Timeliness was acceptable for ABA authorization decisions. Although the measure did not meet the 100% target, it exceeded the threshold for action of 95%.	Motion: Approve - MHN Performance Indicator Report for Behavioral Health

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Services (Q3) (Attachment O) Action Patrick Marabella, M.D, Chair	➢ The Q2 2020 utilization rate was 2.2%. Utilization of services is demonstrating quarter over quarter increases over the past 12 months. (one quarter lag) ➢ There were three non-life-threatening emergent cases and the appointment access standard was met. There were two life-threatening emergent cases and the appointment access standard was met. ➢ There were two PQI cases in Q3 2020 and they were resolved within timeliness standards. MHN Provider Relations staff have implemented several interventions to increase the percentage of providers accepting new CalViva members.	Services (Q3) (Foster/Ramirez) 6-0-0-2
#3 **QI Business** - Facility Site & Medical Record Reviews & PARS Review Report (Q1 & Q2) (Attachment P) Action Patrick Marabella, M.D, Chair	The Facility Site Review (FSR) & Medical Record Review (MRR) & PARS Report was presented and reviewed for the first and second Quarters of 2020. ➢ There were eight (8) Facility Site Reviews (FSR) and eight (8) Medical Record Reviews (MRR) completed in the 1st and 2nd Quarters of 2020. ➢ The overall mean FSR score for Fresno, Kings and Madera Counties was 99% for the 1st and 2nd Quarters of 2020 and the mean FSR score for the 3rd and 4th Quarters of 2019 was 97%. ➢ The overall mean MRR score for Fresno, Kings and Madera Counties was 91% for the 1st and 2nd Quarters of 2020. The mean MRR score for the 3rd and 4th Quarters of 2019 was 93%. ➢ The Pediatric Preventive Care section mean score was 83%. ➢ The Adult Preventive Care section mean score was 86%. ➢ Due to COVID-19, the onsite Facility Site Reviews were stopped after March 13, 2020. The data above reflects sites reviewed prior to stoppage.	Motion: Approve - Facility Site & Medical Record Reviews & PARS Review Report (Q1 & Q2) (Verma/Ramirez) 6-0-0-2
#3 **QI Business** - Initial Health Assessment Quarterly Audit Report (Q3) (Attachment Q) Action Patrick Marabella, M.D, Chair	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. A multi-faceted approach to monitoring is performed for CalViva members to facilitate IHA completion and includes the following: 1. Medical Record Review (MRR) via onsite provider audits. 2. Monitoring of claims and encounters data. 3. Member outreach following a three-step methodology. <u>FSR/MRR Data:</u> Due to the COVID-19 public health emergency, the DHCS APL 20-004 to temporarily halt requirements to complete IHA's from December 1, 2019 to the end of the public health emergency currently in effect. Additionally, there were no on-site medical record reviews completed due to COVID-19.	Motion: Approve - Initial Health Assessment Quarterly Audit Report (Q3) (Ramirez/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Outreach: Three Step outreach includes: 1. Notification of the IHA in the New Member Packet 2. A new member welcome call 3. An IHA postcard mailed to new members Based upon a DHCS Corrective Action Plan (CAP) CalViva is developing a quality improvement activity for IHA/IHEBA completion. This is being accomplished through collaboration with a low-performing IHEBA provider and a high-performing IHEBA provider to identify barriers and test interventions for improvement. Focus at this time is on obtaining the New Member List and addressing coding issues for IHEBA.	
#3 **QI Business** - County Relations Quarterly Update Report (Q3) (Attachment R) Action Patrick Marabella, M.D, Chair	County Relations Quarterly Report Q3 2020 This report provides a summary of the relevant Public Health (PH), County Behavioral Health (BH) and Regional Center (RC) activities, initiatives and updates for Fresno, Kings and Madera Counties. The report also provides CalViva Health with information that includes but is not limited to; care coordination updates, PH/BH referral data, tuberculosis data and ABA services data. All these activities support CalViva Health's compliance with requirements of the Memorandum of Understanding between CalViva Health and the Central Valley counties (Fresno, Kings, and Madera). Some Highlights for this Quarter include: Q3 2020 updates for the Fresno County Department of Behavioral Health (FCDBH): ➢ Many of the FCDBH staff are still primarily working remotely or working from home but where in-person services are required, those services are being provided with PPE, social distancing, etc. ➢ FCDBH advised that their Crisis Continuum has remained fully operational throughout the COVID-19 pandemic: o Crisis Stabilization Center o Crisis Rehabilitation Treatment Program o Psychiatric Health Facilities (PHFs) ➢ FCDBH advised that their Crisis Residential Treatment Program and Inpatient Psychiatric Health Facilities have remained constantly full and that they have explored the possibility of expanding capacity to include spaces for youth. They inquired on whether or not DHCS would grant them a	Motion: Approve - County Relations Quarterly Update Report (Q3) (Foster/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	waiver to include spaces for youth. This was in response to local hospitals reporting an increase in the number of youths being admitted for suicide attempts. ➢ KCBHD continues to collaborate with the Office of Education and School Districts in Kings County to ensure that school staff, parents and children have the proper behavioral health supports during distance learning ➢ KCBHD continues to work on the transition to Wellpath/California Forensic Medical Group (CFMG) as their new healthcare provider for the jail and juvenile center. Wellpath/CFMG is providing behavioral healthcare, as well as substance use disorder treatment in the county jail and juvenile center. ➢ Madera Community Hospital receive a Bridge Program Grant and will now have a BH counselor/navigator in their ED 7 days a week. ➢ MCBHD advised that Turning Point has now gone live with it's First-Episode Psychosis Program and MCBHD will be working very closely with this program to refer youth for services. Turning Point will work with the children to help provide linkage to services, with a special focus on keeping them in services. The goals of this program are as follows: o Reduce Hospitalizations o Increase linkage to psychiatric services o Increase engagement in services o Turning Point will provide Mental Health First Aid to families, psychoeducation, etc. ➢ The CVRC office remain closed due to COVID-19, but remains fully operational with staff working remotely and providing services virtually. There are some limited services being offered face-to-face within the CVRC offices and within some CVRC vendor offices. Quarter 3 data for BH referrals, TB screening and CCS enrollment in Fresno, Kings and Madera counties were also reviewed.	
#4 **Access Business** - Provider Office Wait Time Report (Q3) (Attachment S) Action	**Provider Office Wait Time Report (Q3 2020)** Health plans are required to monitor waiting times in providers' offices to validate timely access to care and services. This report provides a summary that focuses on Quarter 3 2020 wait times for Fresno, Kings and Madera Counties. All counties are within the 30-minute office wait time threshold for both mean and median metrics. Outliers are tracked with follow up occurring when thresholds are passed. Results of monitoring are reported back to the participating providers. Monitoring and analysis will continue in 2021	Motion: Approve - Provider Office Wait Time Report (Q3) (Ayala/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D, Chair	to identify opportunities for improvement associated with specific providers.	
#4 **Access Business** - Specialty Referrals Report – HN (Q3) (Attachment T) Action Patrick Marabella, M.D, Chair	**Specialty Referrals Report – HN (Q3)** The Health Net Specialty Referrals Report provides a summary of Specialty Referral Services that require prior authorization in the tri-county area, (Fresno, Kings, Madera) for the third quarter of 2020. This report provides evidence of the tracking process in place to ensure appropriate access to specialty care for CalViva Health members in 3 areas: o Key services that while within the service area and within the network require clinical review o Services recognized as out of the tri-county area, but within the provider network o Out of network requests These reports provide evidence of a system-wide process for tracking and following up on member referrals requiring prior authorization, and includes a breakdown of SPD and non-SPD member specialty referral requests. CalViva specialty referrals will continue to be monitored quarterly by the Calviva Health Quality Improvement/Utilization Management Committee in collaboration with the CalViva Chief Medical Officer to assess for network adequacy and appropriate quality specialty care for CalViva members.	Motion: Approve - Specialty Referrals Report – HN (Q3) (Verma/Cardona) 6-0-0-2
#5 **UM Business** - Key Indicator Report (September) - Utilization Management Concurrent Review Report (Q3) - Concurrent Review IRR Audit Report (Q3) (Attachment U-W) Action	**Key Indicator Report** Dr. Marabella presented the Key Indicator Report through Q3, 2020. ➢ In-hospital utilization rates have dipped in all areas in Q3. The lower admission numbers may be related to the spikes in COVID-19 cases throughout the year. ➢ Turn-around time compliance in Q3 was 100% ➢ Case Management results in 2020 continue to demonstrate positive trends in all areas. ➢ The Concurrent Review IRR Report provides a summary of the quarterly CCR audit performed to ensure consistent, credible and timely medical management decisions. Overall results were positive at 98% compliance for the quarter.	Motion: Approve - Key Indicator Report (September) - Utilization Management Concurrent Review Report (Q3) - Concurrent Review IRR Audit Report (Q3) (Foster/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D, Chair		
#5 **UM Business** - Case Management and CCM Report (Q3) (Attachment X) Action Patrick Marabella, M.D, Chair	The **Case Management and CCM Report** for Quarter 3 was presented. This report summarizes the case management, transitional care management, MemberConnections, and palliative care activities for 2020 through third quarter. ➢ All programs have demonstrated an increase in referrals and open cases over recent months, except Perinatal Case Management with their referral rate staying about the same this quarter compared to last. Some increases were significant. ➢ Engagement rates have remained strong. ➢ Case Management Outcome measures have been established for all programs.	Motion: Approve - Case Management and CCM Report (Q3) (Foster/Cardona) 6-0-0-2
#6 **Policy & Procedure** - Public Health & County Relations Policy Grid (Attachment Y) Action Patrick Marabella, M.D, Chair	Public Health Policy and Procedure Review grid was presented to the committee. The majority of policies were updated without changes or had minor edits. ➢ Departmental responsibility changed for some policies from Public Programs to County Relations. ➢ The Family Planning Policy had language updated to be consistent with APL 20-013 Proposition 56 Direct Payments for Family Planning Services which allows for add-on payments to providers for certain family planning services. The policy edits were discussed and the Public Health and County Relations policies were approved.	Motion: Approve - Public Health & County Relations Policy Grid (Verma/Foster) 6-0-0-2
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q3) - CalViva Health Pharmacy Call Report (Q3) - Pharmacy Operations Metrics (Q3) - Top 30 Prior Authorizations (Q3)	Pharmacy reports for Quarter 3 2020 were reviewed in order to assess for emerging patterns in authorization requests, compliance around prior authorizations, and to evaluate the consistency of decision making in order to formulate potential process improvement recommendations. ➢ Pharmacy Prior Authorizations (PA) metrics were within 5% of standard for third Quarter 2020. PA turnaround time is monitored to identify PA requests that are approaching required turnaround time limits. ➢ Third Quarter 2020 top medication PA requests were similar to second Quarter 2020. ➢ Third Quarter 2020 Opioid and Diabetes control PA requests continue to be the top driver of PA volume. ➢ Belviq and Belviq XR were withdrawn from the market due to cancer safety risk.	Motion: Approve - Pharmacy Executive Summary (Q3) - CalViva Health Pharmacy Call Report (Q3) - Pharmacy Operations Metrics (Q3) - Top 30 Prior Authorizations (Q3)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Pharmacy Inter Rater Reliability Report (IRR)(Q3) (Attachment Z-DD) Action Patrick Marabella, M.D, Chair	➢ The Interrater Reliability Report summarizes an evaluation of a sample of 10 prior authorization denials per month which are reviewed quarterly to ensure they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold of 90%. Results met the 95% threshold. Results are shared with PA managers.	- Pharmacy Inter Rater Reliability Results (IRR)(Q3) (Ramirez/Cardona) 6-0-0-2
#6 **Credentialing and Peer Review Subcommittee Business** - Credentialing Subcommittee Report Q2 - Peer Review Subcommittee Report Q2 (Attachment EE-FF) Action Patrick Marabella, M.D, Chair	In Quarter 4 the Credentialing Sub-Committee met on October 15, 2020. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q2 2020 were reviewed for delegated entities, the second and third quarters for MHN and Q3 2020 reports were reviewed for Health Net. There was 1 (one) ongoing case to report on the Quarter 3 2020 Credentialing Report from Health Net. This is related to ongoing monitoring of a case in Fresno County following a denial for re-entry into the network. Next report on this case will be in 6 months. The Peer Review Sub-Committee met on October 15, 2020. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2020 were reviewed for approval. There were no significant cases to report. The Q3 2020 Peer Count Report was presented with a total of 8 cases reviewed. There were three (3) cases closed and cleared. There were no cases pending closure for Corrective Action Plan compliance. There were five (5) cases pended for further information. Follow up will be initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue. No significant compliance issues have been identified. Oversight and monitoring processes will continue.	Motion: Approve - Credentialing Subcommittee Report Q2 - Peer Review Subcommittee Report Q2 (Cardona/Foster) 6-0-0-2
#7 **Public Comment**	None	
#8 **Adjourn** Patrick Marabella, M.D, Chair	Meeting was adjourned at 11:59 am.	

NEXT MEETING: February 18th, 2021

Submitted this Day: February 18th 2021

Submitted by: Amy K Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #4

Attachment 4.D

Public Policy Committee Minutes
dated 12/2/2020

Public Policy Committee
Meeting Minutes
December 2, 2020

Teleconference Meeting due
to COVID-19 Executive Order
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
	Leann Floyd, Kings County Representative		**Staff Members**
✓•	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Community Relations Director
✓•	Kristi Hernandez, At-Large Representative	✓	Cheryl Hurley, Commission Clerk
✓•	Kevin Dat Vu, Fresno County Representative	✓	Greg Hund, CEO
✓•*	Norma Mendoza, At-Large Representative	✓	Dr. Marabella, CMO
		✓	Amy Schneider, RN, Director of Medical Management
		✓	Mary Lourdes Leone, Director of Compliance
		✓	Steven Si, Operations & Privacy Specialist
		✓	Lori Norman, Compliance Manager
		✓•	Jeff Nkansah, COO
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:30 am. A quorum was present via conference call in lieu of gathering in public per executive order signed by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of	A roll call was taken.

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Commissioners' physical attendance at the public location or by teleconferencing.	
#2 Meeting Minutes from September 2, 2020 **Action** Joe Neves, Chair	The September 2, 2020 meeting minutes were reviewed. There were no discrepancies.	**Motion:** Approve September 2, 2020 Minutes 7-0-0-2 (R. Garcia / K. Dat Vu) A roll call was taken.
#3 Enrollment Dashboard Information Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the enrollment dashboard through October 2020. Membership as of the end of October was 370,845. CalViva Health maintains a 70.32% market share.	**No motion**
#4 Public Policy Committee Charter 2020 **Action** Joe Neves, Chair	Tabled until 2021.	**No Motion**
#5 Health Education *2020 Executive Summary & Work Plan Mid-Year Evaluation* **Information** Steven Si, Operations & Privacy Specialist	The 2020 Health Education Work Plan Mid-Year Evaluation was presented to the PPC Committee. In summary, the report documents progress of 19 program initiatives. Of the 19 initiatives, 12 key initiatives with 27 objectives are on track to meet the year-end goal. The remaining 7 initiatives with 17 objectives are off track to meet year end goal mainly due to the COVID-19 pandemic. *David Phillips arrived at 11:40 am*	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#6 Cultural and Linguistics *2020 Executive Summary & Work Plan Mid-Year Evaluation* *2020 Summary & Language Assistance Program Mid-Year Report* **Information** Steven Si, Operations & Privacy Specialist	The 2020 Cultural & Linguistics (C&L) Work Plan Mid-Year Evaluation was presented to the PPC Committee. In summary, the report provided information on the C&L Services Department work plan activities, which are based on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. As of June 30, all activities are on target to be completed by the end of the year with some already completed. • Thirty-five staff completed their bilingual assessment/ re-assessment • Sixty-five materials were reviewed for readability level, content and layout • Fifty-four translation reviews were coordinated to ensure accuracy and completeness of translation • Thirty-Five C&L related grievances reviewed and seven cases identified for interventions • Conducted eight trainings for staff on Health Literacy, ACEs, Motivational Interviewing, Gender-Neutral Language, and Cultural Competency • Population Needs Assessment completed in collaboration with Health Education and Quality Improvement departments • Leading workgroup meetings with local CBO partner to plan all components of the Breast Cancer Screening Performance Improvement Project	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• Launched CalViva Community Connect (Aunt Bertha) websites for staff and community/members The C&L Language Assistance reports provide information on the language services utilization by CalViva Health members for January 1 to June 30, 2020 as well as updates on Language Assistance Program (LAP) areas. This report also incorporates MHN Services' Mental Health/Behavioral Health language utilization by CalViva Health members for the same reporting period. A summary of Q1 and Q2 services provided the following information: • Member Services Department representatives handled a total of 49,971 calls across all languages. • A total of 1,888 interpreter requests were fulfilled for CalViva Health members. • MHN Services' Member Services Department representatives handled a total of 2,240 across all languages. • There were 85 requests for interpreter services that were fulfilled. • No requests for Written/Oral/Alternate Format Translations were received from CalViva Health members during this reporting period. • A total of 65 English material reviews completed for CalViva Health documents/materials, including the member newsletter.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• A total of 35 grievance cases were received and reviewed by C&L. C&L language assistance services utilization and language assistance program updates are mostly consistent with previous reporting periods. Interpreter requests particularly for face-to-face interpretation increased slightly compared to same reporting period in 2019. Additionally, while the total membership decreases slightly, the percent of LEP members increased by one percent. The Plan will continue to track C&L and MHN Services language services utilization and program updates and report to QI/UM committee on a semi-annual basis.	
#7 Medical Management *MY 2019 HEDIS Data Results* **Information** Patrick Marabella, MD	Dr. Marabella provided an update on HEDIS®: Managed Care Accountability Set (MCAS). Overall CalViva performed well on the new MCAS with the 50th percentile minimum performance level. Reporting Year 2020 (RY20) data reflects care and services provided during calendar year 2019. Some allowances were made for RY20 due to some of the limitations on data capture associated with the pandemic. All three counties were below the minimum performance levels (MPL) for Antidepressant Medication Management Acute Phase and Antidepressant Medication Continuation	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Phase. This is a new measure for this year. Our COVID-Quality Improvement Project (QIP) includes a Member Outreach effort by Behavioral Health Case Managers in Kings and Madera counties to encourage medication adherence. Fresno County fell below the MPL for Adolescent Well-Care Visits. This will be addressed through a MemberConnections Outreach intervention associated with our new COVID-Quality Improvement Project. Fresno and Kings counties fell below the MPL for Breast Cancer Screening, Childhood Immunizations- Under 2 Years, and Well Child Visits-First 15 Months. Two Performance Improvement Projects (PIPs) that were started approximately 1 year ago and placed on "pause" by the state due to the pandemic, will be restarted in the first quarter of 2021 to address these opportunities for improvement. Madera County fell below the MPL for Chlamydia Screening. A PDSA Improvement Project is being initiated with a high volume, low compliance provider in Madera County to improve compliance with this measure.	
#8 Quarterly Appeals and Grievance Report **Information** Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the appeals, grievances and complaints report for Q3 2020. Total appeals and grievances for Q2 2020 were 514. Total appeals for Q3 2020 were 267. Total grievances for Q3 2020 were 247. Turnaround time compliance standard was met at 100%. The majority of appeals and grievances were from members	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	in Fresno County which has the largest CalViva Health enrollment.	
#9 2020 DHCS Audit Update; 2021 DMHC 18-Month Follow-up Audit **Information** Mary Lourdes Leone, Director of Compliance	The 2020 DHCS audit required the Plan to submit monthly updates on the progress of implementing corrective actions. The last update was filed 11/30/2020. Regarding the upcoming 2021 DMHC 18-month follow-up audit, DMHC will not be onsite. The required information was filed with DMHC on 12/1/2020. The audit is looking for specific improvements the Plan has made in communicating clear and concise information on appeals that have been filed with DMHC.	**No motion**
#10 Medi-Cal RX **Information** Mary Lourdes Leone, Director of Compliance	In reference to the Medi-Cal RX executive order in 2019 by the Governor of California to transition Medi-Cal pharmacy services from managed care delivery system to fee for service delivery system effective 1/1/21, the State has postponed the transition to 4/1/2021 due to the COVID-19 pandemic and other challenges with implementing the transition.	
#11 CalViva Health Website **Information** Courtney, Director Community Relations	The new CalViva Health website has been redesigned with the goal to be more user friendly and ADA compliant for members. The Public Policy Committee was polled for their suggestions and feedback. The goal is for the new website to go live prior to January 1, 2021.	
#12 Final Comments from Committee Members and Staff	Self-Help is finishing a project in Patterson.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	KCAO is working with the County Health Dept to economically help families that have tested positive for COVID-19. In addition, helping essential workers with child care. United Health Centers (UHC) is partnering with the City of Fresno for drive through COVID testing at the Fresno Fair Grounds. In addition, they have opened a drive through testing site in Clovis as well. UHC has opened seven (7) new health centers during 2020. Greg Hund, CEO for CVH, announced the Board approved additional funding to various organizations in all three counties in response to the COVID-19 pandemic. In addition, March 1, 2021 is the 10th anniversary for CalViva Health as an operating Plan. Courtney Shapiro reported that CVH is continuing with sponsorships, and partnering with different organizations to bring flu shot clinics and vision clinics, assistance with foster youth in Fresno and Madera counties, adopt-a-family for the holiday, toy drive with Reading Heart, and Presents on Patrol with Lemoore Police Department to name a few. Tony Gonzalez reported the CVH Health Education department presented to the Fresno County Migrant Education program during their annual conference on 11/14/2020 in the areas of nutrition and physical activity during the pandemic. Tony Gonzalez also acknowledged	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Norma Mendoza and Promotores for the work they are doing via Zoom to continue engaging the community during the pandemic on available resources and connecting families to testing sites.	
#13 Announcements	Next scheduled PPC meeting is March 3, 2021.	
#14 Public Comment	None.	
#15 Adjourn	Meeting adjourned at 12:39 pm.	

NEXT MEETING **March 3, 2020 in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: March 3, 2021

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

Approval Date: March 3, 2021

Approved By: Joe Neves
Joe Neves, Chairman

Item #5

Attachments 5.A – 5.B

- BL 21-004 Independent Auditors Moss Adams
  - Audit and Non-Attest Services Proposal

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

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 18, 2021

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Daniel Maychen, CFO

RE: Reappoint Moss Adams as Independent Auditors

BL #: 21-004
Agenda Item 5
Attachment 5.A

BACKGROUND:

Whereas the Auditor-Controller, with the approval of the Commission, shall contract with an independent certified public accountant or firm or certified public accountants to make an annual audit of the accounts and records of the Commission, and a complete written report of such audit shall be filed as public records annually, within six months of the end of the fiscal year under examination, with the Counties of Fresno, Kings, and Madera.

DISCUSSION:

A proposal from Moss Adams was presented to the Finance Committee on February 18, 2021 for retention of their services through fiscal year 2024. A motion was granted to recommend acceptance by the Commission for reappointment of Moss Adams as Independent Auditors during the March 2021 Commission meeting.

RECOMMENDED ACTION:

Reappoint Moss Adams as Independent Auditors through June 30, 2024.

MOSSADAMS

T (415) 956-1500
F (415) 956-4149

101 Second Street
Suite 900
San Francisco, CA 94105

January 25, 2021

Fresno Kings Madera Regional Health Authority
dba CalViva Health
c/o Mr. Daniel Maychen Chief Financial Officer
7625 North Palm Ave., Suite 109
Fresno, CA 93711

Subject: Fee Proposal for Audit and Nonattest Services

Dear Daniel,

Thank you for the opportunity to provide services to Fresno Kings Madera Regional Health Authority dba CalViva Health. In our engagement, we will audit the Company's statement of net position as of and for the years ending June 30, 2022; June 30, 2023; and June 20, 2024, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended. In addition, we will provide the Company with the following nonattest services:

- Assist management in drafting the financial statements and related footnotes as of and for each of the years ending June 30, 2022; June 30, 2023; and June 20, 2024.

Rianne Suico is responsible for supervising the engagement and authorizing the signing of the report. Our fees for audit services will be:

Service Description	FY 2022	FY 2023	FY 2024
Annual Financial Statement Audit	$62,000	$64,000	$66,000
Presentation of the audit results and Management Letter to the Finance Committee and Board of Commissioners		Included	
Total	$62,000	$64,000	$66,000

You will also be billed for expenses at our cost as they are incurred.

The fee estimates are based on anticipated level of preparation and cooperation from your management and staff, your completion of the year-end closing and adjusting process prior to our arrival to begin fieldwork and the expectation that the records will be in good order. We may experience delays in completing our service due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Our fees are also based on accounting and auditing standards currently in effect and on the assumption there will be minimal changes to the scope of accounting entity.

We appreciate the opportunity to be of service to you. Please let us know if you need additional information.

Very truly yours,

Rianne Suico

Rianne Suico, Partner, for
Moss Adams LLP

Item #6

Attachment 6.A

2021Quality Improvement
Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Amy Wittig, Director Quality Improvement

COMMITTEE DATE: March 18, 2021

SUBJECT: Quality Improvement Program Description Change Summary

CM Redline Page #	Section/Paragraph name	Description of change
Throughout	Title page & footer	Updated year from 2020 to 2021.
Throughout	Throughout	Various grammatical edits and adding bullets to sections with lists that were previously in paragraph format.
2-3	Table of Contents	Page numbering and section titles updated.
15-16	Health Promotion Programs	Removed information for the following programs: • Fit Families for Life • myStrength • Know Your Numbers events • Community Education Classes • Community Health Fairs
18	Disease Management	Changed section title from Disease Management to Health Management Programs
18-19	Health Management Programs	• Added paragraph regarding disease management program • Revised Nurse Advice Line section and updated language
34	Satisfaction	Updated Customer Experience Continuous Improvement (CXCI) Initiatives
38	Cultural and Linguistic Needs	• Updated requirements for non-discrimination • Removed California Association of Health Plans
	Staff Resources and Accountability	•

CalViva Health
Quality Improvement (QI) Program Description

2021~~0~~

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 20 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 preventive 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
Claims and Encounters	Credentialing
Benefits	Member Complaints
Grievance and Appeals	Provider Network Management
Billing	Remittance
Medical Management	Customer Call Centers

~~Analytical~~ Analytic resources are available within the HNCS QI Department and will be made available to CalViva. The ~~manager~~ Manager and ~~director~~ Director of the QI Research and ~~Analysis~~ Analytics Department have 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*

The 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 establishes standards for both the quality and safety of clinical care and service, as well as monitors and evaluates the adequacy and appropriateness of health care and administrative services on a continuous and systematic basis. The QI Program also supports the identification and pursuit of opportunities to improve health outcomes, and both member and provider satisfaction.

C. *Goals*

1. Support CalViva's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations or standards established state regulatory and accreditation agencies.
2. Objectively and systematically monitor and evaluate services provided to CalViva members to ensure conformity to professionally recognized standards of practice and codes of ethics.
3. Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.

4. Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at improving/maintaining performance of target measures, and takes action, as needed, to improve performance.
5. Support a partnership among members, practitioners, providers, regulators and employers to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.
6. Design, implement and measure organization-wide programs that improve member, practitioner and provider satisfaction with CalViva's clinical delivery system. These programs are population-based ongoing clinical assessments and are evaluated to determine the effectiveness of clinical practice guidelines, preventive health guidelines and disease management programs.
7. Monitor and improve CalViva's performance in promoting quality of service to improve member, practitioner and provider satisfaction through the use of satisfaction surveys, focused studies, and analysis of administrative data; emphasizing administrative, primary care, high-volume specialists/specialty services, and behavioral health/chemical dependency services.
8. Promote systems and business operations that provide and protect the confidentiality, privacy and security of member, practitioner and provider information while ensuring the integrity of data collection and reporting systems. This is done in accordance with state and federal requirements and accreditation guidelines.
9. Anticipate, understand and respond to customer needs, be customer-driven and dedicated to a standard of excellence in all customer relationships.
10. Provide a means by which members may seek resolutions of perceived failure by practitioners/providers or CalViva personnel to provide appropriate services, access to care, or quality of care. Identify, review and investigate potential quality of care issues and take corrective action, when appropriate.

III.

Scope

A. *Scope of QI Program*

The CalViva QI Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. 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
- Case Management (CM)
- 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 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. The Plan's Provider Network Management staff 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. *Preventive 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 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 Health 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 members and existing practitioners and providers online and by calling the Health Education Department at 1-800-804-6074.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.

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

C. *Health Promotion Programs*

CalViva Health provides health education programs, services and resources to Medi-Cal members to help manage their health and reach their goals. A whole person approach 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.

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers may obtain more information by contacting the toll-free Health Education Information Line at (800) 804-6074. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website based services are available 24/7. Print educational resources are sent to members within two weeks of request.

- Weight Management Programs –Members have access to a comprehensive Fit Families for Life-Be In Charge!SM 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. The Healthy Habits for Healthy People weight management educational resource is designed specifically for adults and seniors. Other nutrition and weight control education resources are also available upon request. ~~Fit Families for Life community classes teaching basic nutrition and physical activity information are offered at Community Resource Centers, community based organizations and provider clinics located in areas where members reside. The Community Classes are free to all members and the community.~~ Providers should complete and fax a copy of the Fit Families for Life - Be In Charge!~~SM~~ Program Referral Form to the Health Education Department to refer members to the Home Edition program.
- CalViva Pregnancy Program – The pregnancy program incorporates the concepts of case management, care coordination, disease management and health promotion in an effort to teach pregnant members how to have a healthy pregnancy and first year of life for babies. The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- California Smokers' Helpline ~~–~~ The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking. Helpline services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), and specialized services are available to teens, pregnant women, and tobacco chewers. Members are offered a 90 day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.
- Diabetes Prevention Program – Eligible members 18 years old and older with prediabetes can participate in a yearlong evidence-based, lifestyle change program that promotes and focuses on emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.
- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit~~ and community classes~~ to learn how to maintain a healthy heart.
- Digital Health Education -Teens from 13 years old and adults may participate in digital 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 members in learning how to access credible health education information and seek preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with depression, anxiety, stress, opioid and substance use, pain management, postpartum depression, insomnia and more.

- myStrength Program – Members have access to an evidence-based, self-help resource that is available on-line or in a mobile app. It myStrength offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic conditions, pain management and many other conditions.
- Know Your Numbers Community Class and Screening Events – Health Education conducts health screening on Body Mass Index (BMI), diabetes, hypertension and/or cholesterol to help participants understand their current health status. At the same event, participants are provided the appropriate preventive health education to help them adopt healthy behaviors and connect them to health care providers to control their health conditions.
- 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.
- Community Health Fairs – CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide screenings, presentations, and/or health education materials at these events.

The following resources are also available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at www.calvivahealth.org.
- Health Education Member Request Form –- Members complete this pre-stamped form to request free health education resources in threshold languages available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line. They can also get CalViva Health's print resources at contracted providers offices and health education classes.
- Health Education Programs and Services Flyer — This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages. They are mailed to new members and are also available on www.CalvivaHealth.org. These are available in English, Spanish and Hmong.
- Member Newsletter – CalViva Health News is mailed to members once a year regularly and covers various health topics and the most up-to-date information on health education interventions.

MemberConnections® Program

MemberConnections is an special educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections Representatives (MCRs) extend the reach of member engagement and care management efforts by making home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan/providers and members.

More specifically, MCRs:

- ~~conduct~~ Conduct assessments to better understand members' needs such as the Health Risk Screening
- ~~facilitate~~ Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations
- ~~assist~~ Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors
- ~~connect~~ Connect members to case management and disease management to better manage their chronic and/or complex health conditions
- ~~address~~ Address social needs by linking members to county and community resources
- ~~help~~ Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services

D. *Clinical Practice Guidelines*

CalViva Health adopts and disseminates evidenced-based clinical practice guidelines that are relevant to its membership for the provision of preventive and non-preventive health care services, acute and chronic medical services and behavioral health services. These clinical practice guidelines assist practitioners, providers and members to make decisions about appropriate health care for specific clinical circumstances, to improve health care, and to reduce unnecessary variations in care.

CalViva Health adopts guidelines from recognized organizations that develop or disseminate evidence~~d~~-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Directors, network practitioners, and CalViva Health's CMO and the QI/UM Committee. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

Guidelines are evaluated for consistency with CalViva's benefits, utilization management criteria, and member education materials. They are communicated to providers~~actitioners~~ through ~~provider~~ fax~~xes~~ and are available to providers on the Health Net websites and to members upon request. CalViva Health monitors adherence to guideline recommendations and program outcomes using HEDIS measures.

E. *Health Management Programs~~Disease Management~~*

~~The~~ Disease Management~~—~~

CalViva's disease management programs increase awareness of self-care strategies and empower participants to better manage their disease. CalViva targets high-risk members ~~identified with chronic asthma, diabetes and heart failure conditions~~ and encourages them to participate in the disease management program. CalViva Health~~.~~ Disease Management Programs may include, but are not limited to; Asthma; Diabetes and Heart Failure.This program includes a population-based identification process, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to disease management are multichannel and come through provider, Case Management and member self-referrals.

~~*Be In Charge!* SM Program provides disease specific management for members with Asthma, Diabetes, and Heart Failure (HF).. 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, and better clinical outcomes. 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 Case Management program if the member is identified as being at high risk for hospitalizations or poor outcomes.~~

Nurse Advice Line

The n~~N~~urse a~~A~~dvice l~~L~~ine ~~(NAL)~~ provides effective, appropriate, and timely triage for health-related problems through experienced trained Registered Nurses (RNs) and physician-approved guidelines and protocols. ~~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~~365 days a year, in English and Spanish with translation services available for other languages.

Using ~~clinical decision~~nationally recognized algorithms and world-class clinical triage guidelines, the nurse advice line~~NAL~~ ~~registered~~ Registered ~~nurses~~ Nurses accurately identify member needs and ensure they are directed to the appropriate level of care for their situation - whether it be providing self-care guidance or recommending a visit to Urgent Care or~~f~~ the ER. ~~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.~~ Nurse ~~Advice~~ advice ~~Line~~ line nurses may access support from a physician when needed as the nurse interacts 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~~ Dietitians (RDs) 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, and tips for eating out~~, and more~~. Members are offered unlimited inbound calls to program coaches 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~~ Registered ~~dietitians~~Dietitians (RDs), 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 to program coaches~~.~~

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.

A. *Transitional Care Management Program*

The purpose of the Transitional Care Management Program (TCM) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care ~~Transition~~ transition ~~Interventions~~ interventions are focused on coaching the member and the member's support system during ~~the~~ an inpatient stay and the immediate post discharge period~~.~~ to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The TCM Program ~~is a care transition model that~~ utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation of its care transition model. The TCM Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a ~~patient~~ patient-~~centric~~ centered approach, the model incorporates three ~~evidenced~~ evidence based care elements of inter~~-~~disciplinary communication and collaboration, patient/participant engagement, and enhanced post-acute care follow-up.

The focus of this model is based on a coaching intervention rather than a case management intervention. Under this model, the Care Transition nurse helps ~~patients/~~members and/or their primary caregiver~~,~~ learn transition~~-~~specific self-management skills by:

1. ~~1.~~ Introducing the CTI to the member at the time of hospitalization~~,~~
2. ~~2.~~ Use of other tools to transfer skills to patients and family members on how to communicate care needs effectively during direct encounters with their health care team~~,~~
3. ~~3.~~ Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation~~–~~, how to respond to medication discrepancies, and how to utilize a personal health record (PHR)~~, an~~.
   ~~d~~
   ~~4.~~ Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond~~.~~
4. ~~5.~~
5. ~~-~~Follow-up calls with the member are conducted within 30 days of post-discharge, which focuses interventions on:
   - Reviewing ~~the~~ progress toward established goals
   - Discussing encounters with other health care professionals
   - Reinforcement of the importance of maintaining and sharing the PHR
   - Supporting the ~~patient's~~ member's self-management role
   - Medication reconciliation with access to pharmacist~~.~~
   - Ed
   - ~~Ed~~ucating the member to follow up with the PCP/and or specialist within 7 days of discharge~~.~~

During the post discharge period, ~~staff~~ the nurse evaluates the member for ~~Case~~ case ~~Management~~management, ~~Palliative~~ palliative care and other programs that may best support the member in managing their continued needs. A referral to these programs is conducted as applicable to ensure continuity of addressing outstanding member needs/goals.

Member Impact of TCM

The ~~positive impact of the~~ TCM Program has a positive impact on participating members, includeing outcomes such as:

- ~~Better~~ Improved ability to manage member care through coaching interventions. Increasing member engagement ~~will~~ reduces the risk of adverse post discharge outcomes and/or readmissions.
- ~~Positive experience with the Transition Care Management Program increases~~Increased member satisfaction, further strengthening ~~Health Net's~~CalViva's brand and market standing.
- ~~Coaching interventions encourage a~~Active participation of the member~~/~~ and/or the member's ~~representative~~ caregiver in the health care continuum. ~~Member~~ The member becomes more apt to take an assertive role in his/her own care.
- ~~Problem~~Increased problem-solving skills, proactive thinking and ability to anticipate issues,
- ~~Ability~~ Increased ability to collaborate with clinical staff to address the member's ongoing needs ~~of members~~
- ~~Ability~~ Increased ability of clinical staff to understand member's psychosocial barriers and ~~members'~~ needs
- ~~Good understanding of~~Improved access to member's contracted network ~~/~~resources, ~~for assigned medical group~~ including PCP, specialist physicians, radiology, laboratory services, urgent care~~, etc.~~
- ~~Organizational~~ Improved organizational and time management skills

Health Net's TCM staff are linked through common management teams and systems. Health Net's Medical Directors participate in all aspects of Care Transition/Transition Care Management operations.

B. *Case Management (CM) Program*

CalViva partners with HNCS to provide Case Management (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~~ multi-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.

The goals of the CM 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:

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

Members for the Case Management program are identified proactively using utilization, claims, pharmacy, and encounter data sources. This data is stratified using a predictive modeling and care management analytic tool with a built in proprietary risk stratification algorithm to differentiate members who have higher risk and more complex health needs from those with lower risk. In addition, data gathered through assessments ~~and~~ and/or screenings is filtered electronically at least monthly to identify members for the program. Members may also be directly referred by sources including:

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

CM is a telephonic based program which can provide face-to-face contacts, as needed.

Once members are identified for potential inclusion in the case management program, outreach to the member is completed to assess the care need. ~~and t~~The member is then 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.

Each year the program is evaluated for its effectiveness using both established metrics and documented measures of member satisfaction.

C. *Behavioral Health Services*

CalViva ~~'s provider network arrangements to~~ delivers covered mental health services to the majority of its members ~~are administered~~ through a contract Health Net holds with its affiliate MHN Services ("MHN"). MHN contracts directly with psychiatrists as well as non-MD 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, along with their experience with coordination of care
- Network availability and adequacy of behavioral health providers
- Member quality of care and service complaints investigation
- Evaluation of behavioral health HEDIS® measures and other QI behavioral health initiatives.

D. *Palliative Care (Care Connections) Program*

The Palliative Care (Care Connections) Program is a specialized home based program for members with serious progressive disease. It offers an extra layer of support with medical care, psychosocial support and coordination of care. ~~Our~~ The team works with the member's primary care physician (PCP) and specialists to increase the quality of life through prevention, treatment and support, symptom relief and improve quality of life for both the member and the family.

The program's objective is to improve ~~our~~ members' quality of life during a serious progressive disease. Core components of the program focus on pain management, facilitation of person-centered communication, promotion of individual decision-making, and care coordination across the settings throughout the disease trajectory. The tenets of the Palliative Care Program address patient and family centered palliative care, comprehensive palliative care with continuity across health settings (inpatient, outpatient, community and home base), early introduction of palliative care at diagnosis of a serious disease or life threatening condition, interdisciplinary collaborative care, relief of physical, psychological, emotional, and spiritual suffering and distress of patients and families.

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined below in General Criteria and at least One Disease-Specific Criteria

A. General Eligibility Criteria
   - The member is likely to or has started to use the hospital or Emergency Department (ED) as a means to manage their last stage disease (i.e. unanticipated decompensation)
   - The member has an advance illness, as defined in Section B with appropriate documentation of the continued decline in health status and is not eligible for or declines hospice enrollment
   - Member's death within a year would not be unexpected based on clinical status~~.~~
   - The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
   - The member and, if applicable, the family/member-designated support person, agrees to:
     a. Attempt, as medically/clinically appropriate, in-home, residential-based or outpatient disease management/palliative care instead of first going to the emergency department ~~and~~
     b. ~~-~~Participate in Advance Care Planning discussions

B. Disease- Specific Eligibility Criteria

- Congested Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Advance Cancer
- Liver Disease
- Other serious progressive disease

Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section C below, consistent with the provision of EPSDT services.

C. Pediatric Palliative Care Eligibility Criteria

Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and concurrently with curative care.

a. The family and/or legal guardian agree to the provision of pediatric palliative care services~~; and~~
b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
    1. Conditions for which curative treatment is possible, but may fail ~~or~~
    2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life ~~or~~
    3. Progressive conditions for which treatment is exclusively palliative after diagnosis ~~or~~
    4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications

If member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until condition improves, stabilizes, or results in death.

Palliative care services shall include the following services:

- Advance Care Planning, Palliative Care Assessment and Consultation, Individualized Plan of Care, Palliative Care Team, Care Coordination, Pain and Symptom Management, Mental Health and Medical Social Services, Chaplain Services, 24/7 Telephonic Palliative Care Support
- May authorize additional palliative care services medically necessary or reasonable for eligible members (e.g. expressive therapy for the pediatric population)

Referrals can come from multiple sources. This may include:

- Internal health plan case managers and concurrent review nurses~~;~~
- Primary Physician Groups (PPG)~~,~~
- Member's Primary Care Physicians and Specialists~~,~~
- Palliative Care Vendors~~/~~ Providers~~,~~
- Hospitals~~,~~
- Internal Claims Data~~,~~
- California Children's Services (CCS) Program~~, Others~~

E. *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.

All providers undergo a quality process of credentialing prior to finalizing contract agreements and are recredentialed every three years. All providers are monitored monthly for Medicare/Medicaid plan sanctions, license disciplinary actions, quality of care and service incidents, and any other adverse actions. Trendable actions and any high severity leveled cases are reported to the Peer Review Committee where further actions are taken.

F. *Continuity and Coordination of Care*

A major focus of CalViva's QI program is ensuring that the care members receive is seamless and integrated. These activities can be divided into three main areas:

- Across medical care settings that include (but are not limited to) inpatient, residential, ambulatory and other locations where care may be rendered
- Continuity and coordination between medical care locations and public health agencies, 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:

- 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.

For all members with identified complex health needs, CalViva supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. Other programs such as disease management and nurse advice line are also available to members and can help those with complex needs manage their conditions. Provider groups also support members through their coordination of care programs.

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

G. *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 delegate's 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~~ Medical ~~director~~ 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 subsequent 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.

H. *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/medical record 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

I. *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.

J. *Satisfaction*

CalViva Health continuously monitors member satisfaction throughout the year using the CAHPS survey results, member appeals and grievances, and CMS complaint tracking modules (CTMs). CAHPS survey results are integrated into various state and federal performance rating systems and reports including the following:

- Office of the Patient Advocate Report Cards~~;~~
- DHCS Medi-Cal Managed Care Quality Improvement Reports~~.~~

QI activities are focused on educating CAHPS stakeholders and measure owners and implementing improvement activities. Quality Improvement partners with several business areas including Medical Management, Customer Contact Center, Appeals and Grievances, Pharmacy, Claims, Credentialing, Provider Network Management, Provider Engagement Performance Management (PEPM), Delegation Oversight, Sales, Marketing, and MHNS. Annually, QI analyzes data and ~~a,~~ documents and reports to stakeholders the integrated member satisfaction reports ~~required,~~ required to support an improved member experience.

Member materials are assessed to ensure that prospective member and enrollment information includes details on the benefit plan, obtaining primary and specialty care, and how to voice a complaint and submit an appeal. In addition, members receive various communications that highlight general medical information and other focused activities.

The Quality Improvement department partners with the Customer Experience Continuous Improvement team (CXCI) to improve operational and organizational processes. The CXCI team has several initiatives underway including:

- ~~Implementation and monitoring of the Net Promoter Score (NPS).~~
- Member Contact Data: ~~Drive to Digital:~~ Identification of an approach for collecting and storing member contact information and communication preferences~~, and developing the capability to deliver documents electronically for key member communications.~~
- Member Orchestration: Creation of a holistic approach to the member experience by communicating via their preferred methods ~~and improve common transactions.~~
- Value stream mapping to improve work flow and information processing in Utilization Management, Case Management, and Population Health~~,Appeals and Grievances empowerment, claims, prior authorization, and Member Services.~~
- Welcome Experience: ~~Redesigning the member on-boarding process and associated collateral such as the welcome kits and ID cards.~~Launching a redesigned CalViva Welcome Kit and member onboarding materials

K. *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. The access to care standards ~~including~~ include 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): Annual provider telephone survey assessing after-hours ER information and physician after-hours access.
- Provider Appointment Availability Survey (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.
- Provider Satisfaction Survey (PSS): Annual provider survey to assess provider perspective and concerns regarding compliance with the access standards and to evaluate satisfaction with the time-elapsed standards.
- Telephone Access~~nswer~~ Survey: Quarterly provider telephone survey to assess how long it takes a provider's office to answer the phone and return calls to members.
- 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 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 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.

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

Member responsibilities include:

- ~~acting~~ Acting courteously and respectfully toward doctors and staff and being on time for visits~~;~~
- ~~providing~~ Providing up-to-date, accurate and complete information~~;~~
- ~~following~~ Following the doctor's advice and participating in the treatment plan~~;~~
- ~~using~~ Using the Emergency Room only in an emergency~~; and~~
- ~~reporting~~ 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.

M. *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 Managed Care Quality and Monitoring Division of 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. Actions are 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.

N. *Cultural and Linguistic Needs*

CalViva Health is contracted with ~~Health Net Community Solutions (HNCS)~~HNCS to provide cultural and linguistic services and programs for the majority of CalViva Health's membership. CalViva Health may ~~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)~~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. The cultural competency training program adheres and implements HHS guidelines for Section 1557 of the ACA for C&L services and requirement for non-discrimination based on sex, race, color, national origin, creed, ancestry, religion, ethnic group identification, ~~language,~~ age, mental disability, physical disability, medical condition, genetic information, gender, ~~marital status,~~gender identity, or ~~sexual orientation, marital status and health status~~, ~~or disability~~. ~~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 culturally responsive ness education. C&L also analyses the needs of its membership by reviewing various sources of data which may include membership demographic data, call center data, appeals and grievance information, and geo-access analysis of provider network language capabilities.

C&L services are part of a continuing quality improvement endeavor. The C&L program description, work plan, language assistance utilization and mid-year and end of year reports are all submitted to the CalViva Health Quality Improvement / Utilization Management (QI/UM) committee for review and approval.

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 Population Needs Assessment (PNA)
- ~~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, Population Needs Assessment (PNA) 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) and~~,~~ America's Health Insurance Plans (AHIP), and California Association of Health Plans (CAHP)

~~j)~~• Provide C&L services that support member satisfaction, retention, and growth

Additionally, C&L staff perform~~s~~ 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 identify, develop and implement interventions at the member, community and provider levels 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/CLAS Month" activities, 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 documents 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 Work ~~p~~ Plan and QI Work ~~p~~ Plan 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*

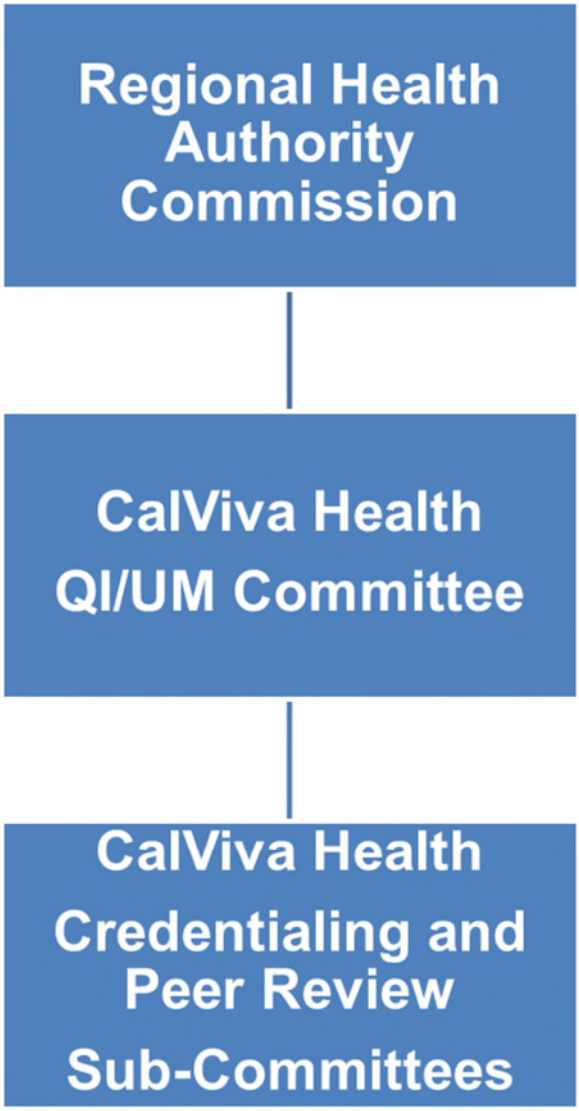
QI/UM Operational Workgroup

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 Medical Management Specialist. 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 multiple 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.

Committee Organizational Chart



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 the ~~a~~ Chief Medical Officer, the Director of Medical Management Services, who is a Registered Nurse, ~~and~~ a Medical Management Specialist and a Nurse Analyst 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's 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 14-004,12-006 and APL 15-023, 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 (including behavioral health), ancillary providers, CBAS 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 diabetes prevention, 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~~Work Plan.

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

~~B.~~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.

~~C.~~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.

~~D.~~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's assistance, updates regularly to reflect progress on QI activities throughout the year. The QI Work Plan documents the annual QI Program initiatives and delineates:

- Objectives, scope and population demographics
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported
- Responsible department(s) and/or person(s) for each activity
- Goals and benchmarks for each activity
- Number of objectives met
- Number of activities met
- Planned monitoring of previously identified issues
- Barriers identified when goals are not achieved
- Follow-up action plan, including continuation status (close, continue, or continue with modifications)

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 #6

Attachment 6.B

2021Quality Improvement
Work Plan

CalViva Health Quality Improvement Work Plan 2021

03.12.21

CalViva Health 2021 Quality Improvement Work Plan

TABLE OF CONTENTS

CalViva Health 2021 Quality Improvement Work Plan

Submitted by:

Patrick Marabella, MD Chief Medical Officer
Amy Schneider, RN, BSN Director Medical Management

CalViva Health 2021 Quality Improvement Work Plan

I. Purpose

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

II. CalViva Health Goals

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

III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2021. The development of this document requires resources of multiple departments.

CalViva Health 2021 Quality Improvement Work Plan

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
CCHRI:	California Cooperative Healthcare Reporting Initiative	**MMCD:**	Medi-Cal Managed Care Division
CDC:	Comprehensive Diabetes Care	**MPL:**	Minimum Performance Level
CM:	Case Management	**PCP:**	Primary Care Physician
CP:	Clinical Pharmacist	**PIP**:	Performance Improvement Project
CVH:	CalViva Health	**PMPM:**	Per Member Per Month
DHCS:	Department of Health Care Services	**PMPY:**	Per Member Per Year
DM:	Disease Management	**PNM:**	Provider Network Management
DMHC:	Department of Managed Health Care	**PRR:**	Provider Relations Representative
DN:	Direct Network	**PTMPY:**	Per Thousand Members Per Year
FFS:	Fee-for-Service	**QI:**	Quality Improvement
HE:	Health Education	**SPD:**	Seniors and Persons with Disabilities
		UM:	Utilization Management

I. ACCESS, AVAILABILITY, & SERVICE

Section A: Description of Intervention (due Q1)				
1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☐ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative
Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. Assessing practitioner compliance with access standards and surveying members allows the identification of areas for improvement.
Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
Timely Appointment Access to Primary Care Physicians and Specialists is measured through eight metrics. The specific goal is 90% for all measures. Success will be evaluated at the end of the survey period. Timely Appointment Access is monitored using the DMHC PAAS Tool and the CVH PAAS Tool.
Timely Appointment Access to Ancillary Providers is measured through two metrics. The goal is 90% for all metrics. Timely Appointment Access is monitored using the DMHC PAAS Tool.
After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey (PAAS). This survey is conducted to assess provider compliance with required after-hours emergency instructions for members and that members can expect to receive a call-back from a qualified health professional within 30 minutes when seeking urgent care/services by telephone. The results are made available to all applicable provider organizations through annual provider updates. When deficiencies are identified, improvement plans are requested of contracted providers and provider groups as described in CVH policy PV-100-007: Accessibility of Providers and Practitioners. These measures assess whether 90% of providers have appropriate emergency instructions whenever their offices are closed/after-hours, and if 90% of providers are available for members to contact them during after-hours for urgent issues within the 30-minute timeframe standard.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement Provider Appointment Access Survey (PAAS) to monitor appointment access at the provider level to comply with DMHC and continue conducting Medi-Cal Appointment Access Survey to comply with DHCS requirements.	P	Q3- Q4	CVH/HN

Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability.	P	Q3-Q4	CVH/HN
Develop and distribute Provider Updates, as applicable, informing providers of upcoming training webinars, surveys, survey results, and educational information for improvement.	P	Q1 - Q4 Q1 – Provider Webinar Trainings Q3 – MY 2021 Survey Prep Q3 – MY 2020 Survey Results	CVH/HN
Conduct provider training webinars related to timely access standards and surveys.	P	Q1-Q4	CVH/HN
Conduct Telephone Access surveys quarterly to monitor provider office answer time and member callback times.	P	Q1-Q4	CVH/HN
Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval.	P	Q1	CVH/HN
Leverage results from the quarterly DHCS Medi-Cal Managed Care Timely Access Report to identify PCPs and specialists that do not meet timely access standards and conduct outreach to these providers.	P	Q1-Q4	CVH/HN
Complete a CAP as necessary when CalViva providers are below standard, including additional interventions for providers not meeting standards for two consecutive years.	P	Q3-Q4	CVH/HN
Annual review, update and distribution of "Improve Health Outcomes – A Guide for Providers Toolkit," After-Hours Script and Timely Appointment Access flyer.	P	Q1-Q4	CVH/HN

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

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Performance Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)

Measure(s)	Performance Goal (Goal for MY 2018 = 80%)	Rate (%) MY 2020 (populated mid-year)	Rate (%) MY 2019	Baseline Value Source	Baseline Value (%) MY 2018
Overall Combined: Urgent Care – PCP & SCP Non-Urgent Care – PCP & SCP First Visit – PCP or SCP Prenatal	90%	Urgent = Non-Urgent = Prenatal =	Urgent = 60.3 Non-Urgent = 78.7 Prenatal = 90.1	CVH Performance MY 2018	Urgent = 65.6 Non-Urgent = 72.4 Prenatal = 89.6
Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	90%	Overall= Fresno= Kings= Madera=	Overall=84.7 Fresno=85.5 Kings= 84.9 Madera= 79.5	CVH Performance MY 2018	Overall=82.1** Fresno=85.7** Kings=85.2** Madera=62.5 **
Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	90%	Overall= Fresno= Kings= Madera=	Overall=75.4 Fresno=77.1 Kings=64.3 Madera=74.2	CVH Performance MY 2018	Overall= 68.1** Fresno=72.2** Kings= 73.7** Madera=43.1**
Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request	90%	Overall= Fresno= Kings= Madera=	Overall=70.9^ Fresno=71.9 Kings=67.3 Madera=70.3	CVH Performance MY 2018	Overall= 71.4** Fresno=74.2** Kings=59.3 Madera=81.3
Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	90%	Overall= Fresno= Kings= Madera=	Overall=52.2^ Fresno=53.8 Kings=42.3 Madera=50.9	CVH Performance MY 2018	Overall=62.8** Fresno=68.0** Kings=44.4** Madera=53.2**
First Prenatal Visit (PCP) – Within 2 weeks of request	90%	Overall= Fresno= Kings= Madera=	Overall=88.4 Fresno=90.0 Kings=91.3 Madera=70.0	CVH Performance MY 2018	Overall=90.3 ** Fresno=94.4** Kings=90.0** Madera=66.7**
First Prenatal Visit (SCP) – Within 2 weeks of request	90%	Overall= Fresno= Kings= Madera=	Overall=91.2 Fresno=90.3 Kings=100* Madera=NR	CVH Performance MY 2018	Overall=88.9** Fresno=87.5** Kings=100** Madera=100**
Well-Child Visit with PCP – within 10 business days of request	90%	Overall= Fresno= Kings= Madera=	Overall=76.9 Fresno=77.5 Kings=79.6 Madera=70.3	CVH Performance MY 2018	Overall=73.6** Fresno=69.8** Kings=85.2** Madera=68.8**

Measure(s)	Performance Goal (Goal for MY 2018 = 80%)	Rate (%) MY 2020 (populated mid-year)	Rate (%) MY 2019	Baseline Value Source	Baseline Value (%) MY 2018
Physical Exams and Wellness Checks – within 30 calendar days of request	90%	Overall= Fresno= Kings= Madera=	Overall=87.8 Fresno=88.1 Kings=91.5^ Madera=81.6	CVH Performance MY 2018	Overall=88.5** Fresno=85.2** Kings=92.6** Madera=93.8**
Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	90%	Overall= Fresno= Kings= Madera=	Overall=93.3 Fresno=90.9 Kings=100* Madera=100*	CVH Performance MY 2018	Overall=66.7 Fresno=60.0 Kings=100 Madera= NR
Appropriate After-Hours (AH) emergency instructions	90%	Overall= Fresno= Kings= Madera=	Overall=97.9 ↑ Fresno=97.9 ↑ Kings=99.0 Madera=96.1 ↑	CVH Performance MY 2018	Overall=93.9 Fresno=95.2 Kings=95.0 Madera=80.5
AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes	90%	Overall= Fresno= Kings= Madera=	Overall=99.4 ↑ Fresno=99.4 ↑ Kings=99.0 ↑ Madera=100 ↑	CVH Performance MY 2018	Overall=82.0 Fresno=82.3 Kings=77.8 Madera=85.0

^Rate for MY 2019 cannot be compared to MY 2018 due to change in the sampling methodology.

* Denominator less than 10. Rates should be interpreted with caution due to the small denominator

↑↓ Statistically significant difference between RY 2019 vs RY 2018, $p<0.05$

NR – No reportable data

** Change in DMHC survey tool for all PCP and specialist urgent and non-urgent metrics - rates should be interpreted with caution

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	
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	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Member satisfaction is affected by member interaction with the providers, provider office staff, the plan, and vendor partners. Results are also impacted by member demographics and individual health status.

Member Experience for CalViva is monitored in two ways:

1. **CalViva Access Survey**
    a. Purpose: Scaled-back CAHPS survey to assess access areas of opportunity.
    b. Administered by: Health Net QI-CAHPS Team through survey vendor, SPH Analytics.
    c. Frequency: Annually.
    d. Look-back Period: Year prior to survey administration date.
        i. Look-back Period for MY2019 Result Rates: October 2019 – April 2020
        ii. Look-back Period for MY2020 Result Rates: October 2020 – April 2021
    e. Results: Final results are shared with CalViva & the Provider Network Management Department (HN internal department).
2. **DHCS CAHPS Survey**
    a. Purpose: Regulatory CAHPS Survey.
    b. Administered by: HSAG (DHCS CAHPS Survey Vendor).
    c. Frequency: Every 2 years.
    d. Look-back Period: Year prior to survey administration date.
        i. Look-back Period for MY2016 Result Rates: August 2015 – May 2016
        ii. Look-back Period for MY2019 Result Rates: August 2019 – May 2020
    e. Results: Results are posted on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx

The CalViva CAHPS Survey is completed every two years and thus, annual rate updates will not be available. The most recent set of CAHPS Rates can be found below in Section C. The CalViva Access Survey is conducted annually, with updated results available in May/June each year (to be included in the mid-year update).

Measure rates captured below for both the CalViva Access Survey and the DHCS CAHPS Survey represent rates based on the percentage of members who chose “Always/Usually” as their response.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
On an annual basis, the CalViva Access Survey collects information on the following measures: • Access to Urgent Care • Access to Routine Care • Access to Specialist Appointment • Ease of Getting Care/Tests/Treatment Our internal goal for the CalViva Access survey is to exceed previous year's performance **Through the DHCS CAHPS Survey, the following measures are evaluated**: • Rating of Health Plan • Rating of Health Care • Rating of Personal Doctor • Rating of Specialist Seen Most Often • Getting Needed Care (composite measure) • Getting Care Quickly (composite measure) • How Well Doctors Communicate (composite measure) • Customer Service (composite measure) • Shared Decision Making (composite measure) Our goal for the DHCS/HSAG-administered CAHPS survey is to be at or above the Quality Compass 50th percentile.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Annually review Provider Tool Kit resources related to member experience. Ensure all are up-to-date and relevant.	P	Q2 2021	CVH/HN
Annually review, update, and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide.	P	Q1-Q2 2021	CVH/HN
Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the Performance Excellence Toolkit to educate and empower members and improve their overall experience.	P/M	Q1-Q2 2021	CVH/HN

Annually review, update and enhance materials on Interpreter services availability 24/7 to remind providers of the availability of these services and how to access them.	P	Q1-Q2 2021	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services.	M	Q2 2021	CVH/HN
Annually, review and update and enhance materials on the Nurse Advice Line to encourage use of this service by members.	P/M	Q1-Q2 2021	CVH/HN
Update (as needed) and conduct scaled-back member survey/Annual CalViva Access Survey to assess effectiveness of interventions implemented. Share and review results once they are made available.	M	Q1 – Q2 2021	CVH/HN
PPG CAHPS Webinar held bi-annually. Webinar covers recommendations and best practices on how provider/provider staff can improve patient satisfaction throughout all patient interactions, as well as the importance of CAHPS.	P	Q3, Q4 2021	CVH/HN
Quarterly perform a root cause analysis on appeals and grievances data to highlight member pain points, trends and opportunities for improvement. Share these results and recommendations with Medical Management leadership at least quarterly.	P	Quarterly basis	CVH/HN

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

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

CalViva Access Survey Measure(s)	Specific Goal	MY2019	MY2020	Baseline Source (Source: Previous Year CalViva Access Survey)	Baseline Value
Got urgent care as soon as needed	Improve YOY	78%	%	MY 2018 Rate	76%
Got routine care as soon as needed	Improve YOY	67%	%	MY 2018 Rate	65%
Ease to get specialist appointment	Improve YOY	59%	%	MY 2018 Rate	59%
Ease of getting care/test/treatment	Improve YOY	76%	%	MY 2018 Rate	77%
DHCS CAHPS Survey Measure(s)	**Specific Goal**	**MY2016**	**MY2019**	**Baseline Source** (Source: Quality Compass Percentiles)	**Baseline Value**
Getting Needed Care	Meet or Exceed Quality Compass 50th Percentile	69%	69.10%	MY2019 50th Percentile	83.06%
Getting Care Quickly	Meet or Exceed Quality Compass 50th Percentile	73%	73.31%	MY2019 50th Percentile	82.34%
How Well Doctors Communicate	Meet or Exceed Quality Compass 50th Percentile	87%	86.52%	MY2019 50th Percentile	92.0%
Customer Service	Meet or Exceed Quality Compass 50th Percentile	NA	NA	MY2019 50th Percentile	88.8%
Shared Decision Making	Meet or Exceed Quality Compass 50th Percentile	77%	77.00%	MY2019 50th Percentile	79.84%
Rating of All Health Care	Meet or Exceed Quality Compass 50th Percentile	63%	63.41%	MY2019 50th Percentile	75.43%

Rating of Personal Doctor	Meet or Exceed Quality Compass 50th Percentile	75%	75.46%	MY2019 50th Percentile	82.34%
Rating of Health Plan	Meet or Exceed Quality Compass 50th Percentile	73%	73.35%	MY2019 50th Percentile	78.45%
Rating of Specialist	Meet or Exceed Quality Compass 50th Percentile	74%	74.44%	MY2019 50th Percentile	82.62%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness With Barrier Analysis	
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

II.QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)				
2-1: Chlamydia Screening (CHL)				
☒ New Initiative ☐ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☒ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department** **Health Net Health Education Department**

Rationale and Aim(s) of Initiative

Overall Aim: The overall aim is to improve the reproductive health of young women in Madera County and thereby reduce infertility and other morbidity later in life.

Rationale: Chlamydia, caused by infection with Chlamydia trachomatis, is the most common notifiable disease in the United States. Untreated infection can result in pelvic inflammatory disease (PID), which is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. (CDC, 2018).[1] Among sexually-active women aged 16-24 years covered by Medicaid, screening rates increased from 40.4% in 2001 to 57.6% in 2017.[2] The actual number of infections probably exceeds 3 million annually, because most chlamydial infections are asymptomatic and go undetected. Persons between 15 and 24 years of age have the highest reported rates of infection. Chlamydia screening is widely promoted as an intervention to prevent reproductive tract morbidity, including infertility, in women by reducing chlamydia transmission. (Wiesenfeld, 2017).[3] The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection. (HealthyPeople, 2020)[4]

1 Centers for Disease Control and Prevention (2018). Sexually Transmitted Disease Surveillance 2018. Chlamydia Background. https://www.cdc.gov/std/stats18/chlamydia.htm#ref8

2 National Committee for Quality Assurance (2019) The State of Healthcare Quality: Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/

3 Wiesenfeld, Harold. (2017). Screening for Chlamydia trachomatis Infections in Women. The New England Journal of Medicine 2017; 376:765-73. https://medicinainternaelsalvador.com/wp-content/uploads/2017/03/nejmcp1412935.pdf
DOI: 10.1056/NEJMcp1412935

4 HealthyPeople 2020 (2020). HealthPeople.gov Evidence-based Resource Summary. https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/chlamydia-screening-in-women.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
The percentage of women 16-24 years of age who were identified as sexually active and who had least one test for chlamydia during the measurement year.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance FQHC in Madera County to improve CHL screening rates.	P/M	Q1-Q2	CVH/HN
Conduct regular meetings with Madera County provider to plan improvements to increase the frequency of CHL screening in young women.	P	Q1-Q2	CVH/HN
Initiate an EHR flag/alert for women between 18 and 24 years of age for inclusion on Daily Huddle sheet, to facilitate completion of the screening test through collaboration between the MA and the provider.	P/M	Q1-Q2	CVH/HN
Develop a Provider Profile (Excel format) in collaboration with the clinic leadership/staff that will be populated with the demographic information of members due for screening. The Profile will facilitate documentation of member outreach attempts and test completion.	P/M	Q1-Q2	CVH/HN

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

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1) Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3) Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)

Measure(s)	Specific Goal	Rate MY 2018	Rate MY 2019	Rate MY 2020	Baseline Source	Baseline Value
HEDIS® Chlamydia Screening in Women (CHL) – County Goal	Meet or Exceed DHCS 50th Percentile 58.34%	Madera: 53.05%	Madera: 55.42%	TBD	MY2019 HEDIS Data	55.42%
HEDIS® Chlamydia Screening in Women (CHL) – Provider Goal	By 2/28/2021 increase the Screening Rate by 15% (60/402)	N/A	43.53%	TBD	MY2019 Provider Results	43.53%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	
Initiation Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

III. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)				
3-1: Addressing Breast Cancer Screening Disparities				
☐ **New Initiative** ☒ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**		☒ **Safety Clinical Care**
Reporting Leaders	**Primary**	**CalViva Health Medical Management**	**Secondary**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: To increase and improve the survival rates of CalViva members in Fresno County who are diagnosed with breast cancer through early detection.

Rationale: Breast cancer is the most common cancer in American women, except for skin cancers. Currently, the average risk of a woman in the United States developing breast cancer sometime in her life is about 13%. This means there is a 1 in 8 chance she will develop breast cancer. The American Cancer society's estimates for breast cancer in the United States are:

- About 276,480 new cases of invasive breast cancer will be diagnosed in women.
- About 48,530 new cases of carcinoma in situ (CIS) will be diagnosed (CIS is non-invasive and is the earliest form of breast cancer).
- About 42,170 women will die from breast cancer. (American Cancer Society, 2020).[1]

The COVID-19 pandemic is expected to have a devastating impact on cancer rates. Experts predict an unprecedented increase in the numbers of cancer cases and deaths because of delays in screening and care, intensifying the disparities already felt by underserved communities. (Kollmer, 2020).[2]

Barriers to breast cancer screening include personal attitudes and beliefs such as fear of positive mammogram result, and the misconception that a lack of breast cancer symptoms indicates lack of disease. Accessibility and associated factors such as concerns about mammogram cost and lack of transportation are additional barriers. Cultural related barriers were connected to racial and ethnic community cultures and immigration status, and included issues such as language barriers that stem from limited English proficiency, and cultural beliefs around modesty. Social and interpersonal barriers, or barriers created by women's interactions with others, include lack of encouragement for screening by friends or family. The most commonly reported barriers were perceived pain from the screening and embarrassment. Lack of physician recommendation was the most commonly identified social barrier. (Miller et al., 2019).[3]

The Hmong population's belief in the spiritual etiology of cancer and attitudes toward cancer have also been identified as potential barriers to cancer screenings. In addition, for many Hmong women, mammograms are unfamiliar and regarded as invasive screening practices. Hmong women are at high-risk for health problems due to poverty, lack of education, low English proficiency, lack of acceptance of the model of preventive care, and gender defined roles.[4]

1 American Cancer Society (2020). About Breast Cancer. https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html

2 Kollmer, J. (2020). Breaking down the barriers to breast cancer screening for high-risk individuals. https://www.uchicagomedicine.org/forefront/cancer-articles/breaking-down-barriers-to-breast-cancer-screening-for-high-risk-individuals

3 Miller, B., Bowers, J., Payne, J. and Moyer, A. (2019). Barriers to mammography screening among racial and ethnic minority women. Social Science & Medicine.
https://www.uchicagomedicine.org/forefront/cancer-articles/breaking-down-barriers-to-breast-cancer-screening-for-high-risk-individuals
4 Kue, Zukoski, Thorburn (2014). Breast and Cervical Cancer Screening: Exploring Perceptions and Barriers with Hmong Women and Men in Oregon.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711956/

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

The HEDIS measure Breast Cancer Screening (BCS) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. The baseline HEDIS result for MY 2019 was 55.26%. The improvement goal is to increase the breast cancer screening rate among the Hmong speaking population at the targeted provider site from a baseline of TBD% to a goal rate of TBD%.

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 FQHC in Fresno County to implement targeted BCS interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Collaborate with a women's imaging center to improve BCS rates.	P	Q1-Q4	CVH/HN
Design and deploy a culturally competent community educational session for the Hmong speaking BCS non-compliant CalViva members, which will be moderated by a female Hmong physician, include a video presentation, introduction to imaging center staff, and address potential barriers such as transportation at a community-based organization to improve BCS rates for this population.	M	Q1-Q4	CVH/HN

Complete Key Driver Diagram with potential interventions (Module 1). Submitted to HSAG 3/1/21; pending approval.	P/M	Q1-Q2	CVH/HN
Complete process map activity with high volume, low compliance clinic in Fresno County (Module 2).	P	Q1	CVH/HN
Develop interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 2).	P/M	Q2-Q3	CVH/HN
Implement and test interventions with the clinic which includes PDSA cycles (Module 3)	P	Q2-Q4	CVH/HN
Health Education to distribute educational materials on the importance of breast cancer screening to members at the educational sessions, cultural center, and women's imaging center.	M	Q2-Q4	CVH/HN
Implement provider incentives to close the gaps and improve HEDIS rates for BCS.	P	Q1-Q4	CVH/HN
Implement member incentive for completion of breast cancer screening to improve HEDIS BCS rates.	M	Q1-Q4	CVH/HN
Deploy cultural and linguistic strategies at targeted convenient and culturally competent provider sites to support members in accessing their breast cancer. screening services. Strategies include: on-site interpreters, and transportation services.	M	Q1-Q4	CVH/HN

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

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)

Measure(s)	Specific Goal	Rate MY2018	Rate MY2019	Rate MY2020	Baseline Source	Baseline Value
HEDIS® Breast Cancer Screening – County Goal	Meet or Exceed the MPL (50th Percentile) 58.73%	Fresno: 51.12 %	Fresno: 55.26%	TBD	MY2019 HEDIS Data	55.26%
HEDIS® Breast Cancer Screening – Provider Goal	Meet or Exceed SMART Aim Goal of TBD%	18.5%	28.46%	TBD	MY2019 Provider Results	28.46%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	
Initiation Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
3-2: Improving Childhood Immunizations (CIS-10)				
☐ New Initiative ☒ Ongoing Initiative from prior year				
Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☒ Safety Clinical Care	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: To improve pediatric health in Fresno County; specifically, to improve the health and safety of our youngest children and other at-risk populations in Fresno County by reducing the chance of preventable infection/illness through immunization.

Rationale: Vaccines are essential for protecting children against infectious diseases such as measles, mumps, rubella and whooping cough. Many of these diseases are largely forgotten in our country. Before vaccines became available, these diseases exacted a huge toll. For example, before the measles vaccine was licensed in 1963, the virus infected at least 2 million Americans a year, causing 500 deaths and 48,000 hospitalizations. When children are vaccinated, their immune system develop infection-fighting antibodies to protect them from contracting the targeted disease if they are exposed to it later in life. (Fauci, 2019).[1]

Many diseases which children in the United States are immunized against are rare in this country because of mass vaccination programs. However, these diseases are still found in other parts of the world and can be reintroduced into the United States by travelers, and then spread within our communities among people who have not been vaccinated. The current resurgence of measles, a highly contagious and potentially deadly disease that was declared eliminated in the United States in 2000, is a painful reminder of the need for vaccination. (Fauci, 2019). According to the US Department of Health and Human Service, five important reasons to vaccinate your child are:

1. Immunizations can save a child's life,
2. Vaccination is very safe and effective,
3. Immunization protects others we care about,
4. Immunizations can save families time and money.
5. Immunizations protects future generations. (HHS.gov, 2018).[2]

Despite the established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. A small but increasing number of children in the United States are not getting some or all of their recommended vaccinations. The percentage of children under 2 years old who haven't received any vaccinations has quadrupled in the last 17 years, according to federal health data (Health & Science, 2018). Approximately 300 children in the United States die each year from vaccine preventable diseases (NCQA, 2019).[3]

With the addition of new vaccines in recent years, and more in development, there is an even greater potential to save millions of more lives. Unfortunately, continuing disease outbreaks across the U.S. remain a public health concern. Lack of access to vaccines, combined with people who are not taking full advantage of opportunities to protect themselves, their families, and their communities, leaves people susceptible to preventable diseases (State of the Immunion, 2018).[4] America's future rests in the hands of our young; here in the U.S., we have the technology to

prevent suffering among our most vulnerable citizens, our newborns (State of Immunion, 2018). Through public health efforts and working together to ensure access to and delivery of vaccines, we can prevent the suffering of families who could otherwise lose their precious newborns to vaccine-preventable diseases (State of Immunion, 2018).

Primary care providers play a key role in ensuring that children and the community receive vaccines on time. Because of the ongoing COVID-19 pandemic, providers are presented with the additional challenge of maintaining and strengthening routine vaccination during a global pandemic. As COVID-19 cases increased and states implemented stay-at-home orders, outpatient visits declined significantly. Increasing communication efforts regarding the importance of vaccination will be worthwhile, as the COVID-19 pandemic has highlighted the threat of infectious disease and has increased awareness of the vaccine development process.

Prior to the tragic events of 2020, many parents had not seen the devastating consequences of an infectious disease. The COVID-19 pandemic may offer an opportunity to change parents' perspective on vaccinations, particularly as it relates to the influenza vaccine. Providers should continue to promote the importance of well-child and vaccination visits. (McNally & Bernstein, 2020).[5]

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1 Fauci, A. (2019). The Importance of Childhood Vaccinations. National Institute of Health.
https://www.niaid.nih.gov/news-events/importance-childhood-vaccinations
2 United States Department of Health and Human Services. (2018). Five Important Reasons to Vaccinate Your Child.
https://www.vaccines.gov/get-vaccinated/for_parents/five_reasons
3 NCQA National Commission Quality Assurance. (2019) Childhood Immunization Status (CIS). https://www.ncqa.org/hedis/measures/childhood-immunization-status. Accessed December 21, 2020.
4 State of the Immunion. (2018) A Report on Vaccine-Preventable Disease in the U.S. Available at: https://www.vaccinateyourfamily.org/wp-content/uploads/2018/07/FINALSOTIReport_2018-1.pdf
5 McNally, V., Bernstein, H. (2020). The Effect of the COVID-19 Pandemic on Childhood Immunizations: Ways to Strengthen Routine Vaccination. Pediatric Annals. 2020; 49(12):e516-e522.
https://www.healio.com/pediatrics/journals/pedann/2020-12-49-12/%7B594dfc0c-a4c6-4247-8243-39f8ee9e665c%7D/the-effect-of-the-covid-19-pandemic-on-childhood-immunizations-ways-to-strengthen-routine-vaccination

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

The HEDIS measure, Childhood Immunization Status - Combination 10 (CIS-10), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of members who turn 2 years old who have been identified to receive the following vaccinations: four diphtheria, tetanus, and acellular pertussis (DTap); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four (pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

The baseline rate of 27.58% was determined based on the MY 2019 HEDIS hybrid data for one high volume, low performing FQHC in Fresno County; with a goal rate of 34.82%.

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 FQHC in Fresno County to implement targeted BCS interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Complete Key Driver Diagram with potential interventions (Module 1). Due to HSAG 3/26/21.	P	Q1-Q2	CVH/HN
Complete process map activity with high volume, low compliance clinic in Fresno County (Module 2).	P	Q1-Q2	CVH/HN
Develop interventions with high volume, low compliance clinic, to address high priority gaps identified in Failure Modes and Effects Analysis Table (Module 2).	P	Q2-Q3	CVH/HN
Implement and test interventions with the clinic which includes PDSA cycles (Module 3)	P	Q2-Q4	CVH/HN
Health Education will design and implement educational activities on the importance of childhood immunizations at the clinic.	M	Q1-Q4	CVH/HN
Create article and distribute in Member newsletter highlighting childhood immunizations annually.	M	Q1-Q4	CVH/HN
Implement direct member incentive for completion of childhood immunizations series to improve CIS-10 measure rates	M	Q1-Q4	CVH/HN
Implement provider incentives to close the care gaps and improve CIS-10 measure rates.	P	Q1-Q4	CVH/HN
Develop Provider Tip Sheet for CIS-10 measure, which is available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines.	P	Q1-Q4	CVH/HN

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

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)

Measure(s)	Specific Goal	Rate MY2018	Rate MY2019	Rate MY2020	Baseline Source	Baseline Value
Childhood Immunization Combo 10 – County Goal	Meet or Exceed the MPL (50th Percentile) 34.79%	Fresno: 32.16%	Fresno 33.82%	TBD	MY2019 HEDIS Results	33.82%
Childhood Immunization Combo 10 – Provider Goal	Meet or Exceed SMART Aim Goal of 34.82%	N/A	27.58%	TBD	MY2019 Provider Results	27.58%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	Health Education		☐		
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN		☐		
3. Monitor CalViva Pregnancy Program and identify high risk members via Case Management	Case Management		☐		
4. Promote CA Smokers' Helpline to smokers	Health Education		☐		
5. Launch a Diabetes Prevention Program	Health Education		☐		
6. Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016.	Quality Improvement/ Case Management		☐		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for appropriate member outreach			☐		
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	C&L		☐		
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	Access & Availability		☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date	Access & Availability		☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers	Access & Availability		☐		
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars	Access & Availability		☐		
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	Access & Availability		☐		
7. DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey.	Access & Availability		☐		
8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review	A&G		☐		
9. Population Needs Assessment Update: Evaluate members' health risks and identify their highest priority health care needs, as basis of targeted Cultural & Linguistics, Health Education and Quality Improvement (QI) programs.	C&L		☐		
10. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement. Analyze and inform Provider Network Management of areas needing increased contracting with a particular provider to improve availability.	C&L		☐		
11. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged	Quality Improvement		☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
outreach requirement: Annual IHA Compliance Monitoring Report					
12. Engage with CVH provider offices to complete MY2021 MCAS training focused on best practices for closing care gaps.	Quality Improvement		☐		
13. Engage with high volume CVH provider offices to complete interventions addressing systemic barriers to HEDIS performance.	Quality Improvement		☐		
QUALITY AND SAFETY OF CARE					
Integrated Case Management (ICM) • Implement ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Case Management		☐		
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	Credentialing		☐		
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	MHN		☐		
QUALITY IMPROVEMENT					
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To	FSR		☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
ensure provider offices and medical records comply with DHCS contracted requirements per MMCD Policy Letter 14-004 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023.					
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	Quality Improvement		☐		

Item #7

Attachment 7.A

2021 Case Management
Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Paula Ackerman, Director Care Management

COMMITTEE DATE: March 18, 2021

SUBJECT: Case Management Program Description Change Summary

CM Redline Page #	Section/Paragraph name	Description of change
2	Title page	Updated year from 2020 to 2021.
3	Table of Contents	Page numbering and section titles updated.
5	Levels of Case Management	Added header for Non-complex Case Management with existing case management and care coordination descriptions as sub-headings
7	Goals of the Case Management Program	Updated timeframe measured for postpartum visit based on change to HEDIS measurement. Clarified goal for pre-term delivery is 2% lower than members not managed.
9-11	Complex Case Management Criteria	Modified criteria to be based on the Population Health Management (PHM) report that includes data from Impact Pro and other resources. To meet NCQA requirements and align criteria with resources, filters were added to identify members who will be referred to CM and managed as complex cases automatically. Previously level of case management was determined after assessing the member.
12	Case Management Criteria	Added example of State mandated criteria. Added criteria for members partially meeting criteria for complex CM maybe referred to case management. Members with designated score on HRA and or who requested an Individualized Care Plan (ICP) or Integrated Care Team (ICT) moved from Complex Criteria to Case Management criteria.
13	Organizational Structure	Added description for Vice President Medical Management.
13	Care Team (CT) Staffing Model	Changed average active case load from 62 to “may be up to 70 cases” to align with Centene goal of 70 cases/CM.
17	Care Team (CT) Staffing Model	Last paragraph in this section changed Integrated Care Team meetings from biweekly to at least monthly. Added reference to CM huddles held at least weekly.
27	Member Experience with Case Management	Modified how satisfaction surveys may be conducted to include mail, email, text, or telephonically for members who have been enrolled in case management and the case closure status meets designated criteria. Changed to align with Centene centralizing this process across Plans.
28-29	Special Programs	Added subsections describing the Transitional Care Management and Palliative Care Programs

Health Net Community Solutions
Case Management
Program Description
2021~~0~~

Table of Contents

PURPOSE

The purpose of the Case Management Program Description is to define case management, identify case management functions, determine methods and processes for member identification and assessment, manage member care and measure outcomes.

Delegated Participating Provider Groups (PPGs) conduct basic case management activities in compliance with the Plan's standards.

In both delegated and non-delegated situations, the Case Management Program provides individualized assistance to members experiencing complex, acute, or catastrophic illnesses and members who are out-of-area. The focus is on early identification of high-risk members, applying a systematic approach to coordinating care and developing treatment plans that will increase satisfaction, and improve health and functional status. In addition, certain Case Management responsibilities are an integral part of Carve-Out and Public Health Programs, for example, CCS or Regional Center Programs.

The Plan makes available a comprehensive, high-risk perinatal Case Management Program to members regardless of delegation status. Care Managers work with Primary Care Physicians and other providers to develop individualized plans for appropriate members.

SCOPE

Definition of Case Management

Case Management is a key vehicle for managing the health of the population. The Plan adheres to the Case Management Society of America's (CMSA) definition of case management which was updated in 2016: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and quality cost effective outcomes".
The Plan also abides by the principles of case management practice, as described in CMSA's most recent version of the Standards of Practice for Case Management, revised in 2016.

The Case Management Program and the tools utilized to manage care were developed based on evidence based clinical practice guidelines and preventive health guidelines adopted by Centene and the Plan. The assessments utilize the CMSA Standards of Practice for Case Management and other evidence based tools including the PHQ2/9. Disease specific assessments include research of latest scientific sources, articles and publications from national organizations, such as the American Diabetes Association. The program also includes adherence to HEDIS effectiveness of care measures and the associated technical specifications to promote member compliance.

The Plan trains and utilizes motivational interviewing techniques to guide member goal identification and actions.

Levels of case management include:

- **Non-complex Case Management**
    - **Care Coordination** – appropriate for members with primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources or

assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of case management is used for continuity of care transitions and supplemental support for members managed by the county.

- **Case Management** – appropriate for members needing a higher level of service, with clinical needs. Members in case management may have a complex condition or multiple co-morbidities that are generally well managed. Members in case management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services included at this level of case management include the level of coordination along with identification of member agreed upon goals and progress towards meeting those goals.

- **Complex Case Management** – a high level of case management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex case management is performed by Health Net for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of complex case management include all coordination and case management services from above, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence.

Goals and Objectives

The Mission of Plan's Case Management Program is to:

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

The Goals of the Case Management Program are:

Measure	Goal	Frequency
Member experience survey – each question and overall	> 90%	Annual
Member complaints/grievances	< 1/10,000	Annual
Reduce Non-Emergent ER Visits	> 3%	Annual
Reduce Readmissions	> 3%	Annual
Members managed in high risk OB program have greater % of members completing the 1st pre-natal visit with in the 1st trimester or 42 days of enrollment than pregnant members not managed.	> 5% difference	Pregnancy
Members managed in high risk OB program have greater % of members completing the post-natal visit between 7-84~~21-56~~ days post-delivery than pregnant members not managed.	> 5% difference	Pregnancy
Members managed in high risk OB program have a lower rate of pre-term delivery than high risk members not managed.	~~<>~~-2% lower rate ~~difference~~	Pregnancy

Case Management Functions:

Case Management functions include:

- Early identification of members who have special needs.
- Assessment of member's risk factors.
- Development of an individualized plan of care in concert with the member and/or member's family, primary care provider (PCP), and managing providers.
- Identification of barriers to meeting goals included in the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Referrals and assistance to ensure timely access to providers.
- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/case management activities.
- Addressing the member's right to decline participation in the case management program or disenroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all case management procedures in compliance with HIPAA and state law.

Program Segments

The Plan has defined a set of case management population criteria for use with all Medi-Cal members (children, adults and seniors, children with special needs (CSHCN), developmentally disabled (DD), seniors and persons with disabilities (SPD) etc.). This creates efficiencies and a consistent measurement process of case management program effectiveness across the Medi-Cal membership. The criteria below is not all inclusive; clinical judgment should be used to determine a member's appropriateness for each level of case management, considering such factors as stability of the condition(s), available support system, current place of residence, etc.

The Plan also offers a case management program specific to our pregnant moms and new babies, called Start Smart for Baby. The program is focused on helping prospective moms to have a

healthy happy pregnancy and the wellness in the fetus and newborn. The program goals are quality of care in prenatal visits acknowledgement of and American College of Obstetricians and Gynecologists (ACOG) standards. The quality measures include HEDIS rates for timelines of prenatal care and timeliness of postpartum care.

~~Complex Case Management Criteria~~

~~The Plan uses Impact Pro a predictive modeling and care management analytic tool with a built in proprietary risk stratification algorithm to differentiate members who are impactable and have higher risk and more complex health needs from those at lower risk. The risk stratification algorithm utilizes member specific data identified through claims, TARs, pharmacy and data provided by the State. Members are stratified into one of ten Population Health Categories: Level 01: Healthy, 02: Acute Episodic, 03: Healthy, At Risk Level and 04A: Chronic Big 5 Stable, 04B: Chronic Other Condition Stable, 04C: BH Primary Stable, Level 05A: Health Coaching, Level 05B: Physical Health CM, Level 05C Behavioral Health CM, Level 06: Rare High Cost Condition, Level 07A: Catastrophic: Dialysis, Level 07B: Catastrophic: Active Cancer, Level 07C: Catastrophic: Transplant Level 08A: Dementia, Level 08B: Institutional (custodial care)_ Level 09A: LTSS and MMP – Service Coordination, Level 09B: LTSS and MMP – High Needs Care Management or Level 10: End of Life. Members stratified into levels 05B and 5C are identified as high risk and impactable and are referred to case management as described below.~~

- ~~Members stratified in Impact Pro into Level 5B: Physical Health CM and Level 05C Behavioral Health CM~~

~~AND have other designated parameters such as:~~

- ~~CM engagement score ≥ 80~~
- ~~ORCA (opioid risk classification) score of medium or high~~
- ~~Priority Flag = Yes~~
- ~~Annual ER designated cost~~

~~Shall be referred to the case management program.~~
~~Additionally, any member, regardless of the risk stratification, who reach a designated score based on responses to the Screening HRA and or who requested an ICP or individualized care team shall be referred to Case Management.~~

~~Case Management Criteria~~

- ~~Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to:~~
  - ~~HIV/AIDS~~
  - ~~Cancer~~
  - ~~Asthma, with associated inpatient admission~~
  - ~~Sickle cell~~
  - ~~Diabetes~~
  - ~~Congestive Heart Failure~~
- ~~Children with special health care needs~~
- ~~Other State-mandated criteria~~

~~Care Coordination Criteria~~

- ~~Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources~~
- ~~Need for assistance with accessing health care services related to continuity of care~~
- ~~Participation in county program requiring supplemental Plan support~~

Complex Case Management Criteria

The Plan uses the Population Health Management (PHM) report to identify members for Complex Case Management. The PHM report combines data from multiple sources to use in its population and program eligibility process. Data elements from multiple sources are stored in corporate-wide data warehouses. Data from the warehouse is extracted into a predictive modeling tool, Impact Pro. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information. Members are stratified into one of ten Population Health Categories in Impact Pro: Level 01: Healthy to Level 10: End of Life. In addition to Impact Pro, a web-based customizable report generating system, Micro Strategies, is used to produce adjunctive analytical reports for related PHM programs including Complex Case Management.

Members stratified as described below are identified as complex and are referred to case management.

Members stratified into one of the PHM report categories below:
07b High Priority PH CM
07a high Priority BH CM
05d Chronic Highly Complex
05c Chronic High Risk - With Care Gap (under Clinical Analytics Population Grouping)

AND are in one of the following Primary Risk categories:

- Acute and chronic renal failure
- Anxiety disorders/ phobias
- Atrial fibrillation/flutter
- Childhood-onset psychiatric disorders
- COPD, including asthma
- CVA
- Diabetes
- Heart failure/cardiomyopathy
- Hypertension
- Ischemic heart disease
- Mood disorder, bipolar
- Mood disorder, depression
- Other Cardiology
- Other mental health
- Psychotic/schizophrenic disorders
- Substance Abuse

AND have:

- 30% inpatient probability
- 3 or more cage gaps
- CM engagement score $\geq$ 80
- Priority Flag = Yes

Members referred from other sources may also be managed as a complex case based on the member's need.

Case Management Criteria

• Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to:
  • HIV/AIDS
  • Cancer
  • Asthma, with associated inpatient admission
  • Sickle cell
  • Diabetes
  • Congestive Heart Failure
  • Children with special health care needs
• Other State-mandated criteria such as members under 21 years of age receiving private duty nursing services
• Members otherwise meeting criteria for Complex Case Management but do not have an additional parameter such as 30% inpatient probability score
• Members who reach a designated score based on responses to the Screening HRA and or who requested an ICP or individualized care team may be referred to Case Management.

Care Coordination Criteria
• Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing health care services related to continuity of care • Participation in county program requiring supplemental Plan support

INFRASTRUCTURE AND TOOLS

Organizational Structure

Vice President Medical Affairs

The Vice President Medical Affairs has operational responsibility for and provides support to the Plan's Case Management Program. The Plan Vice President Medical Affairs(VPMA), Sr. Vice President of Medical Management (VPMM), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the Case Management Program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to case management. A behavioral health practitioner is involved in the implementation, monitoring, and directing of behavioral health aspects of the Case Management Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the VPMA, the Plan may have one or more Medical Director and/or Associate Medical Directors.

The CMD's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations.
- Monitors compliance with the Case Management Program.
- Provides clinical support to the case management staff in the performance of their case management responsibilities.
- Provides a point of contact for practitioners with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.

- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed.
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees.

Behavioral Health Practitioner

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of the Plan's Case Management Program. A behavioral health practitioner may participate in case management rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. The behavioral health practitioner may be a clinical director, a Plan network practitioner, or behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e. doctoral-level clinical psychologist or certified addiction medicine specialist) or pharmacist, as appropriate, may be consulted on cases involving behavioral health issues.

Sr. Vice President of Medical Management (VPMM)

The Sr. VPMM is a registered nurse with experience in utilization management and case management activities. The Sr. VPMM is responsible for overseeing the activities of the Plan's Utilization Management and Case Management Programs. The Sr. VPMM reports to the Plan Chief Operating Officer. The Sr. VPMM, in collaboration with the VPMA, assists with the development of the Case Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Vice President of Medical Management (VPMM)

The VPMM is a registered nurse with experience in case management activities. The VPMM is responsible for overseeing the operational activities of the Plan's Case Management Program. The VPMM reports to the Sr. Vice President of Medical Management and assists with the development and oversight of the strategy, policy, and operational planning and execution of work processes for the Case Management program.

Case Management Director/ Manager

The Director/Manager of Case Management is a registered nurse or other appropriately licensed healthcare professional with case management experience. The Case Management Director/Manager directs and coordinates the activities of the department including supervision of Care Managers, Program Specialists and Program Coordinators. The Case Management Director reports to the ~~Sr.~~ Vice President of Medical Management. The Case Management Manager reports to the Director of Case Management. The Case Management Director/Manager work in conjunction with the Utilization Management Director to execute the strategic vision of Health Plan objectives and attendant policies and procedures and state contractual responsibilities.

Supervisor, Program Coordinator (PC)

The Supervisor PC is highly skilled high school graduates or equivalent with 5 or more years of prior authorization, physician's office, customer service, claims processing or provider relations experience preferably in a managed care setting. The Supervisor PC oversees day to day operations and supervision of the Program Coordinators in CM and performs collaborative duties related to coordinated care programs. The Supervisor PC provides support to the Program Coordinators to promote quality and continuity of services delivered to members and providers. The Supervisor PC reports to the Director of CM.

Care Team (CT) Staffing Model

Care Coordination/Case Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers work closely with the concurrent review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Care Manager's average active case load may ~~would~~ be up to ~~62~~70 cases. The Integrated Care Team roles and responsibilities include: care managers, social workers, other licensed clinical staff, program specialists, program coordinators, care coordinators, and Connection Representatives.

Medical Director

- Physician who holds an unrestricted license to practice medicine in the Plan's state and is board-certified with experience in direct patient care if required.
- Serves as a clinical resource for care managers and members' treating providers.
- Participates in multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases.
- Provides a point of contact for providers with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.

Care Manager (CM)

- Licensed RN, or licensed clinical social worker.
- CM certification preferred.
- Responsible for oversight of non-clinical members of the CC/CM team.
- Responsible for working with the member and their physician to identify needs and create a care plan to help the members achieve their goals.
- Participates in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers.
- Communicates and coordinates with the member and their caregivers, physicians, behavioral health providers, Disease Management staff, and other members of the CT to ensure that member's needs are addressed.

Social Workers/Program Specialists (SW/PS)

- Non-licensed Social Worker or licensed vocational nurse.
- Considered a care manager with an assigned caseload and responsible for following all standards of case management practice.

Program Coordinator (PC) II /Service Coordinator (SC)

- Can be either an LPN or a highly trained non-clinical staff person working under the direction and oversight of a CM.
- Provides support for moderate or low risk members.
- Collects data for Health Risk Screening.
- Provides information to CM/PS for care plan.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager/Program Specialist.

Program Coordinator (PC) I

- Non-clinical staff person working under the direction and oversight of a PC II or CM.
- Provides administrative support to CC/CM team.
- Collects data for Health Risk Screening.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager.

Member Connections Representative (CR)

- Health outreach workers typically hired from within the communities served to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.
- Works both in the office and in the community, sometimes with face to face member interaction.
- Performs member outreach, education, and home safety assessments.

- May assist with community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, Reading Events, etc.
- Member Connections Representatives report to the Manager of Member Connections.

Integrated Care Team meetings are held at least monthly~~bi-weekly~~. The participants are comprised of plan behavioral health and physical health care managers, social workers, non-clinical associates, medical directors, and a pharmacy coordinator. Other participants may include: PCPs or specialists, behavioral health providers and/or County Mental Health Plan staff and/or CR depending on the case. These meetings are augmented by CM huddles held at least weekly and facilitated by a Plan Medical Director.

Information System

Assessments, care plans, and all case management activities are documented in a clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the care team to generate reminder/task prompts for follow-up according to the timelines established in the care plan. Reminders/tasks can be sent to any team member, e.g. allowing Care Managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g. inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of case management interventions.

MEMBER IDENTIFICATION AND ACCESS TO CASE MANAGEMENT

A key objective of Plan's Case Management Program is early identification of members who have the greatest need for care coordination and case management services. This includes, but is not limited to, those classified as children or adults with special health care needs; with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are frail, elderly, disabled, or at the end of life.

Data Sources

Members are identified as potential candidates for case management through several data sources as available to the Plan, including, but not limited to:

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data

- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency department utilization reports
- Laboratory data
- Readmission reports
- State/CMS enrollment process and other State/CMS supplied data
- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD/SSI)
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments, Member Evaluation Tool (MET)
- Information provided by practitioners, such as Notification of Pregnancy

Reports identifying members for case management are run on at least a monthly basis and forwarded to the care team for outreach and further appraisal for case management.

Referral Sources

Additionally, direct referrals for case management may come from resources such as:

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Case Management Program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.
- Envole PeopleCare Nurse Advice Line staff –has policies and procedures in place for referring members to the Health Plan for case management screening. This may be accomplished via a "triage summary report" that is sent to the Plan electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at the Plan.
- Envole PeopleCare Disease Management (DM) Program staff –work closely with the case management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as case management rounds, are held between the care team and DM staff.
- Hospital staff, e.g. hospital discharge planning and emergency department staff - facility staff is notified of the Plan's Case Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform Plan UM staff if they feel a member may benefit from case management services; UM staff then facilitate the referral.
- Health Plan Staff - UM staff work closely with case management staff on a daily basis and can initiate a referral for case management verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - Health Plan MemberConnections® Program - Connections Representatives (CRs) are trained in all departments within the Health Plan and have a full understanding of all staff functions. CRs work closely with the care team, referring members who may benefit from case management services.

    - Health Plan Member Services - Member Services staff is also trained in all departments within the Plan and have a full understanding of all staff functions, including the role and function of the care team.
    - Other intradepartmental referrals e.g., Provider Specialists, Plan Advocates, and QI Department.
- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - members are educated about case management services in the Member Handbook, received upon enrollment and available on the Plan website, member newsletters, and through contact with Member Services and/or other Plan staff.
- Community/social service agencies – community agency staff are informed of the Case Management Program during interactions with the Plan care team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential case management needs to Plan staff.(California Childrens Services (CCS), Local Health Department (LHD), Local Mental Health Plan (MHP) etc.)
- Delegated entity staff (e.g. vision, dental, DME/home health, etc, as applicable) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for case management. The Plan also regularly communicates with delegates through oversight meetings, case management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- State agency/state enrollment center.

The specific means which a member was identified as a potential candidate for case management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to case management. Multiple referral avenues help to minimize the time between need for and initiation of case management services. Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

SCREENING AND ASSESSMENT

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 7calendar days of identification as potential candidates for case management. Care team staff obtain consent to complete the case management screening and/or initial assessment once member contact is made. Case Management staff also explains the care manager role and function and benefits of the Case Management Program to the member and/or their authorized representative or guardian.

General standardized assessments have been developed internally to address the specific issues of the Plan’s unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for case management. All assessments are documented in the clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity.

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Case Management Program, and are informed they are entitled to decline participation in, or disenroll from case management at any time, if allowed per state regulations.

The member/guardian is notified of the potential need for the care team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always obtained prior to any contact. Documentation of verbal member consent to participate in the Case Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented.

Members unable to be contacted via telephone are mailed a letter requesting that the member call the care team. Connections Representatives may also be utilized when necessary, to assist in outreach for members who are difficult to contact. Connection Representatives go the member's physical address and attempt to initiate contact. They may also outreach to local community agencies and provider offices in an effort to locate a member. If a CR is successful in locating the member, they may perform a general screening in person, including observation of the member in their home surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc.

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly stable and the member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are assigned to a care team who confirms the findings of the screening assessment and may complete a more thorough assessment with the member. Outreach to members is initiated within 7 calendar days and completed within 14 calendar days of identification/referral.
A Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history. Stratification as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management may be revised at this time, or following further assessment.

The Care Manager then attempts outreach to the member and/or authorized representative or guardian telephonically within one week for members identified as high priority and thus appropriate for Complex Case Management, to perform an in-depth assessment to more closely identify and prioritize the member's individual needs. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about a member's condition(s). These condition-specific assessments, such as the Diabetes and Asthma assessment, are derived from evidence-based clinical guidelines. During the in-depth case management assessment, the Care Manager evaluates the full scope of the member's situation, including:

- Evaluation of communication barriers; cultural, linguistic, hearing, and visual, preferences or limitations.
- The member's health status, including condition–specific issues and likely co-morbidities.

- Assessment of behavioral health status (e.g. presence of depression and/or anxiety) and cognitive functioning.
- Assessment of social determinants of health issues such as alcohol or drug dependency, smoking, significant life stressors, etc.
- Documentation of the member's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring.
- Assessment of activities and instrumental activities of daily living.
- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.
- Assessment of life planning activities such as living wills, advance directives, etc.
- Evaluation of caregiver resources and potential involvement in care plan implementation.
- Assessment of personal resources, limitations, and presence of social determinants
- Evaluation of available benefits and other financial resources.
- Evaluation of need for, and availability of, community resources.
- Assessment of educational and vocational factors.

Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital case managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. The role and function of the Care Manager is also explained to the member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The care team reviews the gathered information and begins to build a plan of care. The initial assessment and plan of care are completed no later than 60 days after the identification/referral of the member to Case Management, but in most cases is completed earlier. A member is considered eligible for case management services upon their consent to participate unless otherwise defined by individual state laws. Care teams may include Nurse Care Managers, Program Coordinators, Social Workers, Behavioral Health Specialists, and Connection Representatives. Each contributes different skills and functions to the management of the member's case. Other key participants in the development of the care plan may include:

- Member
- Member authorized representative or guardian
- PCP and specialty providers
- Plan Medical Directors
- Hospital discharge planners
- Ancillary providers (e.g.. home health, physical therapy, occupational therapy)
- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g. United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation; companionship, etc.)
- Other non-health care entities (e.g. Meals on Wheels, home construction companies, etc.)

Behavioral Health Services

The Plan is responsible to provide mild to moderate mental health services to all members, including Applied Behavioral Analysis (ABA) when medically necessary. The Plan strongly supports the integration of both physical and behavioral health services through screening and strengthening prevention and early intervention, Specialty mental health services are not covered under the Plan and are paid under Medi-Cal FFS. The Plan will ensure that Members who need Specialty Mental Health Services are referred to and are provided these services by an appropriate Medi-Cal FFS mental health provider or the local mental health plan in accordance with contract requirements. The Plan will assist members with scheduling referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care. The Plan shall also assist individuals requesting Voluntary Inpatient Detoxification (VID) services and provide care coordination to assist the member in locating a general acute care hospital (may not be a chemical dependency treatment facility or Institution for mental disease).

Continuity and Coordination of Care between Medical and Behavioral Health Care

When staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify the Plan Care Manager of the member. If the member's primary diagnosis is a behavioral health condition, the case is referred to a Behavioral Health Care manager, who serves as the lead Case Manager, working in tandem with the medical care team. Whether the member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health Case Manager will serve as the lead Case Manager. The medical and behavioral health Case/Care Managers confer with each other to confirm which Case/Care Manager will serve as the lead or secondary Case/Care Manager. If the Case/Care Managers cannot agree, a supervisor is consulted for a decision.

When assigned to a physical health Care Manager, he/she reviews the member's clinical information to assure the patient is receiving appropriate behavioral health care. If the patient does not appear to be receiving this care, the Care Manager:

- Contacts the medical provider to ask about a behavioral health consult.
- Assists the member, or coordinates with the behavioral health Case Manager, to make arrangements for the behavioral health consult.
- Follows up to make sure a behavioral health consult was conducted.

When appropriate (including but not limited to when the primary Care Manager is revising the plan of care or evaluating a member for discharge from case management), the medical and behavioral Case/Care Managers confer with each other to ensure that the necessary expertise is available to monitor and guide members' care. The primary Care Manager, is responsible for assuring appropriate physical and behavioral health follow-up in case management discharge planning.

Coordination with External Programs

The Plan will refer identified members to external agencies offering appropriate services and programs to complement those provided by the Plan. Programs and services may include, but are not limited to: Public Health Departments, Severe Mental Health Services, California Children's Services (CCS), Transplant services with the exception of kidney, Regional Center for the developmentally disabled, Home and Community-Based Services (HCBS) Waiver program

administered by the State Department of Developmental Services (DDS), Regional Center or local governmental health program as appropriate for the provision of TCM services. The Plan shall continue to provide all Medically Necessary Covered Services per the Memorandum of Understanding for all eligible members that are not authorized or covered by external agencies. The Plan shall ensure the coordination of services and joint case management between its Primary Care Providers, specialty providers, and the local programs or agencies.

ONGOING MANAGEMENT

Plan of Care Development

The initial assessment serves as the foundation for the member's care plan. The care team identifies issues and needs, and utilizing input from team participants, develops a proposed care plan. The care plan is developed in conjunction with the member; the member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care plan as needed. Prioritized goals are established and barriers to meeting goals or complying with the plan of care are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of the discharge plan as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care plan.

The proposed plan of care is discussed with the member and/or member authorized representative or guardian, the PCP, and the health care team. The member's role is discussed and member/caretaker and provider input is obtained and used to modify the goals according to member's ability and willingness to participate. The Care Manager assures all parties are in agreement with the care plan to ensure successful implementation.

Members assigned to Care Coordination, or members identified as moderate/medium priority assigned to Case Management have an abbreviated care plan. The care plan for members in Complex Case Management includes, at a minimum:

- Prioritized goals – goals are specific, realistic, and measurable and are associated with a timeframe for completion. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible.
- Identification of barriers to meeting the goals and recommended solutions for each barrier.
- Resources to be utilized, including the appropriate level of care.
- Interventions to reach those goals, including development of member self-management plans. The care manager assures the member has a full understanding of their responsibilities per the self-management plan.
- Planning for continuity of care.
- Collaboration with and involvement of family and significant others, health care providers, etc.(as applicable).
- The schedule for on-going communication with the member and other involved parties, based on individual needs and member preference.
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated.

The care plan is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines such as for diabetes and asthma management, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Monitoring and Evaluation

Once the plan of care is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Revisions to the care plan are made when necessary, e.g. when the member's condition progresses or regresses, when goals are reached, etc. Significant revisions to the plan of care are also shared with the PCP. A schedule for follow up and monitoring of the member's progress is developed, using as a minimum the intervals defined according to priority level and current needs. The Care Manager may assign tasks to other members of the care team, such as a Program Specialist to manage or assist with social determinants of health issues or a Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/tasks to be created for each case, alerting the care team when follow-up contacts are needed. Follow-up reminders can be set for daily, weekly, monthly, etc. contacts. Intervals for follow-up are based on the goals and time lines in the care plan.

The Care Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers' or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Member or caretaker agreement to participate in the Case Management Program (agreement may be oral or written; if oral, the Care Manager documents the discussion with the member/caretaker).
- Notes, including a summary of team conferences and all communications with the member/family, health care providers and any other parties pertaining to the member's case.
- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available.
- The case management care plan, including:
    - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers.
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - The member's self-management plan.
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below.

The Care Manager regularly evaluates the member's progress considering the following factors:

- Change in the member's medical status.
- Change in the member's social stability.
- Change in the member's functional capability and mobility.

- Progress made in reaching the defined goals.
- The member's adherence to the established care plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels, etc.
- Changes in the member or family's satisfaction with the Case Management Program and other services addressed in the care plan.
- The member's quality of life.
- Benefit limits and financial liability.

The Care Manager completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year if the member remains active in case management. If the member loses eligibility for more than 30 days then a new assessment is performed upon enrollment back into the complex case management program to ensure the member is being assessed for current case management needs. The plan of care is also updated at these times and shared with the PCP, as applicable.

The Care Manager implements necessary changes to the care team care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, or other members of the health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The care team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved are in agreement with changes to the care plan to ensure ongoing success. The care team also monitors the case on an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement Department.

Discharge from Case Management

The Care Manager may receive input from the PCP, member/family/guardian/caretaker, and other health care providers involved in the member's plan of care to determine the appropriateness for closing the case. The following criteria are used on an ongoing basis to determine when discharge from case management should occur:

- Member terminates with the Health Plan.
- Member/family requests to disenroll from the Case Management Program.
- The member/family refuses to participate in case management despite efforts to explain how it can benefit the member.
- Plan is unable to reach member despite at least three (3) different types of attempts (phone attempts at different times during day, visit to home, letter submission with address correction request, and/or contacting PCP/Specialists/Programs) to locate and engage the member.
- The member reaches maximum medical improvement or reaches established goals regarding improvement or medical stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources.
- Insurance benefits are exhausted and community resources are in place.
- Member expires.

If the above criteria indicate a case should be closed, the Care Manager, as appropriate:

- Coordinates care with the new medical entity and community resources as required, allowing for a smooth transition for the member.
- If Complex Case Management has been refused by the member/family, the Care Manager provides the member with contact information for future reference and documents the refusal in the clinical documentation system.
- Contacts the PCP and other providers, when appropriate, regarding impending discharge from case management.
- Discusses the impending discharge from case management with the member/family.
- Presents community resources and assists in making arrangements with those relevant at the time of discharge.

A letter noting the member is discharged from case management is generated and sent to the PCP and the member. The letter documents the reason for discharge and includes, if the member has not terminated with the Plan, a reminder to contact the care team in the future should medical concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented. A member satisfaction survey may be included with the discharge letter, as described below.

PROGRAM ASSESSMENT AND IMPACT MEASUREMENT

Population Health Assessment

At least annually, the Plan assesses the entire member population and any relevant subpopulations (e.g. Children with Special Needs, Seniors and Persons with Disabilities Foster Care) to determine if the Plan's programs meet the needs of members. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age (especially children/adolescents and elderly), gender, ethnicity, race, and/or primary language, and benefit category. Other data used includes diagnostic and utilization data (e.g. overall claims received, inpatient admissions and ED visits, and pharmacy data). The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and members with mild to moderate mental illness.

Results of the population assessment are analyzed and subsequent enhancements made to the Case Management Program if opportunities for improvement or gaps in case management services are identified. Potential revisions to the Case Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.
- Revisions to types of case management activities assigned to specific members of the care team (e.g., clinical versus non-clinical staff responsibilities).
- Implementation of targeted training, e.g. related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff.
- Improvement in identification of appropriate community or other resources provided to members and the resources available to staff and the process for assisting members in accessing resources.

The annual population assessment may be a separate document or included as part of an annual Utilization Management and/or Quality Improvement program evaluation and will be presented to appropriate committees, such as the Quality Improvement Committee, for review and feedback.

Member Experience with Case Management

Member experience with the Case Management Program is assessed no less than annually. Member experience surveys, specific to case management services, are completed at least annually for members enrolled in case management. Surveys may be completed ~~are completed via~~by mail, ~~-~~email, text, or telephonically for members who have been enrolled in case management and the case closure status meets designated criteria.~~for ≥ 45 days.~~ The results of the surveys are aggregated and evaluated annually and are included in the overall evaluation of the Case Management Program, which may be part of the annual Quality Improvement and/or Utilization Management program evaluation as described below.

Member complaints and grievances regarding the Case Management Program are monitored no less than quarterly. Results of the analysis of member experience surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and determine which opportunities to pursue regarding changes to the Case Management Program, as needed.

Outcomes

Case Management Program outcomes are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.
- Improved clinical outcomes.
- Member/provider satisfaction.
- Health Plan specific state requirements/expectations.

The Plan measures effectiveness of Complex Case Management no less than annually using at least three (3) measures that assess the process or outcomes of care for members in Complex Case Management. Additional details regarding these measures are identified in the Utilization Management/Quality Improvement (UM/QI) work plan. Measures of effectiveness may include indicators such as:

- Readmission rates~~.~~
- ED utilization.
- Rate of pregnant members with an appropriate prenatal visit~~.~~
- Rate of pregnant members with an appropriate post-partum discharge visit~~.~~
- Rate of high~~--~~risk pregnant members who have a pre-term delivery~~.~~

Measurement and analysis of the Case Management Program is documented as part of the annual Quality Improvement and/or Utilization Management program evaluation. The Case Management Program is evaluated at least annually and modifications to the program are made as necessary. The Plan evaluates the impact of the Case Management Program by using:

- Results of the population assessment~~.~~
- The results of member experience surveys (i.e. members in case management)~~.~~
- Member complaint and grievance data regarding the Case Management Program~~.~~
- Practitioner complaints and practitioner satisfaction surveys regarding the Case Management Program~~.~~
- Other relevant data as described above~~.~~

The evaluation covers all aspects of the Case Management Program. Problems and/or concerns ~~are identified, recommendations for removing barriers to improvement are provided, and~~

opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Utilization Management Committee for review, action and follow-up. The final document is then submitted to the Board of Directors/governing body through the Quality Improvement Committee for approval.

Condition Specific CM and DM Programs

Members in condition specific Case/Disease Management Programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The case management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from case management when not specifically addressed in the program. Disease Management has been delegated to EnvolePeopleCare and the Plan Care Manager coordinates care and member interaction to prevent duplication of contacts and services.

Plan Case Management Programs may include, but are not limited to:

- Children and Adults with Special Health Care Needs
- Sickle Cell
- Transitional Care Management (post hospitalization follow-up)
- High Risk Pregnancy
- Palliative Care

Plan Disease Management Programs may include, but are not limited to:

- Asthma
- Diabetes
- Heart Failure

SPECIAL PROGRAMS

Transitional Care Management Program

The purpose of the Transitional Care Management Program (TCM) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating The health care continuum and addressing barriers to post discharge success for the member.

The TCM Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

The program includes:

- Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation, use of a personal health record
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond
- Preparation for discussions with other health care professionals
- Supporting the patient's self-management role

- Educating the member to follow up with the PCP/and or specialist within 7 days of discharge

During the post discharge period, staff evaluates the member to provide the best support to the member in managing their continued needs.

Palliative Care Program

Health Net offers the Palliative Care Program to its members with the goal of providing an extra layer of support by providing disease education, pain management, symptom control, and additional resources and guidance to enhance the member's quality of life. Through a partnership of vendors throughout California, Palliative Care is able to provide nurses, medical directors, and social workers in a home setting to members. Palliative Care empowers the member and family through a collaborative effort of communications, coordination of care, and advance planning, while allowing the goals of both the member and family to be the guiding principle.

The Palliative Care Program may be appropriate if there is a chronic or serious illness that is significantly impacting the quality of life or daily activities of the member. Palliative Care is conducted in accordance with the member's current primary physician and specialists to provide pain management, symptom management and disease management to enhance the member's quality of life. Palliative Care services are in addition to other current benefits, and existing curative medical treatment and social services may continue as before. Services include:

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Individualized Plan of Care including Pain and Symptom Management
- Care Coordination
- Mental Health and Medical Social Services
- Chaplain Services
- 24/7 Telephonic Palliative Care Support
- Additional medically necessary or reasonable services as provisioned in regulatory requirements

REFERENCES: NCQA 2020~~18~~ Health Plan Standards and Guidelines

ATTACHMENTS:

DEFINITIONS:

REVISION LOG:	**DATE**
1. Program Segments: Complex Case Management Criteria section updated to reflect new Population Health Categories in ImpactPro. 2. Program Assessment and Impact Measurement: updated to reflect Plan's overall population assessment - not limited to CM. 3. Member Experience with Case Management deleted or 60 days after >45 days. 4. Condition Specific CM and DM Programs deleted DM programs not offered. 5. Attachments: removed reference to Complex CM Program Description as information is consolidated into one document. 0. Other minor grammatical and formatting changes made throughout.	11/28/18
1. Screening and Assessment: changed reference to outreach by priority to calendar days for all for consistency.	2/13/19

1. Goals of CM Program added outcome measure for pre-term delivery and clarified goal percentage is percentage difference for the OB measures. 2. Infrastructure and Tools, Organizational Structure changed Chief Medical	1/13/20

Director to VP Medical Affairs, updated VPCM to Sr. VPMM. 3. Care Team Staffing, changed average caseload of 40-50 to average active caseload of 62. 4. Screening and Assessment, paragraph 1, changed outreach initiated within 30 calendar days to 7 calendar days. Paragraph 5 changed to outreach is initiated within 7 calendar days and completed within 14 calendar days. 5. Discharge from Case Management, bullet 4, deleted WIC. 6. Outcomes, added pre-term delivery as an outcome measure for OB program. 7. Condition Specific CM and DM Programs, plan program list changed Post Hospitalization Follow-up Care to Transitional Care Management.	
1. Levels of Case Management added header for Non-complex CM 2. Goals of CM Program updated time frame for postpartum visit and clarified goal percentage for pre-term delivery. 3. Updated criteria for Complex CM, and Case Management. 4. Integrated care team meetings updated frequency and added weekly huddles 5. Infrastructure and Tools, Organizational Structure added description for VPMM and updated reporting for Director CM. 6. Care Team Staffing, changed average active caseload to up to 70. 7. Member Experience with Case Management updated methods used to complete survey and related criteria. 8. Added Special Program section including subsections for TCM and Palliative Care 9. References – updated NCQA standards to 2020.	1/21/21

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer~~Compliance 360~~, Centene's P&P management software, is considered equivalent to a physical signature.

VP, Medical Management Department: Approval on File

Item #7

Attachment 7.B

2021 UMCM Work Plan

CalViva Health
2021
Utilization Management (UM)/ Case Management (CM)
Annual Work Plan

Last updated: March 5, 2021

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CalViva Health
2021 UM/CM Plan

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

1. Compliance with Regulatory & Accreditation Requirements

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (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. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' 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. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Monthly As needed Ongoing Ongoing Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	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

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers 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 acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire and annually thereafter through the Plan's online learning platform. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Health Net

CalViva HEALTH

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	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 staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing April 2021, July 2021, October 2021, January 2022

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup 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, 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 2021. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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.	☒ Medi-Cal	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 Chief Medical Director (CMD), Regional Medical Directors, Director of Medical Management and Medical Management Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2021 UM and CM Program Descriptions. Write and receive CalViva approval of 2020 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2021 UMCM Work Plan. Write and receive CalViva approval of 2021 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 2021 Q 1 2021 Q 1 2021 Q 3 2021 Ongoing Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

2. Monitoring the UM Process

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2018 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	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

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	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 TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

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2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	Health Net administers Change Healthcare 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 Change Healthcare InterQual® IRR tool in Q3-4 2021. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using Change Healthcare InterQual® IRR tool in Q3-4 2021.	Q3-4 2021 Q3-4 2021

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	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 Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. At least annually Appeals will be analyzed for trends. Opportunities for removing or modifying prior authorization requirements or criteria will be identified based upon appeals that are regularly overturned. This analysis and recommendations will be reported to CalViva Health QI/UM Committee. 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. The data from appeals and grievances is shared with the Provider Network Management, Adverse Action Team, and Utilization Management/ Quality Improvement (UMQI) committees and is aggregated and reviewed for additional actions and recommendations.	Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

3. Monitoring Utilization Metrics

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and Medical Management 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 ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2021 Goals: • 10% reduction in admissions over 2019 • 10% reduction in LOS overall over 2019	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. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement.	Ongoing

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net 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 for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. % 0-2 day admits In addition, PPG metrics will include: 7. Specialty referrals for target specialties 8. C-section rates. PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis.	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers 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 2021 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Specialties and PPG's 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. Results of the reviews will be reported to CVH leadership at least quarterly.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. 3. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. 5. Specialty referral access timeliness The DO Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

4. Monitoring Coordination with Other Programs and Vendor Oversight

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.1 Case Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving 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. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, LCSWs, Program Specialists, Program and Care Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	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. Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

CalViva Health
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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

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2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health 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. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFT, and Care Coordinators to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.4 Disease Management (DM)	☒ Medi-Cal **<u>Diabetes Age Groups</u>** 0-21 CCS Referral (100%) >21 Enrolled in program	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, medical claims, and referrals. Plan Disease Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Member facing materials will be re-evaluated. Review prevalence data to affirm selection of Disease Management conditions.	Ongoing Q3 2021 12/31/2021

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2021 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. State Health Program (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 Medi-Cal plan.	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

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.6 Behavioral Health (BH) Care Coordination	☒ Medi-Cal	CalViva collaborates with BH 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

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	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

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

5. Monitoring Activities for Special Populations

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
5.1 Monitor of California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Health Net identifies 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, case management, pharmacy, claims review and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

CalViva Health
2021 UM/CM Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2021 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	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 UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Case Management, the Pharmacy Program, the Pregnancy Program, or a Disease Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Disease Management and Care Coordination.	Ongoing

CalViva Health
2021 UM/CM Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Item #8

Attachment 8.A

Financials as of January 31, 2021

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of January 31, 2021

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash	211,364,221.70
5	Total Bank Accounts	$ 211,364,221.70
6	Accounts Receivable	
7	Accounts Receivable	99,203,578.91
8	Total Accounts Receivable	$ 99,203,578.91
9	Other Current Assets	
10	Interest Receivable	396.83
11	Investments - CDs	0.00
12	Prepaid Expenses	540,385.98
13	Security Deposit	0.00
14	Total Other Current Assets	$ 540,782.81
15	Total Current Assets	$ 311,108,583.42
16	Fixed Assets	
17	Buildings	6,549,738.18
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	107,493.29
21	Total Fixed Assets	$ 9,818,650.57
22	Other Assets	
23	Investment -Restricted	300,433.29
24	Total Other Assets	$ 300,433.29
25	TOTAL ASSETS	$ 321,227,667.28
26	LIABILITIES AND EQUITY	
27	Liabilities	
28	Current Liabilities	
29	Accounts Payable	
30	Accounts Payable	169,071.28
31	Accrued Admin Service Fee	4,141,148.00
32	Capitation Payable	186,961,886.96
33	Claims Payable	25,292.58
34	Directed Payment Payable	1,691,420.30
35	Total Accounts Payable	$ 192,988,819.12
36	Other Current Liabilities	
37	Accrued Expenses	905,000.00
38	Accrued Payroll	58,534.48
39	Accrued Vacation Pay	365,213.20
40	Amt Due to DHCS	0.00
41	IBNR	4,017.39
42	Loan Payable-Current	0.00
43	Premium Tax Payable	0.00
44	Premium Tax Payable to BOE	5,958,557.70
45	Premium Tax Payable to DHCS	12,468,750.00
46	Total Other Current Liabilities	$ 19,760,072.77
47	Total Current Liabilities	$ 212,748,891.89
48	Long-Term Liabilities	
49	Renters' Security Deposit	0.00
50	Subordinated Loan Payable	0.00
51	Total Long-Term Liabilities	$ 0.00
52	Total Liabilities	$ 212,748,891.89
53	Equity	
54	Retained Earnings	108,757,395.00
55	Net Income/ (Loss)	(278,619.61)
56	Total Equity	$ 108,478,775.39
57	TOTAL LIABILITIES AND EQUITY	$ 321,227,667.28

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2020 - January 2021 (FY 2021)

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Investment Income	81,425.57	231,000.00	(149,574.43)
3	Premium/Capitation Income	739,626,316.65	738,898,431.00	727,885.65
4	**Total Income**	**$ 739,707,742.22**	**$ 739,129,431.00**	**578,311.22**
5	Cost of Medical Care			
6	Capitation - Medical Costs	617,222,962.61	613,013,070.00	4,209,892.61
7	Medical Claim Costs	427,496.54	595,000.00	(167,503.46)
8	**Total Cost of Medical Care**	**$ 617,650,459.15**	**$ 613,608,070.00**	**4,042,389.15**
9	**Gross Margin**	**$ 122,057,283.07**	**$ 125,521,361.00**	**(3,464,077.93)**
10	Expenses			
11	Admin Service Agreement Fees	28,575,745.00	28,027,993.00	547,752.00
12	Bank Charges	998.77	3,850.00	(2,851.23)
13	Computer/IT Services	101,847.32	99,656.00	2,191.32
14	Consulting Fees	0.00	61,250.00	(61,250.00)
15	Depreciation Expense	166,996.96	178,500.00	(11,503.04)
16	Dues & Subscriptions	95,530.75	105,112.00	(9,581.25)
17	Grants	2,762,500.00	2,768,178.00	(5,678.00)
18	Insurance	102,669.99	104,810.00	(2,140.01)
19	Labor	2,113,572.99	2,055,372.00	58,200.99
20	Legal & Professional Fees	69,850.00	111,300.00	(41,450.00)
21	License Expense	440,901.26	498,995.00	(58,093.74)
22	Marketing	832,546.31	945,000.00	(112,453.69)
23	Meals and Entertainment	11,682.55	13,850.00	(2,167.45)
24	Office Expenses	34,802.29	49,000.00	(14,197.71)
25	Parking	0.00	875.00	(875.00)
26	Postage & Delivery	1,318.73	1,960.00	(641.27)
27	Printing & Reproduction	1,949.93	2,800.00	(850.07)
28	Recruitment Expense	1,573.98	21,000.00	(19,426.02)
29	Rent	0.00	7,000.00	(7,000.00)
30	Seminars and Training	1,175.04	14,000.00	(12,824.96)
31	Supplies	4,457.79	6,300.00	(1,842.21)
32	Taxes	87,280,153.50	87,281,250.00	(1,096.50)
33	Telephone	19,701.71	20,300.00	(598.29)
34	Travel	144.34	18,800.00	(18,655.66)
35	**Total Expenses**	**$ 122,620,119.21**	**$ 122,397,151.00**	**222,968.21**
36	**Net Operating Income/ (Loss)**	**(562,836.14)**	**$ 3,124,210.00**	**(3,687,046.14)**
37	Other Income			
38	Other Income	284,216.53	280,000.00	4,216.53
39	**Total Other Income**	**$ 284,216.53**	**$ 280,000.00**	**4,216.53**
40	**Net Other Income**	**$ 284,216.53**	**$ 280,000.00**	**4,216.53**
41	**Net Income/ (Loss)**	**(278,619.61)**	**$ 3,404,210.00**	**(3,682,829.61)**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2021 vs FY 2020

		Total	
		July 2020 - January 2021 (FY 2021)	July 2019 - January 2020 (FY 2020)
1	Income		
2	Investment Income	81,425.57	627,688.52
3	Premium/Capitation Income	739,626,316.65	602,749,398.69
4	Total Income	$ 739,707,742.22	$ 603,377,087.21
5	Cost of Medical Care		
6	Capitation - Medical Costs	617,222,962.61	564,237,709.11
7	Medical Claim Costs	427,496.54	1,941,193.33
8	Total Cost of Medical Care	$ 617,650,459.15	$ 566,178,902.44
9	Gross Margin	$ 122,057,283.07	$ 37,198,184.77
10	Expenses		
11	Admin Service Agreement Fees	28,575,745.00	27,330,116.00
12	Bank Charges	998.77	5.00
13	Computer/IT Services	101,847.32	74,686.39
14	Consulting Fees	0.00	1,575.00
15	Depreciation Expense	166,996.96	169,334.41
16	Dues & Subscriptions	95,530.75	95,849.75
17	Grants	2,762,500.00	869,979.10
18	Insurance	102,669.99	107,033.35
19	Labor	2,113,572.99	1,852,463.06
20	Legal & Professional Fees	69,850.00	61,465.35
21	License Expense	440,901.26	445,145.69
22	Marketing	832,546.31	676,962.98
23	Meals and Entertainment	11,682.55	12,863.28
24	Office Expenses	34,802.29	33,499.57
25	Parking	0.00	939.14
26	Postage & Delivery	1,318.73	1,976.54
27	Printing & Reproduction	1,949.93	2,242.70
28	Recruitment Expense	1,573.98	1,249.26
29	Rent	0.00	2,100.00
30	Seminars and Training	1,175.04	6,060.11
31	Supplies	4,457.79	6,243.45
32	Taxes	87,280,153.50	(984.79)
33	Telephone	19,701.71	19,942.94
34	Travel	144.34	15,662.16
35	Total Expenses	$ 122,620,119.21	$ 31,786,410.44
36	Net Operating Income/ (Loss)	(562,836.14)	5,411,774.33
37	Other Income		
38	Other Income	284,216.53	432,759.76
39	Total Other Income	$ 284,216.53	$ 432,759.76
40	Net Other Income	$ 284,216.53	$ 432,759.76
41	Net Income/ (Loss)	(278,619.61)	5,844,534.09

Item #8

Attachment 8.B

Compliance Report

RHA Commission Compliance – Regulatory Report

Regulatory Filings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021 YTD Total
# of DHCS Filings													
Administrative/ Operational	16	12	3										31
Member & Provider Materials	3	1	0										4
# of DMHC Filings	9	4	3										16

DHCS Administrative/Operational filings include ad-hoc reports, policies & procedures, Commission changes, Plan and Program documents, etc.
DHCS Member & Provider materials include advertising, health education materials, flyers, letter templates, promotional items, etc.
DMHC Filings include ad-hoc reports, Plan and Program documents, policies & procedures, advertising, bylaw changes, Commission changes, undertakings, etc.

Fraud, Waste, & Abuse Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021 YTD Total
# of New MC609 Cases Submitted to DHCS	0	0	0										0
# of Cases Open for Investigation (Active Number)	13	14	17										

Summary of Potential Fraud, Waste & Abuse (FWA) cases

Since the last report, there have not been any new MC609 cases filed. There were no cases that needed to be referred to other law enforcement agencies by the Plan.

Compliance Oversight & Monitoring Activities	Description
CalViva Health Oversight Activities	**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 critical projects or transitions that may affect CalViva Health. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances and appeals, etc.
Oversight Audits	The following annual audits are in-progress: Access & Availability, Credentialing, Emergency Services, Claims & PDR Audit, and the Call Center audit. Since the February 18, 2021 report, the following audits have been completed: Utilization Management & Case Management (CAP), Q2 PDR (CAP), Q3 PDR (CAP)
Regulatory Reviews/Audits and CAPS	**Status**
Department of Health Care Services ("DHCS") Annual Network Certification	On November 25, 2020, the DHCS issued the Plan a CAP for failure to meet the 2020 Network Certification Requirements as it related to time and distance standards. The Plan continues to provide the DHCS-requested "two-month CAP updates. As part of the 2020 Network Certification Requirement, on 2/16/21 DHCS sent the Plan an Alternative Access Standards (AAS) validation request. This validation is the last part of the process in order to give plans a final determination on their AAS. The Plan submitted the requested validation data on 3/8/21 and is waiting for DHCS response.
2021 DMHC 18-Month Follow-Up Audit	The DMHC has rescheduled their follow-up audit from 3/4/21 to 3/30/21. The focus of the audit interviews will be related to the two deficiencies in DMHC's 2/5/20 Final Report and CAP having to do with Appeals & Grievances and Post-Stabilization request from non-contracted hospitals. The Plan continues to meet with Health Net to respond to the DMHC's requests for case files and supporting documentation.
New Regulations / Contractual Requirements	
Medi-Cal Rx Transition	On February 17, 2021 DHCS announced a new delay in the transition of pharmacy services from Medi-Cal managed care to FFS (Medi-Cal Rx). DHCS is delaying the planned Go Live date of April 1, 2021 for Medi-Cal Rx because of the need to review new conflict avoidance protocols submitted by Magellan Health, the project's contracted vendor. These protocols are a result of Centene Corporation announcing that it plans to acquire Magellan. Centene operates – through subsidiaries – managed care plans and pharmacies that participate in Medi-Cal.
CMS Rule on Interoperability & HHS Office of the National Coordinator for Health Information Technology (ONC) **(Released on March 9, 2020)**	The two rules, issued by the HHS Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare & Medicaid Services (CMS), implement interoperability and patient access provisions of the 21st Century Cures Act (Cures Act). Purpose of Rules - Patients and health care entities can easily access, exchange and use health information to support better care decisions and health outcomes. The Rules are to be phased in over time and the first compliance date is July 1, 2021.

	Requires payers, providers and states including Medicaid managed care plans, Medicare Advantage organizations, CHIP managed entities, Medicaid state agencies, etc. to (1) make certain data available in standardized formats and (2) develop APIs (software that allows third party applications to connect to the data). Patient Access API and Provider Directory API compliance is effective 7/1/21 and Payer to Payer data exchange compliance is effective 1/1/22. Data available to patients will include adjudicated claims data, provider remittances, encounters from capitated providers, clinical data (including laboratory results if managed by the payer) provider directory data. Requires the health plan organizations above to track and share five years of data when a member changes a plan. The Plan's administrator Health Net is working to implement this for CalViva Health. Preparations will include IT/system activities, member and provider communications, staff training, call scripts and more. To view the CMS final rule: https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index. To view the ONC final rule: https://healthit.gov/curesrule
California Advancing and Innovating Medi-Cal (CalAIM)	CalViva Health is participating in DHCS calls, association calls and working with Health Net to implement some of the key initiatives: • Major organ transplant carve-in – effective 1/1/22 for all CalViva counties and membership • Enhanced Care Management (ECM) and In lieu of Services (ILOS) will be implemented for Kings County 1/1/22 and Fresno & Madera Counties 7/1/22 Major activities during 2021 include provider contracting, developing a transition plan and Model of Care, preparing regulatory filings, preparing member and provider materials, and update/create policies & procedures.
Behavioral Health Integration (BHI) Incentive Program	The Trailer Bill implementing the 2019 Budget Act authorized DHCS to develop the Behavioral Health Integration (BHI) Incentive Program as part of its Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care. CalViva Health and DHCS approved two provider applicants covering three BHI programs for implementation. In compliance with the BHI program, the Plan will provide DHCS with Quarterly Reports, and the "Readiness Payments" have been received from DHCS and passed on to Health Net.
Plan Administration	
COVID-19 Novel Coronavirus	The DMHC and DHCS are requiring new as well as continuing COVID-19 reporting related to provider network stability and closures, support (monetary and supplies such as PPE) provided by plans to providers, information on relaxing of administrative rules and processes to ease the burden on hospitals and providers, etc. Our administrator has extended the delay in their return to office date and their staff will continue to carry out operations on a remote basis until at least September 2021.
Committee Report	
Public Policy Committee	The Public Policy Committee met on 3/3/21 at 11:30 AM in Fresno County *via* teleconference due to COVID-19 precautions. The following reports were presented: CalViva Health's 2020 Annual Report; the Q4 2020 Grievance and Appeals; the 2020 Annual Compliance Evaluation; and the Health Education Member Incentive Programs Semi-Annual Report (Q3 and Q4 2020). There were no recommendations for referral to the Commission. The next meeting will be held on June 9,2021 and is tentatively scheduled to be held in Kings County depending on the COVID-19 situation and associated public health recommendations.

Bill	Name	Description	Applies to CalViva	Effective Date	Plan Action / Notes
AB 80	Committee on Budget	**Public health omnibus.** This bill makes technical and clarifying statutory revisions affecting health programs necessary to implement the Budget Act of 2020. Specifically, this bill: 1) Establishes the Health Care Payments Data Program, which will collect data on health care expenditures for inclusion in a Health Care Payments Data System. The data system will collect information regarding health care costs, utilization, quality, and equity to provide greater transparency to inform public policy decisions.2) Prohibits termination of Medi-Cal eligibility for incarcerated juveniles to comply with provisions of the federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. The bill has additional provisions that are not applicable to CalViva.	Yes	Not applicable to CVH until Section 12761 et seq take effect—i.e. not before 12/31/21	Information only. Actions needed by Plan will be determined when regulatory guidance is issued.
AB 2276	Reyes	**Childhood lead poisoning: screening and prevention.** This bill requires plans to identify, on a quarterly basis, every child enrollee without a record of completing the blood lead screening tests required pursuant to state regulation, and to remind the contracting health care provider responsible for performing the periodic health assessment of the child enrollee of the requirements to perform required blood lead screening tests for that child, and to provide oral or written anticipatory guidance to a parent or guardian of the child, including at a minimum, the information that children may be harmed by exposure to lead.	Yes	1/1/2021	CVH to work with HN to implement standard and update policies to include new guidelines.
SB 1237	Dodd	**Nurse-midwives: scope of practice.** Requires that the Board of Registered Nursing appoint a Nurse-Midwifery Advisory committee of qualified physicians/surgeons and nurses to make recommendations to the board on all matters related to midwifery practice, education, appropriate standard of care. Also has several provisions related to nurse-midwifery certifications, disclosure and reporting requirements.	TBD	1/1/2021	Potential impact to plans for policy changes if DHCS determines updates to APL 16-017 are needed
SB 803	Beall	**Mental health services: peer support specialist certification**. Requires DHCS to establish statewide requirements for use by counties in developing certification of peer support specialists. Authorizes a county to develop, oversee and enforce a peer specialist certification program in accordance with any standards established by DHCS. Expected to have very little impact to health plans.	Not directly	7/1/2022	Information only

Bill	Name	Description	Applies to CalViva	Effective Date	Plan Action / Notes
AB 890	Wood	**Nurse practitioners: scope of practice: practice without standardized procedures**. Establish the Nurse Practitioner Advisory Committee to advise and give recommendations to the Board of Registered Nursing on matters relating to nurse practitioners. The bill would require the committee to provide recommendations or guidance to the board when the board is considering disciplinary action against a nurse practitioner. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice independently.	No	1/1/2023	Information only.
SB 852	Pan	**Health care: prescription drugs.** Requires the California Health and Human Services Agency (CHHSA) to enter into partnerships to increase patient access to affordable drugs; to determine if viable pathways exist to produce or distribute generic prescription drugs and at least one form of insulin, provided that a viable pathway for manufacturing a more affordable form of insulin exists at a price that results in savings. The bill requires CHHSA to submit a report to the Legislature by July 1, 2023, that assesses the feasibility and advantages of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price.	No	7/1/2023	CVH as a Knox-Keene Health Plan is subject to the law, but this bill does not directly impact CVH.
AB 2537	Rodrigues	**Personal protective equipment: health care employees.** Requires an employer (as defined below) to supply PPE to employees who provide direct patient care or provide services that directly support patient care in a general acute care hospital. Also requires the employer to ensure that these employees use the PPE supplied. Employer is defined as a person or organization that employs workers in the public or private sector to provide direct patient care in a general acute care hospital.	No	Various 1/1/2-21, 1/15/2021, 4/1/2021	Information only

Bill	Name	Description	Applies to CalViva	Effective Date	Plan Action / Notes
SB 275	Pan	**Health Care and Essential Workers: personal protective equipment.** This bill requires the California Department of Public Health (CDPH) and the Office of Emergency Services (OES), upon appropriation and as necessary, establish a personal protective equipment (PPE) state stockpile within 1 year of the this bill's effective date. Also requires the CDPH to establish guidelines for the procurement, management, and distribution of PPE. By January 1, 2023 or one year from adoption of regulations, health care employers are required to have an inventory of unexpired PPE sufficient for 45 days of surge consumptions. A health care employer is defined as a general acute hospital, a health facility, a medical practice that is part of an integrated health system or health facility, or a dialysis clinic. A waiver may be approved if the employer has fewer than 25 employees and agrees to close in-person operations during a public health emergency until sufficient PPE is available.	No	1/1/2023	Information only.
AB 1710	Wood	**Pharmacy practice: vaccines**. Authorizes pharmacists to independently initiate and administer any COVID-19 vaccines approved by the FDA. Current statute grants authority for licensed pharmacists to independently initiate and administer routine vaccines to provide for expanded access to immunization. The bill will allow faster and broader access to the COVID-19 vaccination, once available.	No	1/1/2021	Information only.
AB 2644	Wood	**Skilled nursing facilities: deaths: reporting.** Requires a SNF to have a full-time, dedicated Infection Preventionist (codifies existing CDPH guidance) and report related data, including deaths, to CDPH during a declared emergency related to a communicable disease. Requires a SNF to have a plan in place for infection prevention quality control and provide training to personnel. This bill also has resident/family notification requirements during declared state of emergencies.	No	1/1/2021	Information only.

Item #8

Attachment 8.C

Appeals and Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2021

Current as of End of the Month: January
Revised Date: 02/24/2021

CalViva - 2021

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2020 YTD	2020 YTD
Expedited Grievances Received	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	110
Standard Grievances Received	90	0	0	90	0	0	0	0	0	0	0	0	0	0	0	0	90	997
Total Grievances Received	**98**	**0**	**0**	**98**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**98**	**1107**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
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%**	**100.00%**	**99.7%**
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	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	111
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%**	**100.0%**
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	68	0	0	68	0	0	0	0	0	0	0	0	0	0	0	0	68	1033
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%**	**100.00%**	**100.0%**
Total Grievances Resolved	**76**	**0**	**0**	**76**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**76**	**1144**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**56**	**0**	**0**	**56**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**56**	**878**
Access - Other - DMHC	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	63
Access - PCP - DHCS	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	107
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	48
Administrative	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	191
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	82
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	80
Pharmacy	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	51
Transportation - Access	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13	116
Transportation - Behaviour	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	100
Transportation - Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	37
Quality Of Care Grievances	**20**	**0**	**0**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**20**	**266**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	56
PCP Care	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	95
PCP Delay	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	42
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	46
Specialist Delay	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	15
Exempt Grievances Received	229	0	0	**229**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**229**	2877
Access - Avail of Appt w/ PCP	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	93
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	35
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	17
Access - Panel Disruption	5	0	0	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**5**	57
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	10
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	17
Attitude/Service - Provider	27	0	0	**27**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**27**	285
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	12

Attitude/Service - Vendor	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	11
Attitude/Service - Health Plan	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	11
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	25
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	6
Eligibility Issue - Member not eligible per Provider	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	37
Health Plan Materials - ID Cards-Not Received	28	0	0	**28**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**28**	235
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	7
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
PCP Assignment/Transfer - Health Plan Assignment - Change Request	93	0	0	**93**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**93**	1162
PCP Assignment/Transfer - HCO Assignment - Change Request	11	0	0	**11**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**11**	156
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	19
PCP Assignment/Transfer - Rollout of PPG	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	45
PCP Assignment/Transfer - Mileage Inconvenience	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	58
Pharmacy - Authorization Issue	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	5
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Eligibility Issue	8	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**8**	144
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Pharmacy - Rx Not Covered	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Pharmacy - Pharmacy-Retail	8	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**8**	45
Transportation - Access - Provider No Show	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	24
Transportation - Access - Provider Late	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	52
Transportation - Behaviour	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	119
Transportation - Other	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	12
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	7
OTHER - Balance Billing from Provider	8	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**8**	161

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	115
Standard Appeals Received	46	0	0	46	0	0	0	0	0	0	0	0	0	0	0	0	46	918
Total Appeals Received	**54**	**0**	**0**	**54**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	54	**1033**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
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%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Resolved Compliant	6	0	0	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	6	114
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%**	**100.00%**	**99.1%**
Standard Appeals Resolved Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Standard Appeals Resolved Compliant	51	0	0	51	0	0	0	0	0	0	0	0	0	0	0	0	51	916
Standard Appeals Compliance Rate	**98.0%**	**0.0%**	**0.0%**	**98.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**98.08%**	**100.0%**
Total Appeals Resolved	**58**	**0**	**0**	**58**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**58**	**1031**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**58**	**0**	**0**	**58**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**58**	1029
Continuity of Care	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	17
DME	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	47
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Advanced Imaging	22	0	0	22	0	0	0	0	0	0	0	0	0	0	0	0	22	488
Other	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	67
Pharmacy	20	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	20	362
Surgery	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	46
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	2
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	1
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
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	34	0	0	**34**	0	0	0	0	0	0	0	0	0	0	0	0	34	577
Uphold Rate	**58.6%**	**0.0%**	**0.0%**	**58.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**58.6%**	**56.0%**
Overturns - Full	22	0	0	**22**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	22	432
Overturn Rate - Full	**37.9%**	**0.0%**	**0.0%**	**37.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.9%**	**41.9%**
Overturns - Partials	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	12
Overturn Rate - Partial	**1.7%**	**0.0%**	**0.0%**	**1.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**1.7%**	**1.2%**
Withdrawal	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**1**	10
Withdrawal Rate	**1.7%**	**0.0%**	**0.0%**	**1.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.7%**	**1.0%**
Membership	374,862	-	-		-	-	-		-	-	-		-	-	-			4,316,872
Appeals - PTMPM	0.15	-	-	0.15	-	-	-	-	-	-	-	-	-	-	-	-	0.15	0.24
Grievances - PTMPM	0.20	-	-	0.20	-	-	-	-	-	-	-	-	-	-	-	-	0.20	0.27

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative Grievance	Balance billing issue, claims delay in processing
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist
APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT
Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy	Denied medication due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.

Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy	Denied medication due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).

Exempt Grievance tab key – Calviva Dashboard	
Column Definitions.	
Date Opened	The date the case was received
SF #	The internal HealthNet system ID code for the CCC representative who documented the call
Rep Name	Name of the CCC associate who took the call
Sup Name	Supervisor of the CCC associate who took the call
Mbr ID	The Calviva Health ID number of the member
SPD	Marked “yes” if the member is part of the “Seniors & Persons with Disabilities” population
Date of Birth	Date of birth of the member
Mbr Name	Name of the member
Reason	The case was categorized as a Calviva Exempt Grievance, hence the reason it’s on the report
Preventable	Used if an Exempt Grievance was determined to be preventable
Access to Care	Used if determined Exempt Grievance was related to Access to Care
Issue Main Classification	Case is categorized by type of complaint
Issue Sub Classification	Case is subcategorized by type of complaint
DMHC Complaint Category	Case is categorized based on the DMHC TAR template complaint category
Discrimination?	Marked "yes" if case involved perceived discrimination by the member, otherwise marked "no"
Resolution	The resolution to the exempt grievance is notated here
Date Reviewed	The date the case was reviewed by CCC exempt grievance personnel
Provider Involved	The provider involved in the exempt grievance is notated here
Provider Category	The type of provider that is involved
County	The county the member resides in is notated here
PPG	Whether the member is assigned to a PPG is notated here
Health Plan ID	The Internal HN Plan ID for the Provider Involved in the exempt grievance.
PPG Service Area	Internal HN Code for the PPG to whom the member belongs.
Yes	
Classification Definitions	
Authorization	Used when it’s an Authorization/Referral issue related exempt grievance
Avail of Appt w/ Other Providers	The case is related to appointment availability of ancillary providers
Avail of Appt w/ PCP	The case is related to appointment availability of the PCP
Avail of Appt w/ Specialist	The case is related to appointment availability of a Specialist
Claims Complaint	The case is related to a claims issue/dispute
Eligibility Issue	The case is related to the members eligibilty or lackthereof.
Health Care Benefits	When it’s an exempt grievance related to a specific benefit, eg transportation
ID Card - Not Received	The case is related to the member having not received their ID card
Information Discrepancy	When the exempt grievance is related to being given wrong or misleading information
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	The case is related to the interpersonal behavoir of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavoir of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavoir of a vendor
Other	For miscellaneous exempt grievances
PCP Assignment/Transfer	
PCP Assignment/Transfer-Health Plan Assignment- Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member, whether it be through the auto-assignment logic process or any other health plan assignments reasons.
PCP Assignment/Transfer-HCO Assignment - Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member.This category will represent PCP assignments in which the assignment was made as a result of the 834 file HCO Input. "Electronic Assignment- HCO Input"
Pharmacy	The case is related to a pharmacy issue
Wait Time - In Office for Scheduled Appt	When the Access to Care complaint is in regards to wait time at a providers office
Wait Time - Too Long on Telephone	When the Access to Care complaint is in regards to being placed on hold or unable to get through by telephone
The Outlier Tab	This tab is used by the Reporting Team, CalViva, and A&G. The Reporting Team will use this tab to call out any outliers to the A&G team that were identified during the report creation such as trends or increase in volume of appeals and/or grievances. The Reporting team will send the outliers to the business when the Dashboard is sent for approval. CalViva will use this tab to call out any outliers to the A&G team that were identified during the report creation. The A&G Team will use this tab to document the reasons for the call out, trending, or unusual high numbers of complaints from the Reporting Team or CalViva on the outliers that were identified during the report creation or review of cases.
Month	This is used to track the month effected by the change that was made
Date	This is used to track the date the change was made
Outlier	This is the section that describes a brief explanation of the outlier such as increase number of PCP wait time complaints, trends, etc.
Explanation	This is the section that explains the outlier.

Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Item #8

Attachment 8.D

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 1/01/2021 to 1/31/2021

Report created 2/25/2021

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:

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Azra S. Aslam <Azra.S.Aslam@healthnet.com>
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.com
Authorization Metrics	John Gonzalez

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2021 to 1/31/2021
Report created 2/25/2021

ER utilization based on Claims data	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	2021-01	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
																Quarterly Averages					Annual Averages		
Expansion Mbr Months	84,565	84,035	83,749	84,541	85,974	87,441	88,878	90,707	91,881	92,957	94,284	95,158		96,195		84,116	85,985	90,489	94,133		88,681	96,195	
Family/Adult/Other Mbr Mos	244,967	244,363	243,647	245,048	247,149	249,196	250,944	252,508	253,833	254,934	256,021	256,697		257,350		244,326	247,131	252,428	255,884		249,942	257,350	
SPD Mbr Months	34,628	34,654	34,571	34,627	34,647	34,711	34,741	34,775	34,761	34,778	34,754	34,716		34,647		34,618	34,662	34,759	34,749		34,697	34,647	
Admits - Count	2,339	2,192	2,080	1,616	1,793	1,938	2,059	2,251	2,092	2,164	2,027	2,020		2,004		2,204	1,782	2,134	2,070		2,048	2,004	
Expansion	684	657	600	514	567	613	674	687	688	745	659	590		570		647	565	683	665		640	570	
Family/Adult/Other	1,089	1,016	991	794	863	913	987	1,085	1,005	1,012	959	994		1,011		1,032	857	1,026	988		976	1,011	
SPD	562	515	488	306	361	407	396	476	399	402	407	432		416		522	358	424	414		429	416	
Admits Acute - Count	1,613	1,527	1,397	946	1,172	1,287	1,346	1,491	1,363	1,419	1,432	1,397		1,386		1,512	1,135	1,400	1,416		1,366	1,386	
Expansion	491	485	438	354	427	468	515	522	517	560	527	496		488		471	416	518	528		483	488	
Family/Adult/Other	604	567	510	312	403	428	457	520	479	492	511	491		503		560	381	485	498		481	503	
SPD	517	474	448	279	340	386	373	449	367	367	393	408		395		480	335	396	389		400	395	
Readmit 30 Day - Count	311	274	287	199	236	236	258	309	269	270	241	169		172		291	224	279	227		255	172	
Expansion	81	88	76	55	79	71	88	102	97	98	89	58		56		82	68	96	82		82	56	
Family/Adult/Other	90	78	83	59	75	74	75	96	82	77	73	42		47		84	69	84	64		75	47	
SPD	139	108	128	84	82	89	95	111	90	95	79	69		69		125	85	99	81		97	69	
Readmit 14 Day - Count	0	0	0	0	0	0	0	0	164	155	160	128		127		0	0	55	148		51	127	
Expansion	0	0	0	0	0	0	0	0	63	60	58	39		35		0	0	21	52		18	35	
Family/Adult/Other	0	0	0	0	0	0	0	0	41	48	57	41		54		0	0	14	49		16	54	
SPD	0	0	0	0	0	0	0	0	60	47	45	48		38		0	0	20	47		17	38	
**ER Visits - Count	18,486	17,887	13,499	7,576	9,375	10,751	12,238	11,245	10,552	10,780	10,182	9,293		5,640		16,624	9,234	11,345	10,085		11,822	5,640	
Expansion	4,061	3,838	3,409	2,432	2,926	3,386	3,834	3,600	3,343	3,388	3,165	3,035		1,751		3,769	2,915	3,592	3,196		3,368	1,751	
Family/Adult/Other	12,387	12,113	8,500	4,006	5,117	6,028	6,725	6,262	5,872	6,094	5,807	5,229		3,236		11,000	5,050	6,286	5,710		7,012	3,236	
SPD	2,014	1,917	1,574	1,132	1,322	1,315	1,399	1,371	1,305	1,291	1,179	1,021		645		1,835	1,256	1,358	1,164		1,403	645	
Admits Acute - PTMPY	53.1	50.4	46.3	31.2	38.2	41.6	43.1	47.3	43.0	44.5	44.6	43.3		42.8		50.0	37.0	44.5	44.1		43.9	42.8	
Expansion	69.7	69.3	62.8	50.2	59.6	64.2	69.5	69.1	67.5	72.3	67.1	62.5		60.9		67.2	58.1	68.7	67.3		65.4	60.9	
Family/Adult/Other	29.6	27.8	25.1	15.3	19.6	20.6	21.9	24.7	22.6	23.2	24.0	23.0		23.5		27.5	18.5	23.1	23.4		23.1	23.5	
SPD	179.2	164.1	155.5	96.7	117.8	133.4	128.8	154.9	126.7	126.6	135.7	141.0		136.8		166.3	116.0	136.8	134.4		138.4	136.8	
Bed Days Acute - PTMPY	251.6	244.1	242.1	166.0	207.3	233.0	269.9	264.8	243.5	244.3	247.3	282.8		269.1		246.0	202.3	259.3	258.2		241.7	269.1	
Expansion	356.5	345.7	351.5	243.9	320.9	366.1	439.5	381.1	379.3	415.4	392.9	428.4		417.8		351.2	311.0	399.6	412.3		370.0	417.8	
Family/Adult/Other	108.2	111.0	86.8	75.3	93.5	93.0	125.1	129.4	109.1	106.0	107.6	120.5		119.9		102.0	87.3	121.2	111.3		105.6	119.9	
SPD	1,010.2	935.6	1,069.8	613.7	735.0	894.7	880.1	945.9	867.5	801.9	881.5	1,082.6		966.0		1,005.2	747.9	897.8	921.9		893.2	966.0	
ALOS Acute	4.7	4.8	5.2	5.3	5.4	5.6	6.3	5.6	5.7	5.5	5.5	6.5		6.3		4.9	5.5	5.8	5.8		5.5	6.3	
Expansion	5.1	5.0	5.6	4.9	5.4	5.7	6.3	5.5	5.6	5.7	5.9	6.8		6.9		5.2	5.4	5.8	6.1		5.7	6.9	
Family/Adult/Other	3.7	4.0	3.5	4.9	4.8	4.5	5.7	5.2	4.8	4.6	4.5	5.2		5.1		3.7	4.7	5.3	4.8		4.6	5.1	
SPD	5.6	5.7	6.9	6.3	6.2	6.7	6.8	6.1	6.8	6.3	6.5	7.7		7.1		6.0	6.4	6.6	6.9		6.5	7.1	
Readmit % 30 Day	13.3%	12.5%	13.8%	12.3%	13.2%	12.2%	12.5%	13.7%	12.9%	12.5%	11.9%	8.4%		8.6%		13.2%	12.5%	13.1%	10.9%		12.4%	8.6%	
Expansion	11.8%	13.4%	12.7%	10.7%	13.9%	11.6%	13.1%	14.8%	14.1%	13.2%	13.5%	9.8%		9.8%		12.6%	12.1%	14.0%	12.3%		12.8%	9.8%	
Family/Adult/Other	8.3%	7.7%	8.4%	7.4%	8.7%	8.1%	7.6%	8.8%	8.2%	7.6%	7.6%	4.2%		4.6%		8.1%	8.1%	8.2%	6.5%		7.7%	4.6%	
SPD	24.7%	21.0%	26.2%	27.5%	22.7%	21.9%	24.0%	23.3%	22.6%	23.6%	19.4%	16.0%		16.6%		24.0%	23.7%	23.3%	19.6%		22.7%	16.6%	
Readmit % 14 Day	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.0%	10.9%	11.2%	9.2%		9.2%		0.0%	0.0%	3.9%	10.4%		3.7%	9.2%	
Expansion	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.2%	10.7%	11.0%	7.9%		7.2%		0.0%	0.0%	4.1%	9.9%		3.8%	7.2%	
Family/Adult/Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.6%	9.8%	11.2%	8.4%		10.7%		0.0%	0.0%	2.8%	9.8%		3.2%	10.7%	
SPD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	16.3%	12.8%	11.5%	11.8%		9.6%		0.0%	0.0%	5.0%	12.0%		4.2%	9.6%	
**ER Visits - PTMPY	608.9	590.9	447.3	249.5	305.8	347.3	391.9	356.8	332.7	337.9	317.2	288.4		174.3		549.2	301.1	360.3	314.4		379.8	174.3	
Expansion	576.3	548.1	488.5	345.2	408.4	464.7	517.7	476.3	436.6	437.4	402.8	382.7		218.4		537.7	406.8	476.4	407.4		455.8	218.4	
Family/Adult/Other	606.8	594.8	418.6	196.2	248.4	290.3	321.6	297.6	277.6	286.9	272.2	244.4		150.9		540.3	245.2	298.8	267.8		336.6	150.9	
SPD	697.9	663.8	546.4	392.3	457.9	454.6	483.2	473.1	450.5	445.5	407.1	352.9		223.4		636.1	434.9	468.9	401.8		485.3	223.4	
Services	TAT Compliance Goal: 100%													T Compliance Goal: 10		TAT Compliance Goal: 100%					TAT Compliance Goal: 100%		
Preservice Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%				
Preservice Urgent	100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%		96.0%		98.7%	99.3%	100.0%	99.3%				
Postservice	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.0%		100.0%	98.7%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%				
Deferrals - Urgent	N/A	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	99.0%	100.0%	100.0%				
Deferrals - Post Service	null	null	null	NA	NA	NA	NA	NA	NA	NA	NA	NA		null		null	null	null	null				

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2021 to 1/31/2021
Report created 2/25/2021

ER utilization based on Claims data	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	2021-01	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
	CCS ID RATE													CCS ID RATI		CCS ID RATE					CCS ID RATE		
CCS %	8.36%	8.25%	8.42%	8.24%	8.15%	8.30%	8.18%	8.16%	8.31%	8.29%	8.27%	8.25%		8.17%		8.34%	8.23%	8.22%	8.27%		8.27%	8.17%	
	Perinatal Case Management													inatal Case Manage		Perinatal Case Management					Perinatal Case Management		
Total Number Of Referrals	258	250	275	207	176	178	232	166	161	164	127	113		136		783	561	559	404		2,307	136	
Pending	0	1	0	0	0	0	0	0	0	1	2	2		2		1	0	0	5		6	2	
Ineligible	8	9	9	6	9	15	8	12	11	2	4	2		5		26	30	31	8		95	5	
Total Outreached	250	240	266	201	167	163	224	154	150	161	121	109		129		756	531	528	391		2,206	129	
Engaged	80	67	75	73	59	70	73	42	42	45	41	26		32		222	202	157	112		693	32	
Engagement Rate	32%	28%	28%	36%	35%	43%	33%	27%	28%	28%	34%	24%		25%		29%	38%	30%	29%		31%	25%	
New Cases Opened	80	67	75	73	59	70	73	42	42	45	41	26		32		222	202	157	112		693	32	
Total Cases Managed	324	344	367	383	369	406	416	391	390	365	299	271		258		465	472	485	413		943	258	
Total Cases Closed	44	52	55	73	35	61	74	57	62	84	54	51		45		151	169	193	189		702	45	
Cases Remained Open	266	275	291	292	324	319	267	311	267	205	205	205		212		291	319	267	205		205	212	
	Integrated Case Management													grated Case Manage		Integrated Case Management					Integrated Case Management		
Total Number Of Referrals	97	125	151	139	156	144	214	188	159	178	160	150		114		373	439	561	488		1,861	114	
Pending	1	0	0	0	0	1	0	0	0	4	2	14		2		1	1	0	20		22	2	
Ineligible	10	9	4	10	6	12	12	26	13	32	33	32		13		23	28	51	97		199	13	
Total Outreached	86	116	147	129	150	131	202	162	146	142	125	104		99		349	410	510	371		1,640	99	
Engaged	45	61	66	57	66	70	108	94	88	78	77	69		69		172	193	290	224		879	69	
Engagement Rate	52%	53%	45%	44%	44%	53%	53%	58%	60%	55%	62%	66%		70%		49%	47%	57%	60%		54%	70%	
Total Screened and Refused/Decline	10	17	28	22	22	21	34	22	16	23	16	10		8		55	65	72	49		241	8	
Unable to Reach	31	38	53	50	62	40	60	46	42	41	32	25		22		122	152	148	98		520	22	
New Cases Opened	45	61	66	57	66	70	108	94	88	78	77	69		69		172	193	290	224		879	69	
Total Cases Closed	19	39	47	55	37	50	51	65	80	92	85	63		60		105	142	196	240		683	60	
Cases Remained Open	141	160	184	221	252	289	359	397	314	292	292	292		310		184	289	314	292		292	310	
Total Cases Managed	151	196	221	228	240	276	339	381	417	407	373	357		374		279	367	533	541		990	374	
Critical-Complex Acuity	36	31	30	35	47	55	59	64	64	57	55	55		59		42	65	77	73		130	59	
High/Moderate/Low Acuity	115	165	191	193	193	221	280	317	353	350	318	302		315		237	302	456	468		860	315	
	Transitional Case Management													sitional Case Manage		Transitional Case Management					Transitional Case Management		
Total Number Of Referrals	131	113	177	153	147	179	268	227	245	251	233	204		135		421	479	740	688		2,328	135	
Pending	0	0	0	0	0	0	0	0	0	0	0	25		14		0	0	0	25		25	14	
Ineligible	10	8	9	8	11	14	20	27	27	22	25	22		21		27	33	74	69		203	21	
Total Outreached	121	105	168	145	136	165	248	200	218	229	208	157		100		394	446	666	594		2,100	100	
Engaged	76	57	81	79	62	77	122	105	116	125	99	79		48		214	218	343	303		1,078	48	
Engagement Rate	63%	54%	48%	54%	46%	47%	49%	53%	53%	55%	48%	50%		48%		54%	49%	52%	51%		51%	48%	
Total Screened and Refused/Decline	13	14	38	19	29	27	38	32	25	26	28	19		12		65	75	95	73		308	12	
Unable to Reach	32	34	49	47	45	61	88	63	77	78	81	59		40		115	153	228	218		714	40	
New Cases Opened	76	57	81	79	62	77	122	105	116	125	99	79		48		214	218	343	303		1,078	48	
Total Cases Closed	55	58	86	80	81	65	82	103	118	105	124	113		85		199	226	303	342		1,070	85	
Cases Remained Open	74	62	63	74	54	56	81	93	106	42	42	42		76		63	56	106	42		42	76	
Total Cases Managed	138	140	164	157	141	135	193	217	228	236	230	185		136		280	296	398	394		1136	136	
High/Moderate/Low Acuity	138	140	164	157	141	135	193	217	228	236	230	185		135		280	296	398	394		1136	135	
	Palliative Care													alliative Ca		Palliative Care					Palliative Care		
Total Number Of Referrals	23	24	22	24	22	35	15	10	8	10	20	10		15		69	81	33	40		223	15	
Pending	0	0	0	1	0	0	0	0	0	2	5	0		5		0	1	0	7		4	5	
Ineligible	8	7	9	9	11	14	4	4	3	3	5	6		5		24	34	11	14		83	5	
Total Outreached	15	17	13	14	11	21	11	6	5	5	10	4		5		45	46	22	19		132	5	
Engaged	12	13	9	10	8	17	6	5	5	3	8	3		4		34	35	16	14		99	4	
Engagement Rate	80%	76%	69%	71%	73%	81%	55%	83%	100%	60%	80%	75%		80%		76%	76%	73%	74%		75%	80%	
Total Screened and Refused/Decline	1	4	3	3	2	4	3	1	0	2	2	0		1		8	9	4	4		25	1	
Unable to Reach	2	0	1	1	1	0	2	0	0	0	0	1		0		3	2	2	1		8	0	
New Cases Opened	13	14	9	9	8	16	6	5	5	3	8	3		4		36	33	16	14		99	4	
Total Cases Closed	5	7	11	10	12	3	5	7	10	5	12	11		9		23	25	22	28		98	9	
Cases Remained Open	85	89	88	88	84	96	97	101	91	90	92	87		92		88	96	91	87		87	92	
Total Cases Managed	90	96	100	102	101	103	108	109	106	101	109	105		103		107	122	126	122		262	103	
	Behavioral Health Case Management													oral Health Case Mana		Behavioral Health Case Management					ehavioral Health Case Managemen		

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2021 to 1/31/2021
Report created 2/25/2021

ER utilization based on Claims data	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	2021-01	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
Total Number Of Referrals	24	47	49	111	92	122	112	132	120	111	84	96		71		120	325	364	291		1,100	71	
Pending	0	0	0	0	0	0	0	0	0	0	0	6		0		0	0	0	6		6	0	
Ineligible	2	1	1	4	5	6	2	7	7	5	6	5		5		4	15	16	16		51	5	
Total Outreached	22	46	48	107	87	116	110	125	113	106	78	85		66		116	310	348	269		1,043	66	
Engaged	12	16	23	45	29	45	45	57	54	47	33	34		28		51	119	156	114		440	28	
Engagement Rate	55%	35%	48%	42%	33%	39%	41%	46%	48%	44%	42%	40%		42.4%		44%	38%	45%	42%		42%	42%	
Total Screened and Refused/Decline	0	0	0	1	2	3	3	2	11	1	4	3		0		0	6	16	8		30	0	
Unable to Reach	10	30	25	60	56	68	62	66	48	58	41	48		38		65	184	176	147		572	38	
New Cases Opened	12	16	23	45	29	45	45	57	54	47	33	34		28		51	119	156	114		440	28	
Total Cases Closed	21	15	16	17	24	24	25	42	58	53	36	51		51		52	65	125	140		382	51	
Cases Remained Open	18	19	28	56	60	73	81	66	94	78	78	78		75		28	73	94	78		78	75	
Total Cases Managed	39	37	46	84	96	119	141	177	203	192	151	149		132		81	164	295	279		496	132	
Critical-Complex Acuity	5	4	7	9	11	14	16	15	15	7	8	7		7		9	17	22	13		26	7	
High/Moderate/Low Acuity	34	33	39	75	85	105	125	162	188	185	143	142		125		72	147	273	266		470	125	
	Record Processing													Record Processing		Record Processing						Record Processing	
Total Records	8,341	7,703	7,536	5,414	7,551	7,558	7,566	7,570	6,699	6,785	4,586	4,594		1,972		23,580	20,523	21,835	22,827		81,903	1,972	
Total Admissions	2,244	2,201	2,092	1,595	2,072	2,069	2,066	2,060	2,001	2,055	1,617	1,610		1,821		6,537	5,736	6,127	6,342		23,682	1,821	

Item #8

Attachment 8.E

Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: March 18th, 2021

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2021

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2021 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 18th, 2021. At the February 18th meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.
II. Reports covering the third quarter for 2020 were reviewed for delegated entities and the fourth quarter for MHN and Health Net. A summary of the third quarter data is included in the table below.

III. Table 1. Third Quarter 2020 Credentialing/Recredentialing

	Sante	ChildNet	MHN	Health Net	La Salle	ASH	Envolve Vision	IMG	CVMP	Adventist	**Totals**
Initial credentialing	60	28	18	18	9	1	3	8	41	14	**200**
Recredentialing	114	60	25	7	20	1	0	20	5	0	**252**
Suspensions	0	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	**0**
Totals	**174**	**88**	**43**	**25**	**29**	**2**	**3**	**28**	**46**	**14**	**452**

IV. The 2021 Credentialing Sub-Committee annual policy and procedure review was completed. The majority of policies were updated with minor or no changes. Two policies had somewhat more edits in order to clarify procedures, expand applicability and confirm proceedings. None of the policies had significant changes. The policies and procedures were approved.
V. There was one (1) ongoing case to report on for the Quarter 4 2020 Credentialing Report from Health Net. This was related to the production of records associated with an 805 filing. An extension until January 2021 was requested and approved.

Item #8

Attachment 8.F

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	March 18th, 2021
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2021

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 18th, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2020 were reviewed for approval. There were no significant cases to report.

II. The 2021 Peer Review Sub-Committee Policies and Procedures were reviewed and approved. There were only minor edits to the policies this year.

III. The Quarter 4, 2020 Peer Count Report was presented at the meeting with a total of 4 cases reviewed. The outcomes for these cases are as follows:
   - There were three (3) cases closed and cleared. There were no cases pending closure for Corrective Action Plan compliance or cases with outstanding CAPs. There was one (1) case pended for further information.

IV. Follow up will be initiated to obtain additional information for the tabled case and ongoing monitoring and reporting will continue.

Item #8

Attachment 8.G

Operations Report

IT Communications and Systems	**Active Presence of an External Vulnerability within Systems**	**NO**	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	**NO**	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	**NO**	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	**NO**	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	**NO**	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Age of Workstations	**3 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The COO	At present time, there are no issues, items of significance to report at this time as it relates to the Plan's IT Communications and Systems.		

Privacy and Security	**Risk Analysis (Last Completed mm/yy: 11/20)**	**Privacy Risk Rating: 9 Risks / Grade: A** **Security Risk Rating: 10 Risks / Grade: A**	Description: Conducting an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of PHI and ePHI held by the Health Plan. A Letter Grade is assigned: A (90%-100%), B (80-89%), C (74-79%), D (70%-73%), and D- (0-69%) based on risk assessment questions marked yes and remediated. The denominator is the total # of questions in the assessment.
	Eff. Date & Last Annual Mail Date of NPP (mm/yy)	**4/18 & 2/20**	Description: Notice of Privacy Practices (NPP) describes how PHI may be used and disclosed. The NPP is review and updated when appropriate. The NPP is distributed upon enrollment and annually thereafter
	Active Business Associate Agreements	**5**	Description: A signed agreement is required of any person/entity who is not a member of CalViva Health's workforce who will create or receive PHI of behalf of CalViva Health.

 # Of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)

Year	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**	**2021**
Month	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
No/Low Risk	**3**	**2**	**3**	**3**	**2**	**2**	**1**
High Risk	**1**	**0**	**0**	**0**	**0**	**1**	**0**
Total Cases By Month	**4**	**2**	**3**	**3**	**2**	**3**	**1**
Year	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
No/Low Risk	**54**	**36**	**28**	**38**	**23**	**28**	**5**
High Risk	**3**	**5**	**1**	**1**	**2**	**3**	**1**
Total Cases By Year	**57**	**41**	**29**	**39**	**25**	**31**	**6**

Message from the COO	A High Risk case has been reported since our last meeting. We are currently determining member impact.

Member Call Center CalViva Health Website		**Year**	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**30,232**	**27,416**	**29,707**	**20,544**	**23,684**	**23,685**
		# of Calls Answered	**30,031**	**27,140**	**29,564**	**20,407**	**23,488**	**23,520**
		Abandonment Level (Goal < 5%)	**0.70%**	**1.00%**	**0.50%**	**0.70%**	**0.80%**	**0.70%**
		Service Level (Goal 80%)	**92%**	**86%**	**96%**	**98%**	**93%**	**95%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,204**	**1,132**	**1,228**	**1,028**	**1,798**	**936**
		# of Calls Answered	**1,188**	**1,124**	**1,218**	**1,022**	**1,752**	**927**
		Abandonment Level (Goal < 5%)	**1.30%**	**0.70%**	**0.80%**	**0.60%**	**2.60%**	**1.00%**
		Service Level (Goal 80%)	**88%**	**87%**	**93%**	**94%**	**78%**	**89%**
	Transportation Call Center	**# of Calls Received**	**16,285**	**16,264**	**17,872**	**11,717**	**10,011**	**9,867**
		# of Calls Answered	**15,943**	**16,085**	**17,765**	**11,506**	**9,801**	**9,808**
		Abandonment Level (Goal < 5%)	**2.10%**	**1.10%**	**0.60%**	**1.80%**	**2.10%**	**0.60%**
		Service Level (Goal 80%)	**67%**	**83%**	**83%**	**76%**	**44%**	**76%**
	CalViva Health Website	**# of Users**	**20,000**	**20,000**	**21,000**	**16,000**	**22,000**	**25,000**
		Top Page	**Find a Provider**	**Find a Provider**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (57%)**	**Mobile (57%)**	**Mobile (60%)**	**Mobile (56%)**	**Mobile (63%)**	**Mobile (61%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**
Message from the COO	Q4 2020 numbers were presented during the February 18, 2021 Commission Meeting. There are no additional updates to provide during this meeting.							

Provider Network Activities & Provider Relations	**Year**	**2020**	**2020**	**2020**	**2020**	**2020**	**2020**	**2021**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**132**	**135**	**139**	**141**	**141**	**140**	**144**
	PCP	**382**	**381**	**382**	**377**	**380**	**386**	**389**
	PCP Extender	**216**	**216**	**210**	**217**	**219**	**220**	**229**
	Specialist	**1410**	**1430**	**1435**	**1448**	**1452**	**1456**	**1455**
	Ancillary	**197**	**196**	**197**	**197**	**194**	**195**	**196**
	Year	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Pharmacy	**151**	**151**	**152**	**151**	**153**	**152**	**154**
	Behavioral Health	**343**	**342**	**368**	**356**	**357**	**354**	**359**
	Vision	**39**	**42**	**41**	**42**	**45**	**47**	**46**
	Urgent Care	**14**	**13**	**12**	**12**	**11**	**12**	**11**
	Acupuncture	**6**	**6**	**5**	**4**	**5**	**7**	**7**
	Year	**2019**	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**94%**	**93%**	**90%**	**93%**	**93%**	**93%**	**94%**
	% Of Specialists Accepting New Patients - Goal (85%)	**95%**	**95%**	**95%**	**95%**	**94%**	**97%**	**96%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)			**72%**	**78%**	**82%**	**95%**	**96%**
	Year	**2020**	**2020**	**2020**	**2020**	**2020**	**2020**	**2021**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Providers Touched by Provider Relations	**118**	**84**	**146**	**200**	**205**	**241**	**75**
	Provider Trainings by Provider Relations	**0**	**0**	**0**	**0**	**0**	**0**	**54**
	Year	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
	Total Providers Touched	**2,003**	**2,604**	**2,786**	**2,552**	**1,932**	**3,354**	**75**
	Total Trainings Conducted	**550**	**530**	**762**	**808**	**1,353**	**257**	**54**
Message From the COO	DHCS has closed CalViva Health's Network Adequacy CAP for failing to meet Time and Distance Standards for 19 Provider Type(s) in 3 Counties on 3/11/2021. DMHC has released its Measurement Year 2019 Report Year 2020 Network Findings Report on 2/26/2021.							

Claims Processing	**Year**	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	94% / 99% YES	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	97% / 99% N/A	97%/98% N/A	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	97% / 99% N/A	99% / 99% N/A
	Pharmacy Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	97% / 98% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	95% / 97% NO	100% / 100% NO	100% / 100% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100 % NO	93% / 99% NO	93% / 100% NO	96% / 100% NO	85% / 100% NO	95% / 100% NO	95% / 100% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	95% / 100% NO	99% / 100% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	93% / 100% NO	92% / 100% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	90% / 99% NO	89% / 100% YES	88% / 98% YES	96% / 99% NO	82%/100% YES	100% / 100% YES	99% / 100% YES
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	92% / 99% NO	99% / 100% YES	100% / 100% YES	100% / 100% NO	87% / 100% YES	98% / 98% YES	99% / 100% YES
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 99% NO	99% / 100% YES	98% / 98% YES	98% / 100% NO	73% / 100% YES	99% / 100% YES	90% / 92% YES
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	92% / 100% NO	100% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	98% / 100% NO
Message from the COO	Quarter 4 numbers are available. All areas met the timeliness goals. Deficiency disclosure was noted for the quarter for PPG 4-6. PPG 4-6 are on a CAP for the Deficiency Closures.							

Provider Disputes	**Year**	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	96%	95%	97%	99%	99%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	89%	100%	90%	99%	100%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	100%	N/A	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	100%	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	89%	64%	92%	100%	91%	88%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	97%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	87%	91%	97%	66%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	95%	99%	100%	100%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	93%	100%	100%	100%	100%	100%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	67%	100%	100%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	98%	99%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	100%	100%
Message from the COO	Quarter 4 numbers are available. PPG 1 and PPG 3 did not meet goal. All other PPGs and areas met goal.							

Item #8

Attachment 8.H

Executive Dashboard

Month	2020 February	2020 March	2020 April	2020 May	2020 June	2020 July	2020 August	2020 September	2020 October	2020 November	2020 December	2021 January	2021 Feburary
CVH Members													
Fresno	280,719	280,297	282,402	286,059	289,126	291,870	294,617	298,003	300,085	302,118	303,493	304,759	305,990
Kings	29,575	29,534	29,788	30,168	30,421	30,624	30,827	31,085	31,230	31,450	31,570	31,802	31,984
Madera	37,244	37,259	37,624	38,054	38,457	38,713	39,035	39,329	39,530	39,733	39,919	40,209	40,381
Total	347,538	347,090	349,814	354,281	358,004	361,207	364,479	368,417	370,845	373,301	374,982	376,770	378,355
SPD	32,834	32,797	32,952	33,195	33,406	33,456	33,556	33,578	33,704	33,785	33,844	33,854	33,850
CVH Mrkt Share	71.27%	71.21%	71.15%	71.01%	70.82%	70.68%	70.52%	70.40%	70.32%	70.21%	70.10%	70.02%	69.92%
ABC Members													
Fresno	101,800	102,085	103,359	105,487	107,750	109,576	111,590	113,570	114,867	116,308	117,408	118,389	119,495
Kings	18,996	18,890	18,955	19,218	19,423	19,591	19,758	20,020	20,139	20,380	20,546	20,697	20,865
Madera	19,268	19,345	19,554	19,934	20,344	20,673	21,036	21,340	21,494	21,735	21,992	22,253	22,415
Total	140,064	140,320	141,868	144,639	147,517	149,840	152,384	154,930	156,500	158,423	159,946	161,339	162,775
Default													
Fresno	1,080	1,256	992	1,073	1,313	1,052	1,067	655	747	824	518	616	597
Kings	204	227	173	166	183	178	153	123	143	164	105	150	145
Madera	92	148	105	107	114	123	126	79	89	117	173	97	83
County Share of Choice as %													
Fresno	65.00%	64.80%	65.10%	62.00%	61.50%	61.80%	58.70%	61.60%	60.20%	59.40%	57.80%	59.10%	56.10%
Kings	60.00%	64.30%	59.40%	54.00%	59.50%	48.80%	53.40%	42.90%	47.20%	51.10%	45.40%	48.40%	53.10%
Madera	63.20%	69.70%	62.50%	62.70%	59.80%	55.70%	57.90%	58.90%	61.60%	60.40%	52.70%	57.90%	58.00%
Voluntary Disenrollment's													
Fresno	334	361	402	293	340	352	370	388	359	342	363	421	334
Kings	33	36	39	21	30	31	63	39	42	31	27	36	29
Madera	64	85	80	30	51	54	57	77	70	51	54	59	51