FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, 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

Rose Mary Rahn, 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

Jeff Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: February 11, 2022

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, February 17, 2022
1:30 pm to 3:30 pm

Where to attend:

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

2) 5018 E. Townsend Avenue
Fresno, CA 93727

3) Woodward Park Library
Large Study Room
944 E. Perrin Ave.
Fresno, CA 93720

4) Kings County Government Center
Admin Building Conf. Rm. Bldg. #1
1400 W. Lacey Blvd.
Hanford, CA 93230

Meeting materials have been emailed to you.

Currently, there are **14** 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
February 17, 2022
1:30pm - 3:30pm

Meeting Locations:

Fresno County:

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

2) 5018 E Townsend Avenue
Fresno, CA 93727

3) Woodward Park Library
Large Study Room
944 E. Perrin Ave.
Fresno, CA 93720

Kings County:

4) Kings County Government Center
Administration Building Conference Room, Building #1
1400 W. Lacey Blvd
Hanford, CA 93230

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order** • *Chair to confirm all remote participants have complied with the Brown Act*	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Information	No attachment	**Introduction of Director, Kings County Public Health Department** • Rose Mary Rahn	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B	**Reappointed Board of Supervisors Commissioners** • BL 22-001 2022 Reappointed BOS Commissioners • Appointment confirmations *Action: Ratify reappointment County Board of Supervisors Commissioners*	D. Hodge, MD, Chair
5 Action	Attachment 5.A Attachment 5.B	**Valley Children's Hospital Reappointment** • BL 22-002 Reappointment Letter • VCH Reappointment Letter *Action: Ratify Appointment*	D. Hodge, MD, Chair
6 Action		**Fresno County At-Large Seat Nomination(s)**	D. Hodge, MD, Chair

	Attachment 6.A Attachment 6.B	• BL 22-003 Fresno County At-Large Seat Nomination(s) • Application – J. Frye *Action: Approve appointment*	
7		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)** **1) Government Code section 54956.9(a) – Conference with Legal Counsel-Existing Litigation** Name of case: Case # 21CV381776 **2) Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility** Estimated Date of Public Disclosure: May 2022	
8 Action	Attachment 8.A Attachment 8.B Attachment 8.C Attachment 8.D Attachment 8.E Attachment 8.F	**Consent Agenda:** • Commission Minutes dated 10/21/2021 • Finance Committee Minutes dated 9/16/2021 • QI/UM Committee Minutes dated 9/16/2021 • QI/UM Committee Minutes dated 10/21/2021 • Public Policy Committee Minutes dated 9/1/2021 • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
9 Information	Attachment 9.A Attachment 9.B *No attachment*	**Annual Administration** • BL 22-004 Annual Administration • Form 700 • Ethics Training (*link will be emailed*)	D. Hodge, MD, Chair
10 Action	*No attachment*	**Community Support Program Ad-Hoc Committee Selection** • Select ad-hoc Committee *Action: Selection of Ad-Hoc Committee*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 11 & 12* ***One vote will be taken for combined items 11 & 12***	
11 Action	Attachment 11.A Attachment 11.B	**2021 Annual Quality Improvement Work Plan Evaluation** • Executive Summary • Year End Evaluation	P. Marabella, MD, CMO
12 Action	Attachment 12.A Attachment 12.B Attachment 12.C	**2021 Annual Utilization Management Case Management Workplan Evaluation** • Executive Summary • Year End Evaluation **2022 Utilization Management Program Description**	P. Marabella, MD, CMO

		Action: Approve 2021 Quality Improvement Year End Evaluation, and the 2021 Utilization Management Case Management Year End Evaluation, and 2022 Utilization Management Program Description.	
		PowerPoint Presentations will be used for item 13 - 17 ***One vote will be taken for combined items 13 – 17***	
13 Action	Attachment 13.A	**2021 Annual Compliance Evaluation**	M.L. Leone, CCO
14 Action	Attachment 14.A	**2022 Compliance Program Description**	M.L. Leone, CCO
15 Action	Attachment 15.A	**2022 Code of Conduct**	M.L. Leone, CCO
16 Action	Attachment 16.A	**2022 Anti-Fraud Plan**	M.L. Leone, CCO
17 Action	Attachment 17.A	**2022 Privacy and Security Plan** *Action: Approve 2021 Compliance Evaluation, 2022 Compliance Program Description, Code of Conduct, Anti-Fraud Plan, and Privacy and Security Plan.*	M.L. Leone, CCO
18 Action		**Standing Reports**	
		Finance Report	
	Attachment 18.A	• Financials as of December 31, 2021	D. Maychen, CFO
		Medical Management	
	Attachment 18.B	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 18.C	• Key Indicator Report	
	Attachment 18.D	• QIUM Quarterly Report	
	Attachment 18.E	• Credentialing Quarterly Report	
	Attachment 18.F	• Peer Review Quarterly Report	
		Executive Report	J. Nkansah, CEO
	Attachment 18.G	• Executive Dashboard	J. Epperson, General Counsel
	No attachment	• Annual Report – *hard copy provided independent of packet*	
	No attachment	• Medi-Cal Procurement Update	
	No attachment	• AB 361 – remote participation	
		Action: Accept Standing Reports	
19		**Final Comments from Commission Members and Staff**	
20		**Announcements**	
21		**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.	
22	**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 March 17, 2022 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 #4

Attachment 4.A-4.B

A. BL 22-001 2022 Reappointed BOS Commissioners
B. Appointment Confirmations

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, 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

Rose Mary Rahn, Director
Public Health Department

Harold Nikoghosian- At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
Public Health Department

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

Jeffrey Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: February 17, 2022

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Appointed / Re-Appointed County BOS Commissioners

BL #: 21-001
Agenda Item 3
Attachment 3.A

Discussion Points:

Fresno County has re-appointed Supervisor Sal Quintero
Fresno County Alternate is Supervisor Pacheco
Kings County has re-appointed Supervisor Joe Neves
Kings County Alternate is Supervisor Doug VerBoon
Madera County has re-appointed Supervisor David Rogers
Madera County Alternate is Brett Frazier

Term thru:	**Commission Seat**	**Currently Occupied By:**
January 2023 January 2023 January 2023 January 2023 January 2023 January 2023	Board of Supervisors—Fresno County Board of Supervisors—Fresno County Alt Board of Supervisors—Kings County Board of Supervisors—Kings County Alt Board of Supervisors—Madera County Board of Supervisors—Madera County Alt	Sal Quintero Brian Pacheco Joe Neves Doug VerBoon David Rogers Brett Frazier
March 2024	Madera At-Large Commission Appointed	Paulo Soares
May 2024	Fresno At-Large County Appointed Community Medical Center	Soyla Griffin Aldo De La Torre
January 2022	Fresno At-Large Commission Appointed	John Frye Jr.
January 2022	Valley Children's Hospital	Brian Smullin
May 2022	Fresno At-Large County Appointed Fresno At-Large County Appointed	David Cardona, MD David S. Hodge, MD
March 2023	Kings At-Large County Appointed	Harold Nikoghosian
April 2023	Kings At-Large Commission Appointed	Kerry Hydash
May 2023	Fresno At-Large County Appointed	Joyce Fields-Keene
September 2023	Madera At-Large	Aftab Naz, MD
	Indefinite terms:	
	David Luchini, Fresno County Health Dept	
	Rose Mary Rahn, Kings County Health Dept	
	Sara Bosse, Madera County Health Dept	

BOARDS, COMMISSIONS OR COMMITTEES ON WHICH THE BOARD OF SUPERVISORS SERVE 2022		
	COMMITTEE	**2022**
19	**Fresno-Kings-Madera Regional Health Authority** *Alternate	Quintero *Pacheco
20	**Fresno/Clovis Convention & Visitors Bureau** (Chairman or designees)	Magsig PW&P Designee
21	**Fresno-Madera Area Agency on Aging - Governing Board** *Alternate	Brandau *Remaining 4 Board Members
22	**Fresno Regional Workforce Development Board**	Quintero
23	**Indian Gaming Local Benefit Committee**	Magsig Brandau
24	**Kings River East Groundwater Sustainability Agency** ***Alternate**	Mendes *PW&P Designee
25	**Law Library Board of Trustees** (Chairman, another Board Member or a member of the Bar Association)	Brandau
26	**Local Agency Formation Commission** *Alternate	Brandau Magsig *Quintero
27	**McMullin Area of Kings Groundwater Subbasin** ***Alternate**	Pacheco *Mendes
28	**North Fork Kings Groundwater Sustainability Agency**	Mendes
29	**North Kings Groundwater Sustainability Agency** *Alternate	Pacheco *Mendes
30	**Pleasant Valley State Prison Citizens Advisory Committee**	Pacheco Mendes
31	**Retirement Board**	Magsig
32	**San Joaquin River Conservancy** *Alternates	Brandau *Pacheco *Magsig
33	**San Joaquin Valley Insurance Authority (SJVIA)** 4 members *Alternate	Mendes, Brandau, Magsig, Pacheco *Quintero
34	**San Joaquin Valley Supervisors Association**	All Board Members
35	**San Joaquin Valley Unified Air Pollution Control District**	Mendes
36	**San Joaquin Valley Water Infrastructure Authority** *Alternate	Mendes *Pacheco

COUNTY OF KINGS
BOARD OF SUPERVISORS

KINGS COUNTY GOVERNMENT CENTER
1400 W. LACEY BOULEVARD.HANFORD, CA 93230
(559) 582-3211, EXT. 2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

JOE NEVES – DISTRICT 1
LEMOORE & STRATFORD

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

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

CRAIG PEDERSEN – DISTRICT 4
ARMONA & HANFORD

RICHARD FAGUNDES – DISTRICT 5
HANFORD & BURRIS PARK

January 28, 2022

CalViva - Fresno/Kings/Madera Regional Health Authority
Attn: Cheryl Hurley, Committee Coordinator
7625 N. Palm Avenue #109
Fresno, CA 93711

Re: County Representation on CalViva - Fresno/Kings/Madera Regional Health Authority

Dear Cheryl;

At a regular meeting of Kings County Board of Supervisors on January 25, 2022, the following members were appointed to the CalViva - Fresno/Kings/Madera Regional Health Authority:

Primary Appointments
Joe Neves, Supervisor Dist. 1
1400 W. Lacey Blvd
Hanford, CA 93230
(559) 852-2368
joe.neves@co.kings.ca.us

Alternate Appointments
Doug Verboon, Supervisor Dist. 4
1400 W. Lacey Blvd
Hanford, CA 93230
(559) 852-2366
doug.verboon@co.kings.ca.us

Please direct staff to coordinate directly with the Board member concerning meeting dates, times and other issues.

Respectfully,

Catherine Venturella,
Clerk to the Board of Supervisors

2022 BOARD OF SUPERVISORS MEMBERSHIPS

APPOINTMENTS ARE FOR ONE YEAR UNLESS INDICATED OTHERWISE

AGENCY	PRIMARY MEMBER	ALT MEMBER	TERM	CURRENT EXPIRATION (P)	CURRENT EXPIRATION (A)
Behavioral Health Board	Leticia Gonzalez	Robert Poythress		1/1/2022	1/1/2022
Review/evaluate mental health needs, insures appropriate and economical use of funds. Meets: 3rd Wednesday of every month, 11:30am-1:00pm					
CAL ID-Remote Access Committee (RAN)	Robert Poythress	David Rogers			
California Women's Facility Citizens Advisory Committee	David Rogers	Brett Frazier	2 Years	1/1/2023	1/1/2023
Can be a BOS member or a liaison from the Community at large. Meets: 1st Thursday of every other month, 3pm @ the Prison.					
California Development Block Grant Committee (CDBG)	Robert Poythress	Leticia Gonzalez			
Children & Families Commission (First 5)	Leticia Gonzalez	David Rogers	2 Years	1/1/2023	
Administration of Prop 10 (Tobacco) funds. Meets: 1st Wednesday of each month.					
Community Action Partnership of Madera County (CAPMC)	Leticia Gonzalez	Robert Poythress			
A social service agency: adminsters programs such as Headstart, Emergency Services, Victim Services. Meets: 2nd Thursday each month @5:30pm @1225 Gill Ave. Madera					
Community Corrections Partnership Committee	Robert Poythress	Brett Frazier			
Countywide Oversite Board of the Successor Agencies to the Redevelopment Agencies*	Robert Poythress	Leticia Gonzalez			
Per Resolution: Chairman and Chairman Pro Tem					
Courthouse Park Resotration Committee	Robert Poythress				
California State Assocation of Counties Policy Committees (CSAC)*	Tom Wheeler	Brett Frazier			
Appointment for 2020-2021 approved 11-10-2020					
Ag & Natural Resources	David Rogers		2 Years	1/1/2023	
Labor & Employment	Brett Frazier		2 Years	1/1/2023	
Government Finance & Operations	Robert Poythress		2 Years	1/1/2023	
Health & Welfare	Leticia Gonzalez		2 Years	1/1/2023	
Housing/Land Use/ Transportation (Native American Issues)	Tom Wheeler	Brett Frazier	2 Years	1/1/2023	
Administration of Justice	Robert Poythress		2 Years	1/1/2023	
CSAC Board of Directors (Sets Policy for CSAC)	Tom Wheeler	Brett Frazier	2 Years	1/1/2023	
Meets: Twice per year as determined by Committee Chairperson Conferences:	**Spring Conference & Annual Meeting**				
Crane Valley Project	Tom Wheeler				
Economic Development Commission	Brett Frazier	Leticia Gonzalez			
Promote Economic growth of Madera County. Meets: 2nd Wednesday of every month @3:00pm Conference: EDC Annual Planning Conference (Bass Lake)					
Fresno/Madera Area Agency on Aging Board of Directors (FMAAA)	Leticia Gonzalez	Brett Frazier			
Advocacy for elderly; Advance the aims of the Older American Act. Meets: 3rd Thursday @10am					
Fresno-Kings-Madera Regional Health Authority Commission	David Rogers	Brett Frazier	3 Years	1/1/2023	1/1/2023

Item #5

Attachment 5.A-5.B

A. BL 22-002 Reappointment Letter
B. VCH Reappointment Letter

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, 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

Rose Mary Rahn, Director
Public Health Department

Harold Nikoghosian- At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
Public Health Department

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

Jeffrey Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: February 17, 2022

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Commission Appointed—Hospital: Valley Children's Hospital

BL #: 22-002
Agenda Item 4
Attachment 4.A

BACKGROUND:

Under the terms of the Bylaws of the Fresno-Kings-Madera Regional Health Authority Commission (Section 2.3.5), one Commission member shall be a representative of the Children's Hospital Central California (the "Hospital"). The designation of this Commissioner shall be made by the Hospital, but each such designation is subject to confirmation by the Commission. The Commission may, in its discretion, reject any person designated by the Hospital and request additional designations.

DISCUSSION:

The Commission Appointed Valley Children's Hospital position is up for re-appointment as of January 2022.

Mr. Todd Suntrapak, President & CEO, Valley Children's Hospital, requests and approves the reappointment of Mr. Brian Smullin, Vice President Managed Care, for a term of three (3) years.

RECOMMENDED ACTION:

Ratify the appointment Mr. Brian Smullin as the Commission Appointed representative for Valley Children's Hospital

Valley Children's HEALTHCARE

February 8, 2022

David Hodge, M.D.
Fresno-Kings-Madera Regional Authority Commission
7625 N. Palm Avenue, #109
Fresno, CA 93711

Dear Chairperson Hodge,

By this letter, Valley Children's Healthcare requests and approves the reappointment of Brian Smullin, Vice President, Managed Care, for a term of three (3) years as Valley Children's representative to the Fresno-Kings-Madera Regional Health Authority Commission.

Sincerely,

Todd A. Suntrapak,
President & Chief Executive Officer

Office of the President
Valley Children's | HOSPITAL | MEDICAL GROUP | HOME CARE | FOUNDATION
9300 Valley Children's Place, Madera, CA 93636 • (559) 353-3000 • valleychildrens.org

Item #6

Attachment 6.A-6.B

A. BL 22-003 Fresno Co At-Large Seat Nomination
B. Application – J. Frye

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, 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

Rose Mary Rahn, Director
Public Health Department

Harold Nikoghosian- At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
Public Health Department

Aftab Naz, M.D.
At-large

Regional Hospital

Brian Smullin
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Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

Jeffrey Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: February 17, 2022

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Commission Appointed – Fresno At-Large Seat

BL #: 22-003
Agenda Item 5
Attachment 5.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 Fresno At-Large position is up for reappointment as of January 2019.

Mr. Frye has expressed his interest and has submitted his application to continue serving in his current position. No other applications were received.

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

RECOMMENDED ACTION:

Review application and reappoint Fresno 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: John W Frye Jr
Home Address: City: Fresno. Zip: 93711
Current Employer: Retired (Jan 1, 2019)
Business Address: N/A City: _____Zip: _____
Home Phone: (559) 974-1530 Work Phone: N/A. E-mail Address: jwfryejr@aol.com

---

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

RHA Commissioner Fresno County at Large (---to Present)

RHA Commissioner Madera County at Large (---to---)

List past or present affiliations with private and/or public health plans.

Central Valley Health Plan (2016-17)

Valu Care (1997-2000)

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

Healthcare Executive in area hospitals (urban & rural) for 38 years

Experience with health plans & Medi-Cal

List community organizations to which you belong:

Poverello House Board Finance Committee (1998 – present)

Poverello Board Member (1992-2019) Chair (2016-17)

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 Greg Hund
   Affiliation Retired CEO – Cal Viva
   Contact Phone Number (559) 967-2317
2. Name Nancy Hollingsworth
   Affiliation CEO-Saint Agnes Medical Center
   Contact Phone Number (559) 450-3000
3. Name Steve Barsotti
   Affiliation Past Board Chair – Madera Community Hospital
   Contact Phone Number (559) 674-8536

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)

11/04/2021
(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 #8

Attachment 8.A

Commission Minutes
Dated 10/21/21

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
October 21, 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	✓●	**David Luchini**, Interim Director, Fresno County Dept. of Public Health
✓●	**David Cardona**, M.D., Fresno County At-large Appointee	✓	**Aftab Naz**, Madera County At-large Appointee
✓●	**Aldo De La Torre**, Community Medical Center Representative	✓	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
✓●	**Joyce Fields-Keene,** Fresno County At-large Appointee	✓●	**Harold Nikoghosian**, Kings County At-large Appointee
	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
✓	**David Hodge**, M.D., Chair, Fresno County At-large Appointee		**Brian Smullin**, Valley Children's Hospital Appointee
	Kerry Hydash, Commission At-large Appointee, Kings County	✓●	**Paulo Soares**, Commission At-large Appointee, Madera County
	Commission Staff		
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)	✓	**Mary Lourdes Leone**, Chief Compliance Officer
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Amy Schneider**, R.N., Director of Medical Management
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Cheryl Hurley**, Commission Clerk
	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 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	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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 Consent Agenda a) Commission Minutes 9/16/2021 b) Finance Committee Minutes 7/15/2021 c) QIUM Committee Minutes dated 7/15/2021 d) Commission Calendar e) Finance Committee Calendar f) QIUM Calendar g) Credentialing Sub-Committee Calendar h) Peer Review Calendar i) Public Policy Committee Calendar Action J. Neves, Co-Chair	All consent items were presented and accepted as read. *Supervisor Quintero arrived after the vote*	***Motion**: Approve Consent Agenda* *10 – 0 – 0 – 6* *No vote for Supervisor Quintero* *(Neves / Naz)* *A roll call was taken*
#4 Financial Audit Report for Fiscal Year 2021	Rianne Suico and Eleanor Garibaldi, representatives with Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an	***Motion**: Approve Financial Audit Report for FY 2021*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Moss Adams Representative R. Suico and E. Garibaldi	unmodified opinion on the financial statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances were discussed. The required communications and the organization's accounting policies are in compliance with GAAP. After completing the work, it was found that the financial statements do not need to be adjusted and no issues were encountered when completing the work.	*10 – 0 – 0 – 6* *No vote for Aldo De La Torre* *(Luchini / Neves)* *A roll call was taken*
#5 2021 Cultural & Linguistics Executive Summary and Work Plan Mid-Year Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2021 Cultural & Linguistics (C&L) Work Plan Mid-Year Evaluation. The 4 categories for the 2021 Work Plan are: 1. Language Assistance Services 2. Compliance Monitoring 3. Communication, Training, and Education 4. Health Literacy, Cultural Competency & Health Equity By June 30, 2021 all activities were on target for year end. Some of the activities completed consist of: 1. Population Needs Assessment was completed in collaboration with Health Education and Quality Improvement. (Formerly GNA) 2. C & L related grievances reviewed. Follow up completed including four (4) interventions. 3. Completed and disseminated a Member Newsletter on how to access language services. 4. Four (4) Call Center trainings conducted.	**See #7 for Motion**

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	5. Collaborated on Breast Cancer Screening Disparity PIP intervention development. 6. Conducted Motivational Interviewing training. All of the Work Plan activities continue on target for completion by the end of calendar year 2021.	
#6 2021 Health Education Executive Summary and Work Plan Mid-Year Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2021 Health Education Work Plan Mid-Year Evaluation. Two areas of focus for 2021 consist of: 1. Programs and Services 2. Department Operations, Reporting and Oversight Of the 17 Program Initiatives, 12 are on track to meet year-end goals. These consist of: 3. Chronic Disease Education: Asthma 4. Chronic Disease: Hypertension 5. Community Engagement 6. Fluvention & COVID-19 7. Health Equity Project 8. Member Newsletter 9. Obesity Prevention 10. Pediatric Education 11. Perinatal Education 12. Promotores Health Network 13. Compliance: Oversight and Reporting 14. Department Materials Development, Utilization and Inventory The five (5) initiatives that are off track consist of: 1. Chronic Disease: Diabetes Prevention Program – finalize contract and obtain approvals.	**See #7 for Motion**

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2. Mental Health: Educate members to increase ACEs screenings. 3. Tobacco Cessation: complete program enhancement and obtain approvals. 4. Women's Health: Evaluate outcomes of other email/IVR programs before proceeding. 5. Geographic Information Systems: Outreach to departments to identify activities that might benefit from spatial analysis. 15. Barriers to full implementation of planned activities have been identified and are being addressed. 2021 initiatives will continue to be implemented in order to meet or exceed year-end goals.	
#7 Quality Improvement Update 2021-2022 Action P. Marabella, MD, CMO	Dr. Marabella provided an update on HEDIS®, PIP, and PDSA Projects. Two new PDSA projects include: 1. Diabetes: A1c> 9% with Clinica Sierra Vista, Fresno County. 2. Cervical Cancer Screening with Clinica Sierra Vista, Fresno County. Continuing Performance Improvement Projects (PIP) include: 1. Childhood Immunizations with Family HealthCare Network, Fresno County. 2. Breast Cancer Screening with Greater Fresno Health Organization, Fresno County. The continuing Quality Improvement Projects (QIP) relating to COVID-19 includes: 1. Antidepressant Outreach 2. HTN & Diabetes outreach 3. Well-Child & Chlamydia screening	***Motion**: Approve 2021 C&L Executive Summary, Work Plan Mid-Year Evaluation; 2021 HE Executive Summary, Work Plan Mid-Year Evaluation; and 2021-2022 QI Update* *11 – 0 – 0 – 5* *(Naz / Neves)* *A roll call was taken*
#8 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**<u>Finance</u>** **Financials as of August 31, 2021**:	***Motion**: Standing Reports Approved* *11 – 0 – 0 – 5* *(Naz / Nikoghosian)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Total current assets recorded were approximately $340.3M; total current liabilities were approximately $231M. Current ratio is approximately 1.47. Total net equity as of August 2021 was approximately $119.3M which is approximately 737% above the minimum DMHC required TNE amount. Premium capitation income actual recorded was approximately $226.7M which is approximately $393K less than budgeted due to the retroactive rate adjustment that DHCS made in August 2021 which related to DHCS updating the pharmacy component of the rate for the entire 2021 calendar year which reduced the Plan's rates and revenues. Total cost of medical care expense actual recorded is approximately $187.8M which is approximately $896K less than budgeted due to the same reason as stated above. The revenue difference is smaller than the medical cost difference because the MCO tax loss was not as great as what was budgeted. Admin service agreement fees expense actual recorded was approximately $8.5M, which is approximately $154k more than budgeted due to higher than expected enrollment. All other line-item expense items are in line with what was budgeted. For the first two months of FY 2022 net income was approximately $206k primarily due to front loading grants made to various entities and CBOs which is approximately $542K more than budgeted primarily due to the MCO tax loss not being as high as projected due to enrollment being higher than anticipated.	*A roll call was taken*
• **Compliance** M.L. Leone, CCO	**<u>Compliance</u>** There were no new breaches reported to DHCS since the September Commission meeting. No new MC609 filings with DHCS; 24 cases are still open for investigation.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Three oversight audits completed include: • Pharmacy (No CAP) • Emergency Services (No CAP) • Annual 2020 Claims resulted in a corrective action plan (CAP) relating to misdirected claims not being forwarded on time, and Prop 56 payments not paid within 90-calendar days of claims receipt. In reference to Regulatory Reviews and Audits, and CAPs, 2021 DMHC 18-month Follow-Up Audit: Audit interviews were held 3/30/21; the Plan is currently awaiting the final report. The next DMHC audit is scheduled for September 2022. The 2020 DHCS Audit CAP: the Plan filed its final CAP update on 8/27/21; the Plan is currently awaiting response from DHCS regarding CAP closure. DHCS Subcontracted Network Certification (SNC) Readiness Plan: The Plan submitted the Subcontracted Network Certification Readiness Plan on 5/27/21; at the request of DHCS the Plan submitted responses as a result of three separate requests for additional information; currently pending final determination by DHCS. The Medi-Cal RX transition will become effective 1/1/2022. The enhanced Care Management (ECM) and In Lieu of Services (ILOS) under California Advancing and Innovating Medi-Cal (CalAIM) will become effective 1/1/22 in Kings County, and 7/1/22 in Fresno and Madera counties. The Plan's initial ECM-ILOS Model of Care Part 1 was filed with DHCS 7/1/21 and approved. The Plan submitted the MOC Part 2 deliverable on 9/1/21, and MOC part 3 on 10/1/21 and is responding to any additional request for information/updates.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	The Major Organ Transplant (MOT) carve-in will become effective 1/1/22 for all CVH service counties and membership. The Plan submitted its MOT Network Certification listing California transplant centers on 9/2/21. The Plan's administrator is currently negotiating contracts with these centers to cover transplants for the Plan's Medi-Cal membership. On 8/30/21 the Plan submitted the Q2 Behavioral Milestone Report to DHCS. This included the 2019 Baseline Data Report for Adventist, and the 2020 Baseline Data Report for both Adventist and Camarena. The Plan expects to receive payment this month. The next Public Policy Committee meeting will be held on December 1, 2021 at 11:30 am and it is still to be determined if the meeting will be in person or if it will be a teleconference due to COVID-19. **<u>Medical Management</u>** **Appeals and Grievances Dashboard** Dr. Marabella presented the Appeals & Grievances Dashboard through August 2021. • The total number of grievances received in August decreased compared to recent months, however the number resolved remained consistent. • An increase was noted in the number of *Quality-of-Care* grievances resolved in August, mainly attributable to ancillary services and specialist care as members obtain services postponed due to the pandemic. • One (1) grievance Ack Letter and one (1) Expedited Appeal were noted to be out of compliance. Follow up completed. • Exempt Grievances had a slight increase from previous months.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Appeals continue to demonstrate variation with the majority of cases related to Advanced Imaging and Pharmacy consistent with last month. **Key Indicator Report** Dr. Marabella presented the Key Indicator Report (KIR) through August 2021. Acute Care Admission rates for SPDs remain low, however they appear to be increasing for the Family/Adult and Expansion populations. Length of Stay remains higher than prior years for Family/Adult and Expansion populations. Turn-around Times for Prior Authorizations were noted to have some opportunities for improvement this month. An increase in the number of requests submitted as "urgent" was noted along with some COVID-related staffing issues. The volume of Deferrals is low and therefore the rate is highly sensitive to variations. Adjustments are in progress, anticipate improvement next month. Case Management results remain strong and demonstrate positive results in all areas consistent with previous months. **QIUM Quarterly Report – Q3** Dr. Marabella provided the QI/UM Qtr. 3, 2021 update. Two QI/UM meetings were held in Quarter 3; one in July and one in September. The following guiding documents were approved at these meetings:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	1. 2021 QI Work Plan Mid-Year Evaluation 2. 2021 UMCM Work Plan Mid-Year Evaluation 3. Clinical Practice Guidelines In addition, the following general documents were approved: • Pharmacy Formulary & Provider Updates. • Medical Policies. The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard & Quarterly A & G Reports, the A & G Validation Audit Report, and Initial Health Assessment. Additional QI reports include Potential Quality Issues (PQI) Report, Facility Site and Medical Record Review Report, Provider Office Wait Time, County Relations Report and others scheduled for presentation at the QIUM Committee during Q3. The Utilization Management & Case Management reports reviewed were the Key Indicator Report, PA Member Letter Monitoring Report, and UM Top 10 Diagnosis Report. Additional UMCM Reports include Concurrent Review IRR Report, TurningPoint, Standing Referrals Report, Specialty Referrals Report, Case Management and CCM Report and others scheduled for presentation at the QIUM Committee during Q3. Pharmacy reports reviewed included Executive Summary, Pharmacy Call Report, Operation Metrics, Top 30 Medication Prior Authorization (PA) Requests, Pharmacy Interrater Reliability Results (IRR), and quarterly Formulary changes. All Q2 2021 pharmacy prior authorization metrics were within 5% of standard. Overall TAT for Q2 was 96.66%. Total PA requests were comparable to Q1 2021. Inter-Rater Reliability Results for Q2 2021 reached 95% accuracy (90% threshold met). Follow up to occur	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	when opportunities for improvement are identified both on an individual and team basis. HEDIS® Activity: In Q1, HEDIS® related activities focused on data capture for MY20. Managed Care Medi-Cal health plans will have 18 quality measures that they will be evaluated on for RY21 and the Minimum Performance Level (MPL) is the 50th percentile. In Q3, HEDIS® related activities were focused on analyzing the results for MY2020 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. The areas that CalViva reported results below the 50th percentile MPL are: • Antidepressant Medication Management (AMM), for both the Acute Phase and the Continuation Phase, for all three counties. • Breast Cancer Screening for Fresno and Kings Counties. • Cervical Cancer Screening for Fresno County. • Chlamydia Screening for Fresno and Madera Counties. • Childhood Immunizations – Combo 10 for Fresno and Kings Counties. • Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9%) for Fresno and Madera Counties. • Controlling High Blood Pressure for Fresno County. • Weight Assessment and Counseling – BMI Percentile for Fresno County. • Well-Child Visits in the first 15 months of life for all three counties. There were no sanctions or Corrective Action Plans (CAPs) for failure to meet MPLs for MY 2020.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	For MY2021 each MCP is required to develop no more than three (3) PDSA rapid cycle improvement projects from the MCAS measures that are below the MPL. CalViva is required to complete two (2) new PDSA Projects over the next 9 months: one for Cervical Cancer Screening and one for CDC- HbA1c Poor Control. Additionally, each Plan is required to continue to report on the "COVID-19 Quality Improvement Plan (QIP)". This is a selection of 3 or more improvement strategies that demonstrate how the Plan has adapted to improve the health and wellness of its members during the COVID 19 Emergency. These interventions are to be associated with preventive services, chronic illness and/or behavioral health. **<u>Executive Report</u>** CVH Membership continues to increase. Market share continues to trend down primarily due to the moratorium on enrollment as a result of the Public Health Emergency (PHE), and the default algorithm measures in terms of the methodology used by the State to auto-assign members that do not choose a plan. The State will continue with the current default rate for another year. There are no significant issues, concerns, or items to note as it pertains to the Member Call Center and CVH website. There are no significant issues, concerns, or items to note as it pertains to the Plan's IT Communications and Systems. As it pertains to the Provider Network Activities, the August 2021 numbers have slightly decreased in the areas of PCP and Specialists. The Plan's Administrator is conducting a roster clean up and validating information. The bulk of the activity is related to data clean-up, accuracy, and integrity. In relation to Provider Relations,	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	the team continues to engage Providers through a variety of mechanisms which is working well and productivity is better in the sense of being able to engage Providers in a timely matter and more frequently. There are no updates to provide at this time for Claims Processing and Provider Disputes. As an update to CalAIM Care Coordination and Dual Special Needs Plan (DSNP), DHCS leadership and CMS leadership have come to an understanding and support the Plan's model and arrangement to continue the Plan's Care Coordination efforts with Health Net and their Dual Special Needs Plan (DNSP) in Fresno County and are receptive with the Plan continuing to extend those arrangements in all CVH service area counties. In relation to the Plan's social media campaigns, CalViva Health is in process of launching a Facebook page. Once it becomes available communication will go out to all Commissioners.	
#9 Closed Session **A.** Government Code section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation.	Jason Epperson, General Counsel, reported out of Closed Session. The Commission went into closed session to discuss item agendized for closed session specifically conference with legal counsel; anticipated litigation pursuant to Government Code section 54956.9(b). Discussion was held and direction was given to staff. Closed Session concluded at 2:46 pm.	
#10 Final Comments from Commission Members and Staff	Dr. Naz has asked the Commission to look into the feasibility of increasing payments to Providers, potentially via a bonus. Jeff Nkansah, CVH CEO, stated the Plan will look into the request as part of the Commission's funding of Community Support Programs.	
#11 Announcements	None.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#12 Public Comment	None.	
#13 Adjourn	The meeting was adjourned at 2:50 pm The next Commission meeting is scheduled for November 18, 2021 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #8

Attachment 8.B

Finance Committee Minutes
Dated 9/16/2021

CalViva Health
Finance
Committee Meeting Minutes

September 16, 2021

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
✓	Jeff Nkansah, 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 July 15, 2021	The minutes from the July 15, 2021 Finance meeting were approved as read.	Motion: *Minutes were approved 6 – 0 – 0 – 1*

Attachment 2.A Action D. Maychen, Chair		*(Nikoghosian / Frye)* A roll call was taken.
#3 Financials – Fiscal Year End 2021 Action D. Maychen, Chair	Fiscal year end 2021 financials are currently being audited by Moss Adams, LLP and are in the final review stages. To date, there are no proposed audit adjustments or corrections to the financial statements. Moss Adams will be present during the October Finance meeting and the October Commission meeting to present the final audited financials for Fiscal Year 2021. Current total assets are approximately $266.1M; current liabilities recorded are $157M, this gives a current ratio of 1.69. TNE as of June 30, 2021 is approximately $119.1M which is approximately 736% of the minimum required TNE by DMHC. Investment income actual recorded was approximately $299k less than budgeted primarily due to declining yields on the Plan's money market accounts. Premium capitation income actual recorded was approximately $1.33B which is approximately $148.4M higher than what was budgeted due to the FY 2021 budget accounting for the Pharmacy Carve-Out being effective mid-way through FY 2021 and was delayed by DHCS and was not effective at all during FY 2021. This created higher revenues than projected; that in conjunction with enrollment being higher than projected and higher rates also contributed to the higher revenue. In late July 2021 DHCS confirmed that the new Pharmacy Carve-Out date will be 1/1/2022 which is consistent with what was budgeted in the FY 2022 budget. Total costs of medical care expense actual recorded is approximately $1.12B which is approximately $142.9M above what was budgeted primarily due to the delay of the Pharmacy Carve-Out and higher enrollment and rates than expected. Admin service agreement fees expense actual recorded	Motion*: Financials Year End 2021 were approved* *6 – 0 – 0 – 1* *(Nikoghosian / Soares)* A roll call was taken.

	was approximately $49.6M which is approximately $1.5M above what was budgeted primarily due to enrollment being higher than anticipated. Grants expense actual recorded is approximately $3.5M which is approximately $667k less than budgeted due to the Plan's Grants/Community Support Program related funds not being fully utilized. All other expense items line items are in line with what was budgeted. Total net income for FY 2021 was approximately $10.3M, which is approximately $5M more than budgeted, primarily due to the Pharmacy Carve-Out delay, higher enrollment than projected, and rates being higher than budgeted.	
#4 Financial Statements as of July 31, 2021 Action D. Maychen, Chair	Total current assets recorded were approximately $240M; total current liabilities were approximately $131.3M. Current ratio is approximately 1.89. Two new line items have been added to the Balance Sheet; Lease Receivable and Deferred Inflows of Resources. These two new items were added due to a new accounting standard through GASB 87. Total net equity as of July 2021 was approximately $118.7M which is approximately 733% above the minimum DMHC required TNE amount. Premium capitation income actual recorded was approximately $115M which is approximately $1.5M higher than budgeted due to enrollment being higher than budgeted. Total cost of medical care expense actual recorded is approximately $95.5M which is approximately $1.2M more than budgeted due to higher enrollment than expected. Admin service agreement fees expense actual recorded was approximately $4.3M, which is approximately $76k more than budgeted due to enrollment being higher than budgeted. All other line-item expense items are in line with what was budgeted. For the first month of FY 2022 there was a net loss of approximately $403k primarily due to front loading grants made to various entities and CBOs which is consistent with what was budgeted and the prior year. The $403k net loss is $313k less than the projected net loss of $716K due to the MCO tax loss not being as high as anticipated.	Motion: *Financials as of July 31, 2021 were approved* *6 – 0 – 0 – 1* *(Frye / Nikoghosian)* A roll call was taken.

#5 Proposed 2022 Finance Meeting Calendar Action D. Maychen, Chair	The proposed 2021 Finance meeting calendar was presented to the Committee. No revisions recommended.	Motion: Motion: *Approve Proposed Finance Meeting Calendar to move forward to Commission for Approval* *6 – 0 – 0 – 1* *(Frye / Nikoghosian)* A roll call was taken.
#5 Announcements		
#6 Adjourn	Meeting was adjourned at 11:43 am	

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

Dated: Oct. 21, 2021

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 10/21/2021

Item #8

Attachment 8.C

QIUM Committee Minutes
dated 9/16/2021

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

September 16th, 2021

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	✓	**Amy Schneider, RN,** Director of Medical Management Services
✓•	**Fenglaly Lee, M.D.,** Central California Faculty Medical Group	✓	**Ashelee Alvarado,** Medical Management Specialist
✓•	**Brandon Foster, PhD.** Family Health Care Network	✓	**Iris Poveda**, Medical Management Administrative Coordinator
✓•	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers	✓	**Mary Lourdes Leone,** Chief Compliance Officer (CCO)
	Raul Ayala, MD, Adventist Health, Kings County		**Maria Sanchez**, Compliance Manager
	Joel Ramirez, M.D., Camarena Health Madera County	✓	**Lori Norman,** Senior Compliance Analyst
	Rajeev Verma, M.D., UCSF Fresno Medical Center		
	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 10:38 am. A quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: July 15, 2021 - Appeals & Grievances Classification Audit Report (Q2) - Appeals & Grievances Inter Rater Reliability Report (Q2) - Appeals & Grievances Validation Audit Summary Report (Q2) - Concurrent Review IRR Report (Q2)	The July 15th, 2021 QIUM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. The full August Formulary (PDL) was available for review upon request.	Motion: *Approve* Consent Agenda (Foste/Lee) 4-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Customer Contact Center DMHC Expedited Grievance Report (Q2) - Member Incentive Programs – Semi Annual report (Q1-Q2) - California Children's Service Report (Q2) - County Relations Quarterly Update (Q2) - Medical Policies Provider Updates (Q2) - CalViva Health Pharmacy Call Report (Q2) - Pharmacy Provider Updates (Q2) (Attachments A-L) **Action** Patrick Marabella, M.D Chair		
#3 **QI Business** - Appeals & Grievances Dashboard (July) - Appeals & Grievances Executive Summary (Q2) - Appeals & Grievances Quarterly Member Report (Q2) - Quarterly Appeals & Grievances Member Letter Monitoring Report (Q2) (Attachments M-P) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **Appeals & Grievances Dashboard** through July 2021. ➢ The total number of grievances through July 2021 has increased compared to last year. However, the total number of grievances this year is similar to 2019 results. ➢ Quality of Service (QOS) for Access, Administrative, and Transportation continue to represent the majority of these grievances. ➢ The volume of Quality of Care (QOC) grievances has remained consistent. ➢ Exempt Grievances have increased slightly compared to year. ➢ The total number of Appeals Received through Q2 2021 has remained consistent.	Motion: *Approve* - Appeals & Grievances Dashboard (July) - Appeals & Grievances Executive Summary (Q2) - Appeals & Grievances Quarterly Member Report (Q2) - Quarterly Appeals & Grievances

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
		Member Letter Monitoring Report (Cardona/Lee) 4-0-0-2
#3 **QI Business** - Initial Health Assessment Quarterly Audit Report (Q4-2020) (Attachments Q) **Action** Patrick Marabella, M.D Chair	The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an **Initial Health Assessment** (IHA) and Individual Health Education Behavioral Assessment (IHEBA) completed within the first 120 days of enrollment. CalViva Health is required to facilitate and support members and providers through this process. The current approach to monitoring has three components: ➢ Medical Record Review (MRR) via onsite provider audits. ➢ Monitoring of claims and encounters data. ➢ Member outreach following a three-step methodology. The Q4 2020 IHA Quarterly Report demonstrates CalViva Health's performance on IHA/IHEBA compliance monitoring from January – December, 2020. ➢ Because COVID-19 prevented Facility Site Review audits from occurring from March 2020 to date, FSR/MRR audits only occurred for 7 sites in 2020. IHA/IHEBA completion rates were 64% for pediatric IHA visits and 40% for adult visits. ➢ Member outreach completed by the Plan resulted in a range of 48.45% - 69.91% plan outreach compliance for January – December, 2020. ➢ In response to a DHCS audit finding CalViva decided to take a quality improvement approach to increasing IHA/IHEBA completion. Working with a high volume, low performing clinic in Madera County, the IHA Improvement Team established a process for providers to obtain their list of new members, contact them to schedule an initial appointment and appropriately document (including coding) when an IHA/IHEBA has been completed. ➢ The IHA report will be modified to document the continued efforts to improve IHA completion as the new process is shared and monitored with providers throughout the three CalViva Health counties.	Motion: *Approve* - Initial Health Assessment Quarterly Audit Report (Q4-2020) (Foster/Lee) 4-0-0-2
#3 **QI Business** - Potential Quality Issues (Q2) (Attachments R)	**Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review-activities. Peer review	Motion: *Approve* - Potential Quality Issues (Q2)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data for Q2 was reviewed for all case types including the follow up actions taken when indicated. ➢ Non-member initiated PQI category cases were in range when compared to the last three Quarters. Of the 13 cases closed, zero were documented as being generated from provider preventable conditions (PPCs). ➢ Member generated PQI's slight increased based on previous quarters with a total of 72 cases. The number of peer review cases varies from quarter to quarter independent of the other case types. Follow up has been initiated when appropriate.	(Foster/Lee) 4-0-0-2
#4 **Quality Improvement/Utilization Management Business** - Quality Improvement Wok Plan Mid-Year Evaluation and Executive Summary 2021 - Utilization Management (UM)/Case Management (CM) Work Plan Mid-Year Evaluation and Executive Summary 2021 (Attachments S-T) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **2021 Quality Improvement Work Plan Mid-Year Evaluation**. Initiatives on track to be completed by year end include: ➢ Access, Availability, and Service: o Improve Access to Care by continuing to monitor appointment access via the Provider Appointment Availability Survey (PAAS). After-hours access (urgent & emergent services) is monitored via the Provider After Hours Access Survey (PAHAS). o Corrective Action Plans (CAPs). A targeted PPG approach will be used to address non-compliance with an established escalation process for non-responding PPGs. Educational packets will be distributed to Fee for Services (FFS) and Direct Network providers who are non-compliant. Any providers in this group who are non-compliant for 2 years in a row will be required to complete a CAP. o Mandatory webinars will be required for non-compliant PPGs. ➢ Quality & Safety of Care o Default Measures: Fresno and Kings Counties fell below the MPL in Childhood Immunizations. Fresno County fell below the MPL for Controlling High Blood Pressure. All three counties exceeded MPL in Timeliness of Prenatal Care. Fresno and Madera counties fell below the MPL in HbA1c testing. And Fresno County fell below the MPL for Cervical Cancer Screening. ➢ Performance Improvement Projects (PIPs): o Childhood Immunizations (birth to 2 years) CIS-10: Modules 1, 2 & 3 are	Motion: *Approve* - Quality Improvement Wok Plan Mid-Year Evaluation and Executive Summary 2021 - Utilization Management (UM)/Case Management (CM) Work Plan Mid-Year Evaluation and Executive Summary 2021 (Cardona/Foster) 4-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	complete and approved. The first intervention will utilize text messaging to attempt to engage parents in dialogue and encourage them to schedule an appointment for immunizations. The first messages were sent September 14th. o Breast Cancer Screening Disparity: Modules 1 & 2 are complete and approved. Module 3 has been submitted and is pending approval. The first intervention is an in-person educational event including a physician speaker, video in Hmong, testimonials, and staff from Imaging Center. The first event is scheduled for September 24th. o Several metrics have been established for each intervention to evaluate their success. Dr Marabella also presented the **2021 Utilization Management (UM)/Case Management (CM) Work Plan Mid-Year Evaluation**. ➢ Activities focused on: o Compliance with Regulatory & Accreditation Requirements o Monitoring the UM Process o Monitoring Utilization Metrics o Monitoring Coordination with Other Programs and Vendor Oversight o Monitoring Activities for Special Populations ➢ Data metrics o Turn Around Times for Processing Authorizations: Jan-June 99.5.% (CAP monitoring in progress). o Turn Around Times for Appeals: Jan-Jun 99.76% ➢ Additional key findings include the following o Compliance activities are on target for year-end completion. o Too Soon to Tell if monitoring of Turn-around Times for authorization requests will meet goals. o PPG specific dashboard reports continue to be refined and include Bed Days/K, Admits/K and Average Length of Stay (ALOS). They are produced and reviewed quarterly. o Too Soon to Tell if 10% goal to reduce admissions year over year and reduced LOS will be met in 2021. o Integrated Case Management Outcome Measures show Positive results when	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	evaluated 90 days prior and 90 days post services. Member satisfaction is high. o MHN (Behavioral Health) authorization timeliness improved and Bi-directional referrals remain consistent. o Activities for monitoring Special Populations such as CCS and SPD are on target. CCS issues related to delayed surgeries/authorizations has been addressed. Health Risk Assessment timeliness at 100% year to date. **HEDIS Update 2021-2022** The measures that reported results from the Managed Care Accountability Set (MCAS) that were below the minimum performance level (MPL) or 50th percentile, were: o Antidepressant Medication Management (AMM), for both the Acute Phase and the Continuation Phase, for all three counties. o Breast Cancer Screening for Fresno and Kings Counties. o Cervical Cancer Screening for Fresno County. o Chlamydia Screening for Fresno and Madera Counties. o Childhood Immunizations – Combo 10 for Fresno and Kings Counties. o HbA1c Poor Control (>9%) for Fresno and Madera Counties. o Controlling High Blood Pressure for Fresno County. o Weight Assessment and Counseling – BMI Percentile for Fresno County. o Well-Child Visits in the first 15 months of life for all three counties. o The two (2) Performance Improvement Projects (PIPs) on Breast Cancer Screening and Childhood Immunizations started in 2020 will continue through 12/31/2022. **Managed Care Accountability Set Requirements – September 2021** o DHCS will not impose sanctions or Corrective Action Plans (CAPs) for failure to meet MPLs for measurement year (MY) 2021. o No more than three (3) PDSA rapid cycle improvement projects will be required for each MCP this year. CalViva is required to do two (2) PDSA projects this year and these will focus on Cervical Cancer Screening and Comprehensive Diabetes Care-HbA1c < 9. Additionally, the State is continuing the COVID-19 Quality Improvement Plan (QIP) this year. This involves the selection of three (3) improvement strategies that demonstrate how the Plan has adapted to improve the health/wellness of its members during the COVID 19	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Emergency. Two reports per year are required. Medical Management has selected AMM outreach in Kings and Madera Counties and Well Child Visits with Chlamydia Screening in Fresno County for this year's COVID-19 QIP.	
#5 **Access Business** - Provider Appt Availability & After-Hours Access Survey Results (Attachment U) **Action** Patrick Marabella, M.D Chair	**The 2020 annual Provider Appointment Availability Survey (PAAS) and Provider After-Hours Access Survey (PAHAS)** results are used to monitor provider compliance with timely access and after-hours regulations, and evaluate the effectiveness of the network to meet the needs and preferences of CalViva Health members. The following DMHC and DHCS appointment access metrics did not meet the performance goal of 90%: ➢ Urgent care appointment with PCP within 48 hours. ➢ Urgent care appointment with specialist that requires prior authorization within 96 hours ➢ Non-urgent appointment with PCP within 10 business days. ➢ Non-urgent appointment with specialist within 15 business days. ➢ Preventive health or well-child appointment with PCP within 10 business days. ➢ Physical exam/wellness check appointment with PCP within 30 calendar days. ➢ Initial prenatal appointment with PCP/specialist within two weeks. **After Hours Availability** metrics both declined this year, but the *Appropriate Emergency Instructions* metric still exceeded the goal overall. The *Call-back within 30 minutes* metric did not meet the 90% performance goal at 84% overall. Corrective action plans are issued to contracted PPGs and providers who do not meet the timely access standards. Reasonable access to care and services is important for patient safety. CalViva offers a number of resources to assist providers. Monitoring will continue annually.	Motion: *Approve* - Provider Appt Availability & After-Hours Access Survey Results (Cardona/Lee) 4-0-0-2
#6 **UM/CM Business** - Key Indicator Report and TAT Report (June) - PA Member Letter Monitoring Report (Q2) - MedZed Report (Q2) (Attachments V-X) **Action**	Dr. Marabella presented the **Key Indicator Report and TAT Report** through June 2021. ➢ In-hospital utilization rates have decreased when compared to Q1 2021. The admission rate has slightly increased. However, utilization rates are likely to increase again in Q3 based upon recent activity. ➢ Turn-around-time compliance improved in Q2 in all metrics with the exception of Deferrals – Urgent. The volume of Deferrals is low and therefore the rate is highly sensitive to variations. ➢ Case Management results remain strong and demonstrate positive results in all areas consistent with previous months.	Motion: *Approve* - Key Indicator Report and TAT Report (June) - PA Member Letter Monitoring Report (Q2) - MedZed Report (Q2)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	**PA Member Letter Monitoring Report** Quarter 2 was presented and reviewed. This report monitors Notice of Action (NOA) letters including Prior Authorizations (PAs), Concurrent, and Post Service denials. Findings are discussed with UM Management Directors on a monthly basis. All metrics are expected to meet standard of 100% compliance. Medical Management Monitoring and Reporting Team collects CAP information on metrics that fall below the 100% threshold. All categories had audit scores above 95%. Medical Management has implemented several Actions to sustain the improvements, including: ➢ Weekly audit meeting for any identified failures. ➢ Weekly progressive coaching to staff with any opportunities identified during audits. ➢ Deferral letter templates reviewed by the Letter Compliance team to identify any opportunities. ➢ Deferral letter training given to Referral Specialists and Nurses in January. ➢ In August, training given to all PA staff to review clinical notes for referring physician for DME requests ➢ In August, PA team implemented 100% leadership review of letters prior to mailing. **MedZed Report** Quarter 2 was presented. This report monitors the volume and engagement of members referred to the MedZed Care Management program. This program is designed as a bridge and support for member engagement and focuses on members that are high utilizers with complex needs who are not engaged in care management. Once located, the goal is to build a trusting relationship and work to re-engage the member with their PCP. Results were as follows: • 788 Cases being managed at this time. • Engagement rate decreased compared to Q1 2021 from 39% to 25% • However, an increase in referrals is noted in Q2. The only metric that did not meet established goals is related to the timeliness (within 72 hours) of the initial post-discharge in-home appointment. They have experienced difficulty with contacting the member to schedule, members rescheduling and member no shows. MedZed will continue to engage Community Health Navigators for urgent field outreach (face-to-face/door knocks) following one unsuccessful phone attempt, while also reminding members about the importance of keeping their post-discharge appointments.	(Lee/Foster) 4-0-0-2
#7 **Pharmacy Business** - Pharmacy Executive Summary (Q2)	The **Pharmacy Reports** for Q2 2021 are presented in order to assess for emerging patterns in authorization requests, evaluate compliance for prior authorizations, and to evaluate the	Motion: *Approve* - Pharmacy

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Pharmacy Operations Metrics (Q2) - Pharmacy Top 30 Prior Authorizations (Q2) - Pharmacy Inter-Rater Reliability Results (IRR) (Q2) (Attachments Y-BB) **Action** Patrick Marabella, M.D Chair	consistency of decision making in order to formulate potential process improvement recommendations. ➢ Pharmacy Prior Authorizations (PA) metrics were within 5% of standard for the 2nd Quarter of 2021. ➢ Overall TAT for Q2 was 96.66% ➢ Total PA requests were comparable to Q1 2021. **Top 30 Prior Authorization** 2nd Quarter 2021 top 30 medication PA requests were slightly lower compared to 1st Quarter 2020. ➢ No significant differences seen in 2nd Quarter 2021 compared to 1st Quarter 2021. ➢ Opioid and Diabetes control medications continue to be the top drivers of PA volume. **Inter-Rater Reliability Results for Q2 2021** ➢ 95% accuracy (90% threshold met) ➢ Follow up to occur when opportunities for improvement are identified both on an individual and team basis.	Executive Summary (Q2) - Pharmacy Operations Metrics (Q2) - Pharmacy Top 30 Prior Authorizations (Q2) - Pharmacy Inter-Rater Reliability Results (IRR) (Q2) (Lee/Cardona) 4-0-0-2
#8 Policy & Procedure - Public Health Policies and Procedures (Attachment CC) **Action** Patrick Marabella, M.D Chair	**The Public Health Policies and Procedures** were presented to the committee. The majority of the policies were updated with minor or no changes per the Policy Grid. • Three (3) policies were noted to be transitioning to the UM function to address upcoming changes in regulations. • One (1) policy was retired related to *Transportation for SPDs* as this was incorporated into the overall Transportation policy. • One (1) other policy is currently under revision in order to address regulatory changes related to *Major Organ Transplant* which will no longer be a carved-out benefit as of January 1, 2022. • *Non-Emergency, Non-Medical Transportation (NEMT) Assistance and Coordination* Policy was included for committee review related to the inclusion of SPD member issues, changes to the advance notice requirements for non-urgent medical services and other minor edits.	Motion: *Approve* - Public Health Policies and Procedures (Foster/Lee) 4-0-0-2
#9 **Credentialing and Peer Review Subcommittee Business**	**Credentialing Sub-Committee Quarterly Report** was presented. In Quarter 3 the Credentialing Sub-Committee met on July 15, 2021. Routine credentialing and re-	Motion: *Approve* - Credentialing Sub-

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Credentialing Sub-Committee Quarterly Report (Attachment DD) **Action** Patrick Marabella, M.D Chair	credentialing reports were reviewed for both delegated and non-delegated services. Reports covering the first quarter for 2021 were reviewed for delegated entities and the second quarter 2021 reports were reviewed for Health Net. The Credentialing Sub-Committee 2021 Charter was reviewed and approved without changes. The Credentialing/Recredentialing Oversight Audit of HN was in progress during Quarter 3 and is expected to close by the end of September. Generally good compliance is noted and any issues of non-compliance will be addressed with a corrective action plan. There was no case activity to report for the Quarter 2 2021 Credentialing Report from Health Net.	Committee Quarterly Report (Foster/Lee) 4-0-0-2
#9 **Credentialing and Peer Review Subcommittee Business** - Peer Review Sub-Committee Quarterly Report (Attachment EE) **Action** Patrick Marabella, M.D Chair	**Peer Review Sub-Committee Quarterly Report** was presented. The Peer Review Sub-Committee met on July 15, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 2021 were reviewed and approved. There were no significant cases to report. The Quarter 2 2021 Peer Count Report was presented at the meeting with a total of 3 cases reviewed. The outcomes for these cases are as follows: All three (3) cases were closed and cleared. There were no (0) cases pending closure for Corrective Action Plan compliance. There were no cases (0) with outstanding CAPs. There were no (0) cases pended for further information. Follow up will be completed to close out cases and ongoing monitoring and reporting will continue.	Motion: *Approve* - Peer Review Sub-Committee Quarterly Report (Lee/Foster) 4-0-0-2
#10 Compliance Update - Compliance Regulatory Report (Attachment FF)	Mary Lourdes Leone presented the **Compliance Report**. ➢ Privacy & Security: One new high-risk case was reported in which only one member's PHI was impacted. ➢ Fraud, Waste & Abuse: There has not been any new MC609 filings with DHCS; 22 cases still open for investigation. ➢ Oversight Audits: Provider dispute resolution audit (CAP), Fraud, waste & abuse audit (No CAP). ➢ Regulatory Reviews/Audits and CAPS o 2021 DMHC 18-Month Follow-Up Audit – Audit Interviews were held 3/30/21 and we are still awaiting the Final Report; Next DMHC Audit scheduled for September 2022. o 2020 DHCS Audit CAP - The Plan filed its "Final CAP Update" 8/27/21. o DHCS Annual Network Certification (ANC) - 8/12/21 DHCS notified the Plan that it passed the ANC with no deficiencies. o DHCS Subcontracted Network Certification (SNC) Readiness Plan – Initially filed	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	5/27/21; three separate requests for additional information with the last one submitted 8/17/21. We are awaiting DHCS' final determination. o U. S. Health and Human Services (HHS) – On 8/16/21 the Plan received correspondence from the U.S. Department of Human Services' Office of Civil Rights (OCR) stating that it was in receipt of a breach notification report filed on March 25, 2021. The breach notification was related to the Plan's Administrator's (Health Net's) business associate, Accellion, that reported it had been a victim of a cyber-attack. o U. S. Health and Human Services (HHS) – On 8/16/21 the Plan received correspondence from the U.S. Department of Human Services' Office of Civil Rights (OCR) stating that it was in receipt of a breach notification report filed on March 25, 2021. The breach notification was related to the Plan's Administrator's (Health Net's) business associate, Accellion, that reported it had been a victim of a cyber-attack. OCR's intent to investigate whether the Plan is compliant with the applicable Federal Standards for Privacy and/or the Security Standards. ➢ New Regulations / Contractual Requirements o Medi-Cal Rx Transition – Effective 1/1/2022 o California Advancing and Innovating Medi-Cal (CalAIM). Enhanced Care Management (ECM) and In lieu of Services (ILOS) – Effective 1/1/22 in Kings County, and 7/1/22 in Fresno & Madera Counties. o DHCS Pre-Approved ILOS: CalViva through its Plan Administrator is planning to offer new services beginning 1/1/22 in Kings County. o Major Organ Transplant (MOT) carve-in – Effective 1/1/22 for all CalViva counties and membership. The Plan submitted its MOT Network Certification listing California transplant centers on 9/2/21. ➢ Public Policy Committee: The Public Policy Committee met on September 1, 2021, via telephone conference due to the COVID-19 state of emergency. The following reports were presented: Q2 2021 Grievance and Appeals; Health Education Q1 & Q2 Member Incentive Programs Semi-Annual Report. A Population Needs Assessment Update was also provided to the Committee. There were no recommendations for referral to the Commission. The next meeting will be held on December 1, 2021.	
#9 **Old Business**	None.	
#10 **Announcements**	Next meeting October 21st, 2021	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#11 **Public Comment**	None.	
#12 **Adjourn**	Meeting was adjourned at 12:08pm	

NEXT MEETING: October 21st, 2021

Submitted this Day: Oct 21, 2021

Submitted by: _____
Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

_____
Patrick Marabella, MD Committee Chair

Item #8

Attachment 8.D

QIUM Committee Minutes
dated 10/21/2021

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
October 21st, 2021

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	✓	**Amy Schneider, RN,** Director of Medical Management Services
✓•	**Fenglaly Lee, M.D.,** Central California Faculty Medical Group	✓	**Ashelee Alvarado,** Medical Management Specialist
✓•	**Brandon Foster, PhD.** Family Health Care Network	✓	**Iris Poveda,** Medical Management Administrative Coordinator
✓•	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers	✓	**Tommi Romagnoli,** Medical Management Nurse Analyst
✓•*	**Raul Ayala, MD, Adventist Health**, Kings County	✓	**Mary Lourdes Leone,** Chief Compliance Officer (CCO)
✓•*	**Joel Ramirez, M.D.,** Camarena Health Madera County	✓	**Maria Sanchez**, Compliance Manager
	Rajeev Verma, M.D., UCSF Fresno Medical Center	✓	**Lori Norman,** Senior Compliance 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: September 16, 2021 - Provider Preventable Conditions (PPC) (Q2) - Standing Referrals Report (Q2) (Attachments A-C) **Action** Patrick Marabella, M.D Chair	The September 16th, 2021 QIUM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. The full October Formulary (PDL) was available for review. *Dr. Ramirez announced his presence at 10:44 am. *Dr. Ayala announced his presence at 10:49 am and call dropped at 10:53am.	Motion: *Approve* Consent Agenda (Foster/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business** - Appeals & Grievances Dashboard and TAT Report (August) - MHN Performance Indicator Report (Q2) - SPD HRA Outreach (Q2) - Provider Office Wait Time Report (Q3) - QIUM 2022 Meeting Schedule (Attachments D-H) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **Appeals & Grievances Dashboard** through August 2021. ➢ The total number of grievances received in August decreased compared to recent months, however the number resolved remained consistent. ➢ An increase was noted in the number of *Quality-of-Care* grievances resolved in August, mainly attributable to ancillary services and specialist care as members obtain services postponed due to the pandemic. ➢ One (1) grievance Ack Letter and one (1) Expedited Appeal were noted to be out of compliance. Follow up discussed. ➢ Appeals continue to demonstrate variation with the majority of cases related to Advanced Imaging and Pharmacy consistent with last month. The **MHN Performance Indicator Report for Behavioral Health Services** (Q2 2021) was presented. 15 out of the 15 metrics met or exceeded their targets. The ABA authorization timeliness metric result was slightly below 100% but exceeded the threshold for action at 95%. Utilization appears to be up this year with an increase in members seeking services for mild to moderate issues. The raw number of PQIs has returned to baseline this quarter. The majority of Provider Disputes were noted to have been submitted by one provider. This provider has been re-educated and monitoring for improvement will continue. The **SPD Health Risk Assessment** report for Q2 was presented. This is a state mandated member outreach activity intended to identify higher risk new members and offer case management and other care coordination services and resources. A minimum of 3 outreach calls within 45 days are attempted for high-risk individuals and 3 outreach calls to low-risk individuals attempted within 90 days of enrollment in the Plan. Results for Quarter 2 2021 include the following: ➢ the completion rate for HRAs increased from 1.71% in Q1 to 4.29% in Q2. ➢ 6,736 members were outreached (100% on time) ➢ 289 completed HRAs, 4.29% completion rate (tracked for program quality; not a regulatory requirement). The **Provider Office Wait Time** Report for Q3 was presented. Health plans are required to monitor waiting times in providers' offices to validate timely access to care and services. This report	Motion: *Approve* - Appeals & Grievances Dashboard and TAT Report (August) - MHN Performance Indicator Report (Q2) - SPD HRA Outreach (Q2) - Provider Office Wait Time Report (Q3) - QIUM 2022 Meeting Schedule (Cardona/Lee) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	provides a summary that focuses on Quarter 3 2021 monitoring for Fresno, Kings and Madera Counties. All counties were within the 30-minute office wait time threshold for both mean and median metrics. ➢ The number of providers per county who submitted data in Quarter 3 is as follows: Fresno-44, Kings-3, and Madera-5 for a total of 52 providers and 977 patients monitored. ➢ The number of providers submitting data decreased slightly in Quarter 3 2021 for all counties combined when compared to Q2 2021 which had 58 providers, and 1055 patients. Two (2) providers were identified this quarter to have an overall average rate above the 30-minute standard. Both providers were from Fresno County with an average wait time of 31 and 38 minutes each. No trends identified as neither provider had an average wait time beyond 30 minutes in Q2. The **2022 QI/UM Committee Meeting schedule** was presented and reviewed. No concerns were raised by committee members with the schedule as proposed.	
#4 **Culture & Linguistics / Health Education** - Culture & Linguistics 2021 Work Plan Mid-Year Evaluation & Executive Summary - Culture & Linguistics 2021 Language Assistance Program Mid-Year Report - Health Education Work Plan Mid-Year Evaluation & Executive Summary (Attachments I - K) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **2021 Culture & Linguistics Work Plan Mid-Year Evaluation and Executive Summary** The 4 categories for the 2021 Work Plan are: ➢ Language Assistance Services (LAP) ➢ Compliance Monitoring ➢ Communication, Training and Education ➢ Health Literacy, Cultural Competency and Health Equity By June 30, 2021 all activities were on target. Some of the activities completed consist of: o Population Needs Assessment was completed in collaboration with Health Ed and QI. *(Formerly GNA)* o C & L related grievances reviewed. Follow up completed including four (4) interventions. o Completed and disseminated a Member Newsletter on how to access language services.	Motion: *Approve* - Culture & Linguistics 2021 Work Plan Mid-Year Evaluation & Executive Summary - Culture & Linguistics 2021 Language Assistance Program Mid-Year Report - Health Education Work Plan Mid-

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Four Call Center trainings conducted. ○ Collaborated on BCS PIP intervention development. ○ Conducted Motivational Interviewing training. All of the Work Plan activities continue on target for completion by the end of calendar year 2021. C & L staff will continue to assess circumstances to modify plans as needed in order to continue to implement, monitor and track C&L related services and activities. **Health Education Work Plan Mid-Year Evaluation & Executive Summary** Dr. Marabella presented the 2021 Health Education Work Plan Mid-Year Evaluation. Two areas of focus for 2021 consist of: ➢ Programs and Services ➢ Department Operations, Reporting and Oversight Of the 17 Program Initiatives, 12 are on track to meet year-end goals. These consist of: ➢ Chronic Disease Education: Asthma ➢ Hypertension ➢ Community Health ➢ Fluvention - Flu Vaccine Campaign ➢ Health Equity Project ➢ Member Newsletter ➢ Obesity Prevention ➢ Pediatric Education ➢ Perinatal Education ➢ Promotores Health Network: Diabetes Classes ➢ Oversight and Reporting ➢ Materials Development, Utilization and Inventory The five (5) initiatives that are off track consist of: ➢ Chronic Disease: Diabetes Prevention Program – finalize contract and obtain approvals. ➢ Mental Health: Educate members to increase ACEs screenings. ➢ Tobacco Cessation: complete program enhancement and obtain approvals. ➢ Women's Health: Evaluate outcomes of other email/IVR programs before proceeding. ➢ Geographic Information Systems: Outreach to departments to identify activities that might benefit from spatial analysis.	Year Evaluation & Executive Summary (Foster/Ramirez) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Barriers to full implementation of planned activities have been identified and are being addressed. 2021 initiatives will continue to be implemented in order to meet or exceed year end goals. **<u>Culture & Linguistics Language Assistance Program Mid-Year Report</u>** This Report provides information on the language service utilization by CalViva Health members for January 1st to June 30th, 2021. The Language Assistance Program incorporates MHN Services' Mental Health/Behavioral Health language utilization for the same reporting period. It also evaluates telephonic and in-person interpretation services, Sign Language and document translations. ➢ Member Services Department representatives handled a total of 52,783 calls across all languages. Of these, 8,960 (17%) were handled in Spanish and Hmong languages. ➢ A total of 1,706 interpreter requests were fulfilled for CalViva Health members, 1,290 (76%) of these requests were fulfilled utilizing telephonic interpreter services with 368 (22%) for in-person, 48 (3%) for sign language interpretation, and zero requests for video remote interpreting. ➢ A total of 12 grievance cases were received and reviewed by C&L. ➢ Elements unique to MHN Services are the following: Calls handled by MHN Services' member services, telephone, face to face and sign language utilization, and requests for written, oral and alternate format translations. All other language service elements utilized by members receiving MHN Services are incorporated as part of the C&L LAP report.	
#5 **Access Business** - Culture & Linguistics 2021 Geo Access Report (Attachments L) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **<u>2021 Culture & Linguistics Geo Access Report.</u>** The purpose of the Geo Access Assessment of Culture and Linguistic Needs Report is to examine race, ethnicity and language of CalViva Health's members and provider network for the prior year and examine the concordance of provider languages spoken in the office with member language needs. The data illustrates counties where members who identified as speaking a given language did not live within an appropriate time and distance parameter. ➢ Gaps were identified for various languages for PCPs and specialists or both except for Spanish.	Motion: *Approve* - Culture & Linguistics 2021 Geo Access Report (Ramirez/Lee) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	➢ All members identified as Spanish-speaking members residing in Fresno, Kings and Madera counties had their access needs met. ➢ Madera appears to be the county with the least gaps. ➢ The Culture and Linguistics Services Department staff developed and executed a plan to address the gaps in provider language capabilities and member language needs with the goal of increasing awareness and utilization of the language support services that are available through CalViva Health. Monitoring and reporting will continue.	
#6 **UM/CM Business** - Key Indicator Report and TAT Report (August) - Utilization Management Concurrent Review Report (Q2) - Case Management & CCM Quarterly Report (Q2) - TurningPoint Musculoskeletal Utilization Review (Q2) (Attachments M-P) **Action** Patrick Marabella, M.D Chair	**Key Indicator Report and TAT Report (August)** were presented and reviewed. The following trends were noted: ➢ Acute Care Admission rates for SPDs remain low, however they appear to be increasing for the Family/Adult and Expansion populations. ➢ Length of Stay remains higher than prior years for Family/Adult and Expansion populations. ➢ Turn-around Times for Prior Authorizations were noted to have some opportunities for improvement this month. An increase in the number of requests submitted as "urgent" was noted along with some COVID-related staffing issues. Adjustments in progress, anticipate improvement next month. **UM Concurrent Review Report.** This report presents inpatient data metrics and clinical concurrent review activities and interventions for April 1, 2021 – June 30, 2021 (Quarter 2). Health Net Medical Management supports Concurrent Review (CCR) activities for CalViva Health to optimize health outcomes across the care continuum for all members. ➢ 2020-2021 data is not following normal patterns due to the COVID-19 pandemic. The COVID pandemic restrictions across the region and state are affecting the overall utilization patterns. ➢ The average length of stay declined in all major populations (SPDs, TANFs and MCEs) Members that have been delaying treatments and are now seeking care due to loosening of restrictions. Readmissions have also declined for all populations with the exception of SPDs. Concurrent Review actions include Daily UM huddles (with Care Management, Member connections, Public Programs and Medical Directors), weekly telephonic huddles with local hospitals' Care	Motion: *Approve* - Key Indicator Report and TAT Report (August) - Utilization Management Concurrent Review Report (Q2) - Case Management & CCM Quarterly Report (Q2) - TurningPoint Musculoskeletal Utilization Review (Q2) (Ramirez/Foster) 5-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Management Departments, and Emergency department telephonic support to prevent admissions when appropriate. The **Case Management and CCM Report** for Quarter 2 was presented. This report summarizes the case management, transitional care management, MemberConnections, palliative care and Emergency Department activities for 2021 through second quarter. ➢ Most of these programs have demonstrated an increase in referrals and open cases over recent months or remained consistent except for Perinatal Case Management with their referral rate decreasing about the same this quarter as last. ➢ Outcome measures have been established for all programs with most metrics demonstrating positive results. ➢ Telephonic outreach to members referred to some CM programs with limited success due to incorrect phone numbers. ➢ Potential alternate sources and systems reviewed with staff regarding obtaining member contact information including: utilization and pharmacy data, and OMNI. ➢ Plan in development for provider education on CM referral process. **TurningPoint Musculoskeletal Utilization Review Q2 2021** is a newer report established to evaluate compliance with the prior authorization (PA) performance standards for TurningPoint which began processing PAs for CalViva members in July 2020. ➢ Compliance was achieved for turnaround times and Pre-service urgent and non-urgent authorization determination. ➢ Prior authorization denial rates are monitored. ➢ Call Center functioning metrics for provider support were also met. A number of denials were noted for this first quarter. This was attributed to the low number of authorizations submitted and also the fact that this is a new process for providers. It is anticipated that denials will decrease over time as volumes increase and providers become more familiar with the guidelines used by TurningPoint. Provider education on the guidelines and process is ongoing.	
#7 **Compliance Update** - Compliance Regulatory Report	Mary Lourdes Leone presented the **Compliance Report**. **Oversight Activities:** CalViva Health's management team continues to review monthly/quarterly	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment Q) **Action** Patrick Marabella, M.D Chair	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. **Oversight Audits:** The following annual audits are in-progress: Access and Availability, Credentialing, Call Center, Appeals & Grievances, Continuity of Care, and Provider Network/ Provider Relations. The following audits have been completed since the last Commission report: Claims (CAP) Pharmacy (No CAP) and Emergency Services (No CAP). **2021 DMHC 18-Month Follow-Up Audit:** The DMHC follow-up audit interviews were held 3/30/21. The Plan is awaiting the DMHC final report findings. The next routine DMHC medical survey for CalViva will be on 9/19/22. **Department of Health Care Services ("DHCS") 2020 Medical Audit – CAP:** On 8/27/2021, the Plan submitted its final CAP Update to DHCS indicating that all corrective actions have been implemented, and that the results of the actions can be reviewed by DHCS at the next Medical Audit in 2022. Based on this final update, the Plan requested DHCS to accept it as final and close the CAP. We are still awaiting DHCS' response. The next routine DHCS medical audit for CalViva is expected to be in April 2022 and will cover a 2-year look-back period as the 2021 audit was deferred due to the COVID-19 PHE. **California Advancing and Innovating Medi-Cal (CalAIM):** CalViva Health continues to participate in DHCS calls, association calls and working with Health Net to implement the following key initiatives: ➢ Enhanced Care Management (ECM) and In lieu of Services (ILOS) – Effective 1/1/22 in Kings County, and 7/1/22 in Fresno & Madera Counties. ➢ Major Organ Transplant (MOT) carve-in – Effective 1/1/22 for all CalViva counties and membership. **COVID-19 Novel Coronavirus:** Our downtown office for walk-ins is still closed. Our administrator Health Net has indicated they will still continue to carry out operations on a semi-remote basis until March 2022. **Public Policy Committee:** The next meeting will be held on December 1, 2021, at 11:30am and it is still to be determined if the meeting will be in person or if it will be a teleconference due to COVID-19.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#8 **Old Business**	None.	
#9 **Announcements**	Next meeting November 18th 2021	
#10 **Public Comment**	None.	
#11 **Adjourn**	Meeting was adjourned at 11:35am	

NEXT MEETING: November 18th, 2021

Submitted this Day: November 18th, 2021

Submitted by: Amy P Schneider
Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #8

Attachment 8.E

Public Policy Committee Minutes
dated 9/1/2021

Public Policy Committee
Meeting Minutes
September 1, 2021

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, Director Community Relations
	Kristi Hernandez, At-Large Representative	✓	Cheryl Hurley, Commission Clerk / Director HR
✓•	Kevin Dat Vu, Fresno County Representative	✓	Jeff Nkansah, CEO
✓•	Norma Mendoza, At-Large Representative	✓	Mary Lourdes Leone, Chief Compliance Officer
		✓	Steven Si, Senior Compliance & Privacy/Security Specialist
		✓	Lori Norman, Senior Compliance Analyst
		*	= 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 Commissioners' physical attendance at the public location or by teleconferencing.	A roll call was taken.
#2 Meeting Minutes from June 9, 2021	The June 9, 2021 meeting minutes were reviewed. There was one edit needed and minutes were approved as amended.	**Motion:** Approve June 9, 2021 Minutes

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Action Joe Neves, Chair		6-0-0-3 (J. Garner / D. Phillips) A roll call was taken.
#3 Committee Membership Update **Information** Courtney Shapiro, Director, Community Relations	Leann Floyd's membership has been extended to August 2023. Jeff Garner and Roberto Garcia memberships have been extended to August 2024.	**No Motion**
#4 Proposed 2022 PPC Meeting Calendar **Action** Courtney Shapiro, Director, Community Relations	The 2022 proposed meeting calendar was presented to the PPC. No conflicts were noted.	**Motion:** Approve Proposed 2022 Calendar to move to Commission for final approval 6-0-0-3 (R. Garcia / D. Phillips) A roll call was taken.
#5 Enrollment Dashboard Information Mary Lourdes Leone, Chief Compliance Officer	Mary Lourdes Leone presented the enrollment dashboard through July 2021. Membership as of the end of July 2021 was 386,814. CalViva Health maintains a 69.51% market share.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#6 Health Education Member Incentive Programs – Semi-Annual Report Q1 and Q2 2021 **Information** Steven Si, Senior Compliance Operations/Privacy Specialist	A report out was given in response to a question asked during the June 9, 2021 PPC Meeting: 1. The name change to Provider Engagement has no impact on Health Education programs. 2. The establishment of Community Engagement is not affected as to the addition or removal of any Health Education programs. The new department is an allocation of resources to further increase the community awareness of CalViva Health's Health Education programs. More details of the community awareness for this program will be presented during the December 1, 2021 PPC meeting. With regard to the Member Incentive Programs – Semi-Annual Report Q1 and Q2 2021, a total of 482 CalViva Health (CVH) members participated in one health education program during Q1 and Q2 in 2021. Of the 482 participants, 22 members received an incentive. In total, $470 worth in gift cards were given to CVH members. Of the 22 award recipients, (36%) were from Fresno County and (64%) from Madera County. In Q1 & Q2, 2021, CalViva Health did not launch any plan-wide QI incentive programs. COVID-19 pandemic presented challenges and limited deployment of direct care programs, including PIPs and PDSA projects with an incentive component included. As COVID-19 evolves, CalViva Health will continue to follow CDC, state and local data to make informed decisions concerning outreach events and special projects.	**No Motion**
#7 Health Education Update	Upon submission of the PNA to DHCS, the Plan received an Additional Information Requested (AIR) from DHCS to revise the PNA report. In doing so, a	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Population Needs Assessment Report **Information** Steven Si, Senior Compliance Operations/Privacy Specialist	revised PNA report was submitted to DHCS with an approval received in return on 8/12/21. There will be a PNA summary presented at the December 1, 2021 PPC meeting.	
#8 Appeals, Grievances, and Complaints **Information** Mary Lourdes Leone, Chief Compliance Officer	Mary Lourdes Leone presented the appeals, grievances and complaints report for Q2 2021. Total appeals and grievances for Q2 2021 were 619. There was a total of 201 appeals. There was a total of 418 grievances. Turnaround time for resolved grievance and appeal cases was met at 100% in all areas. The majority of appeals and grievances were from members in Fresno County which has the largest CalViva Health enrollment. The majority of the Quality of Service cases resolved were categorized as "Admnistrative, "Access-Other" and "Transportation access". The majority of the Quality of Care cases resolved were "PCP Care", "Other" and "PCP Delay". The top categories for Exempt grievances were "Provider Attitude/Service" and "Health Plan Materials/ID Cards Not Received".	**No Motion**
#9 2020 DMHC Audit Update / 2020 DHCS Audit Update **Information** Mary Lourdes Leone, Chief Compliance Officer	The 2020 DMHC 18-month follow-up audit results are still pending. The Plan recently submitted the last Corrective Action Plan (CAP) to DHCS for the 2020 audit and has asked that the CAP be closed. Results of implementation of activities will be apparent to DHCS when they are onsite for the next audit in 2022.	**No Motion**
#10 Medi-Cal RX Update **Information** Mary Lourdes Leone, Chief Compliance Officer	The Medi-Cal RX program will officially go live January 1, 2022. Members' outpatient prescriptions will be the responsibility of DHCS and no longer the Managed Care Plan.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#11 CalAim Initiatives: Enhanced Care Management (ECM) & In Lieu of Services (ILOS); Major Organ Transplants (MOT) **Information** Mary Lourdes Leone, Chief Compliance Officer	The first three initiatives of the CalAim program; Enhanced Care Management (ECM), In Lieu of Services (ILOS); and Major Organ Transplant (MOT) will become effective January 1, 2022.	**No Motion**
#12 Final Comments from Committee Members and Staff	Jeffrey Nkansah, the Plan's newly appointed CEO, expressed the importance of encouraging the COVID vaccine. Mary Lourdes Leone is the Plan's newly appointed Chief Compliance Officer. Courtney Shapiro, Director Community Relations, reported on activity within the three service area counties in assisting with COVID vaccinations providing supplies, incentives, and grants. CVH partnered with Reading Heart over the weekend giving out free books to 450 teachers to fill their libraries. CVH also presented a check over the weekend for $100,000 to Tzu Chi to continue providing free glasses at school sites. Supervisor Neves shared that CVH partnered with Kings County Housing Authority in providing supplies during their food distribution and COVID vaccination clinic over the weekend. Jeff Garner reported he received a call from a community leader in Corcoran seeking assistance for an incentive program to encourage high school students to get vaccinated. CVH will follow-up after the meeting. David Phillips reported upcoming chamber mixers at their UHC locations.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#13 Announcements	None.	
#14 Public Comment	None.	
#15 Adjourn	Meeting adjourned at 12:23 pm.	

NEXT MEETING **December 1, 2021 in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: December 1, 2021

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

Approval Date: December 1, 2021

Approved By: Joe Neves
Joe Neves, Chairman

Item #8

Attachment 8.F

Compliance 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	13	13	12	13	19	16	25	24	26	13	202
Member & Provider Materials	5	2	2	3	2	0	0	2	0	0	1	3	20
# of DMHC Filings	7	1	5	5	7	2	4	7	10	4	1	6	59

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.

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	2	2	4	6	4	5	3	0	0	0	2	0	28
High-Risk	0	1	1	0	0	1	1	0	0	0	0	0	4

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	0	1	0	0	1	0	0	2	4
# of Cases Open for Investigation (Active Number)	13	14	13	13	13	18	18	19	22	24	22	23	212

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the last report, there has been two MC609 cases filed. One was specific to diabetic testing supplies and one was for a provider subscribing pain medication without conducting the proper protocols. 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 and Availability, Appeals & Grievances, Continuity of Care, and Provider Network/ Provider Relations. The following audits have been completed since the last Commission report: Call Center (No CAP), Credentialing (CAP), and the Q2 2021 PDRs (CAP).
Regulatory Reviews/Audits and CAPS	**Status**
2021 Department of Managed Health Care ("DMHC") 18-Month Follow-Up Audit	The DMHC issued its Final Report on November 2, 2021. The reported stated that one of the two outstanding deficiencies from the February 2019 audit had been corrected. The second deficiency remains uncorrected and under DMHC review and will be assessed at the next triennial DMHC Audit scheduled for September 2022.
Department of Health Care Services ("DHCS") 2020 Medical Audit - CAP	On 8/27/2021, the Plan submitted its final CAP Update to DHCS indicating that all corrective actions have been implemented, and that the results of the actions can be reviewed by DHCS at the next Medical Audit in 2022. Based on this final update, the DHCS has since requested additional information to which the Plan most recently responded on 2/4/22. We are still awaiting DHCS' final response in order to close the CAP..
Department of Health Care Services ("DHCS") 2022 Medical Audit	On 1/25/22, the Plan received written from DHCS confirming the schedule of the DHCS' 2022 medical audit of the Plan. The audit will be conducted on 4/18/22 through 4/29/22. All pre-audit document requests are to be submitted to DHCS by 2/24/22.
New Regulations / Contractual Requirements	**Status**
California Advancing and Innovating Medi-Cal (CalAIM)	A. <u>Enhanced Care Management (ECM) and Community Supports (CS)</u> The Plan's initial ECM and CS Models of Care (Parts 1, 2 and 3) were all approved by the DHCS, and these programs became effective 1/1/22 in Kings county. These programs are scheduled to become effective in Fresno and Madera counties by 7/1/2022. For these counties, the Plan continues to develop the Model of Care and associated provider capacities. The deliverable due date for these documents is 2/15/22. Commensurate with the launch of ECM/CS on January 1, 2022, the DHCS will be implemented the CalAIM Incentive Program which is designed to complement/expand ECM/CS capacity building, investment in delivery system

	infrastructure and achieve improvements in quality. The Plan agreed to participate in the CalAIM Incentive Program with required deliverables submitted in January 2022. B. Major Organ Transplant (MOT) Carve-In - This benefit became effective 1/1/22 for all CalViva counties and membership. On 9/1/2021, the Plan submitted the required MOT Network Certification to DHCS. On 12/10/21, the Plan received DHCS' notice of a corrective action plan for failure to comply with the CalAIM Benefit Standardization of Major Organ Transplants (MOT) network certification requirements. Specifically, the Plan failed to demonstrate a minimum of one executed contract with a Center of Excellence (COE) for the following organ types: bone marrow, heart, kidney-pancreas, liver and lung. It should be noted that the DHCS issued CAPs to all Managed Care plans as this issue resulted from the DHCS' delay in establishing reimbursements rates for the COEs which are primarily California state universities. The Plan's Administrator, Health Net, is delegated for contracting with all COEs. Since the CAP notification, the Plan has submitted two monthly CAP updates reflecting Health Net's progress to complete COE contracting. Monthly CAP updates will be required through 6/10/22.
Medi-Cal Rx	Medi-Cal RX became effective 1/1/2022. The Plan was made aware of issues upon implementation. These issues include, but were not limited to: 1) Long wait times at Magellan Medi-Cal RX Call Center. 2)Eligibility issues for patients 3) Issues billing Physician Administered Drugs 4) historical data that should have been tranmitted to Magellan as part of the Medi-Cal RX was not transmitted. DHCS, Magellan, and the Plans are all working to resolve issues and mitigate impact.
Behavioral Health Incentive (BHI) Program	The Plan has received the Q4 BHI Milestone Report on 1/31/22 and is reviewing it. It must be submitted to DHCS by 3/1/22.
Plan Administration	
COVID-19 Novel Coronavirus	Our downtown office for walk-ins is still closed. Our administrator, Health Net, has indicated they will still continue to carry out operations on a semi-remote basis until March 2022.
Committee Report	
Public Policy Committee	The Public Policy Committee last met on 12/1/21 via teleconference due to the COVID-19 state of emergency. The following reports were presented: The Health Education 2021 Mid-Year Work Plan Evaluation, the 2021 C&L Mid-Year Work Plan Evaluation, the MY2020 HEDIS Data Results, the Q3 2021 Appeals & Grievance Report, and the 2021 Population Needs Assessment Report. There were no recommendations for referral to the Commission. The next meeting will be held on March 2, 2022 at 11:30am in the Plan's Administrative Office.

Item #9

Attachment 9.A-9.B

A. BL 22-004 – Annual Administration
B. Form 700

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, 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

Rose Mary Rahn, 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

Jeffrey Nkansah
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: February 17, 2022

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Annual Administration

BL #: 22-004
Agenda Item 7
Attachment 7.A

Discussion Points:

Ethics Training:

Ethics Training must be completed every two years. If you have completed ethics training within the last two years by virtue of employment or membership on another board or commission then a copy of that certificate will suffice. If not, you can use the Fair Political Practices Commission (FPPC) free online training seminar website at http://localethics.fppc.ca.gov.

The Commission Clerk, and/or their designee, will follow-up with Commission members to obtain the necessary records.

Form 700:

The Statement of Economic Interests must be completed annually. The form is attached, or you can access the complete document with instructions at this website: http://www.fppc.ca.gov/Form700.html

Please complete and return to the Clerk, Cheryl Hurley, by April 1, 2022.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

STATEMENT OF ECONOMIC INTERESTS
COVER PAGE
A PUBLIC DOCUMENT

Date Initial Filing Received
Filing Official Use Only

Please type or print in ink.

NAME OF FILER (LAST) **(FIRST)** **(MIDDLE)**

1. Office, Agency, or Court

Agency Name *(Do not use acronyms)*

Division, Board, Department, District, if applicable

Your Position

► If filing for multiple positions, list below or on an attachment. *(Do not use acronyms)*

Agency: _____ Position: _____

2. Jurisdiction of Office *(Check at least one box)*

- ☐ State
- ☐ Judge, Retired Judge, Pro Tem Judge, or Court Commissioner (Statewide Jurisdiction)
- ☐ Multi-County _____
- ☐ County of _____
- ☐ City of _____
- ☐ Other _____

3. Type of Statement *(Check at least one box)*

☐ **Annual:** The period covered is January 1, **2021,** through December 31, **2021**.

-or-

The period covered is _____/_____/_____, through December 31, **2021**.

☐ **Assuming Office:** Date assumed _____/_____/_____

☐ **Leaving Office:** Date Left _____/_____/_____
(Check one circle.)

☐ The period covered is January 1, **2021**, through the date of leaving office.

-or-

☐ The period covered is _____/_____/_____, through the date of leaving office.

☐ **Candidate:** Date of Election _____ and office sought, if different than Part 1: _____

4. Schedule Summary (must complete) ► *Total number of pages including this cover page:* _____

Schedules attached

- ☐ **Schedule A-1 -** *Investments* – schedule attached
- ☐ **Schedule A-2 -** *Investments* – schedule attached
- ☐ **Schedule B -** *Real Property* – schedule attached
- ☐ **Schedule C -** *Income, Loans, & Business Positions* – schedule attached
- ☐ **Schedule D -** *Income – Gifts* – schedule attached
- ☐ **Schedule E -** *Income – Gifts – Travel Payments* – schedule attached

-or- ☐ ***None*** **-** *No reportable interests on any schedule*

5. Verification

MAILING ADDRESS STREET CITY STATE ZIP CODE
(Business or Agency Address Recommended - Public Document)

DAYTIME TELEPHONE NUMBER
( )

EMAIL ADDRESS

I have used all reasonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein and in any attached schedules is true and complete. I acknowledge this is a public document.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed _____
(month, day, year)

Signature _____
(File the originally signed paper statement with your filing official.)

Print **Clear**

SCHEDULE A-1
Investments
Stocks, Bonds, and Other Interests
(Ownership Interest is Less Than 10%)

Investments must be itemized.
Do not attach brokerage or financial statements.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE

☐ $2,000 - $10,000 ☐ $10,001 - $100,000
☐ $100,001 - $1,000,000 ☐ Over $1,000,000

NATURE OF INVESTMENT

☐ Stock ☐ Other ____________ (Describe)
☐ Partnership ☐ Income Received of $0 - $499
☐ Income Received of $500 or More *(Report on Schedule C)*

IF APPLICABLE, LIST DATE:

__/__/**21** __/__/**21**
ACQUIRED DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE

☐ $2,000 - $10,000 ☐ $10,001 - $100,000
☐ $100,001 - $1,000,000 ☐ Over $1,000,000

NATURE OF INVESTMENT

☐ Stock ☐ Other ____________ (Describe)
☐ Partnership ☐ Income Received of $0 - $499
☐ Income Received of $500 or More *(Report on Schedule C)*

IF APPLICABLE, LIST DATE:

__/__/**21** __/__/**21**
ACQUIRED DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE

☐ $2,000 - $10,000 ☐ $10,001 - $100,000
☐ $100,001 - $1,000,000 ☐ Over $1,000,000

NATURE OF INVESTMENT

☐ Stock ☐ Other ____________ (Describe)
☐ Partnership ☐ Income Received of $0 - $499
☐ Income Received of $500 or More *(Report on Schedule C)*

IF APPLICABLE, LIST DATE:

__/__/**21** __/__/**21**
ACQUIRED DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE

☐ $2,000 - $10,000 ☐ $10,001 - $100,000
☐ $100,001 - $1,000,000 ☐ Over $1,000,000

NATURE OF INVESTMENT

☐ Stock ☐ Other ____________ (Describe)
☐ Partnership ☐ Income Received of $0 - $499
☐ Income Received of $500 or More *(Report on Schedule C)*

IF APPLICABLE, LIST DATE:

__/__/**21** __/__/**21**
ACQUIRED DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE

☐ $2,000 - $10,000 ☐ $10,001 - $100,000
☐ $100,001 - $1,000,000 ☐ Over $1,000,000

NATURE OF INVESTMENT

☐ Stock ☐ Other ____________ (Describe)
☐ Partnership ☐ Income Received of $0 - $499
☐ Income Received of $500 or More *(Report on Schedule C)*

IF APPLICABLE, LIST DATE:

__/__/**21** __/__/**21**
ACQUIRED DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE

☐ $2,000 - $10,000 ☐ $10,001 - $100,000
☐ $100,001 - $1,000,000 ☐ Over $1,000,000

NATURE OF INVESTMENT

☐ Stock ☐ Other ____________ (Describe)
☐ Partnership ☐ Income Received of $0 - $499
☐ Income Received of $500 or More *(Report on Schedule C)*

IF APPLICABLE, LIST DATE:

__/__/**21** __/__/**21**
ACQUIRED DISPOSED

Comments: ____________

Print **Clear**

SCHEDULE A-2
Investments, Income, and Assets of Business Entities/Trusts
(Ownership Interest is 10% or Greater)

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

Check one

☐ Trust, *go to 2* ☐ Business Entity, *complete the box, then go to 2*

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE
- ☐ $0 - $1,999
- ☐ $2,000 - $10,000
- ☐ $10,001 - $100,000
- ☐ $100,001 - $1,000,000
- ☐ Over $1,000,000

IF APPLICABLE, LIST DATE:

___/___/21 ACQUIRED ___/___/21 DISPOSED

NATURE OF INVESTMENT

☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

► 2. IDENTIFY THE GROSS INCOME RECEIVED (INCLUDE YOUR PRO RATA SHARE OF THE GROSS INCOME TO THE ENTITY/TRUST)

- ☐ $0 - $499
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

► 3. LIST THE NAME OF EACH REPORTABLE SINGLE SOURCE OF INCOME OF $10,000 OR MORE (Attach a separate sheet if necessary.)

☐ None or ☐ Names listed below

► 4. INVESTMENTS AND INTERESTS IN REAL PROPERTY HELD OR LEASED BY THE BUSINESS ENTITY OR TRUST

Check one box:

☐ INVESTMENT ☐ REAL PROPERTY

Name of Business Entity, if Investment, or
Assessor's Parcel Number or Street Address of Real Property

Description of Business Activity or
City or Other Precise Location of Real Property

FAIR MARKET VALUE
- ☐ $2,000 - $10,000
- ☐ $10,001 - $100,000
- ☐ $100,001 - $1,000,000
- ☐ Over $1,000,000

IF APPLICABLE, LIST DATE:

___/___/21 ACQUIRED ___/___/21 DISPOSED

NATURE OF INTEREST

☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership

☐ Leasehold _____ Yrs. remaining ☐ Other _____

☐ Check box if additional schedules reporting investments or real property are attached

---

► 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

Check one

☐ Trust, *go to 2* ☐ Business Entity, *complete the box, then go to 2*

GENERAL DESCRIPTION OF THIS BUSINESS

FAIR MARKET VALUE
- ☐ $0 - $1,999
- ☐ $2,000 - $10,000
- ☐ $10,001 - $100,000
- ☐ $100,001 - $1,000,000
- ☐ Over $1,000,000

IF APPLICABLE, LIST DATE:

___/___/21 ACQUIRED ___/___/21 DISPOSED

NATURE OF INVESTMENT

☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

► 2. IDENTIFY THE GROSS INCOME RECEIVED (INCLUDE YOUR PRO RATA SHARE OF THE GROSS INCOME TO THE ENTITY/TRUST)

- ☐ $0 - $499
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

► 3. LIST THE NAME OF EACH REPORTABLE SINGLE SOURCE OF INCOME OF $10,000 OR MORE (Attach a separate sheet if necessary.)

☐ None or ☐ Names listed below

► 4. INVESTMENTS AND INTERESTS IN REAL PROPERTY HELD OR LEASED BY THE BUSINESS ENTITY OR TRUST

Check one box:

☐ INVESTMENT ☐ REAL PROPERTY

Name of Business Entity, if Investment, or
Assessor's Parcel Number or Street Address of Real Property

Description of Business Activity or
City or Other Precise Location of Real Property

FAIR MARKET VALUE
- ☐ $2,000 - $10,000
- ☐ $10,001 - $100,000
- ☐ $100,001 - $1,000,000
- ☐ Over $1,000,000

IF APPLICABLE, LIST DATE:

___/___/21 ACQUIRED ___/___/21 DISPOSED

NATURE OF INTEREST

☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership

☐ Leasehold _____ Yrs. remaining ☐ Other _____

☐ Check box if additional schedules reporting investments or real property are attached

Comments: _____

Print Clear

SCHEDULE B
Interests in Real Property
(Including Rental Income)

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

FAIR MARKET VALUE
- ☐ $2,000 - $10,000
- ☐ $10,001 - $100,000
- ☐ $100,001 - $1,000,000
- ☐ Over $1,000,000

IF APPLICABLE, LIST DATE:
__/__/21 ACQUIRED __/__/21 DISPOSED

NATURE OF INTEREST
- ☐ Ownership/Deed of Trust
- ☐ Easement
- ☐ Leasehold _____ Yrs. remaining
- ☐ _____ Other

IF RENTAL PROPERTY, GROSS INCOME RECEIVED
- ☐ $0 - $499
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

SOURCES OF RENTAL INCOME: If you own a 10% or greater interest, list the name of each tenant that is a single source of income of $10,000 or more.
- ☐ None

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

FAIR MARKET VALUE
- ☐ $2,000 - $10,000
- ☐ $10,001 - $100,000
- ☐ $100,001 - $1,000,000
- ☐ Over $1,000,000

IF APPLICABLE, LIST DATE:
__/__/21 ACQUIRED __/__/21 DISPOSED

NATURE OF INTEREST
- ☐ Ownership/Deed of Trust
- ☐ Easement
- ☐ Leasehold _____ Yrs. remaining
- ☐ _____ Other

IF RENTAL PROPERTY, GROSS INCOME RECEIVED
- ☐ $0 - $499
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

SOURCES OF RENTAL INCOME: If you own a 10% or greater interest, list the name of each tenant that is a single source of income of $10,000 or more.
- ☐ None

* You are not required to report loans from a commercial lending institution made in the lender's regular course of business on terms available to members of the public without regard to your official status. Personal loans and loans received not in a lender's regular course of business must be disclosed as follows:

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE _____% ☐ None

TERM (Months/Years)

HIGHEST BALANCE DURING REPORTING PERIOD
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

☐ Guarantor, if applicable

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE _____% ☐ None

TERM (Months/Years)

HIGHEST BALANCE DURING REPORTING PERIOD
- ☐ $500 - $1,000
- ☐ $1,001 - $10,000
- ☐ $10,001 - $100,000
- ☐ OVER $100,000

☐ Guarantor, if applicable

Comments: _____

Print **Clear**

SCHEDULE C
Income, Loans, & Business Positions
(Other than Gifts and Travel Payments)

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

YOUR BUSINESS POSITION

GROSS INCOME RECEIVED

☐ No Income - Business Position Only
☐ $500 - $1,000
☐ $1,001 - $10,000
☐ $10,001 - $100,000
☐ OVER $100,000

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

☐ Salary ☐ Spouse's or registered domestic partner's income (For self-employed use Schedule A-2.)

☐ Partnership (Less than 10% ownership. For 10% or greater use Schedule A-2.)

☐ Sale of _____ *(Real property, car, boat, etc.)*

☐ Loan repayment

☐ Commission or ☐ Rental Income, *list each source of $10,000 or more*

_____ *(Describe)*

☐ Other _____ *(Describe)*

► 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

YOUR BUSINESS POSITION

GROSS INCOME RECEIVED

☐ No Income - Business Position Only
☐ $500 - $1,000
☐ $1,001 - $10,000
☐ $10,001 - $100,000
☐ OVER $100,000

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

☐ Salary ☐ Spouse's or registered domestic partner's income (For self-employed use Schedule A-2.)

☐ Partnership (Less than 10% ownership. For 10% or greater use Schedule A-2.)

☐ Sale of _____ *(Real property, car, boat, etc.)*

☐ Loan repayment

☐ Commission or ☐ Rental Income, *list each source of $10,000 or more*

_____ *(Describe)*

☐ Other _____ *(Describe)*

► 2. LOANS RECEIVED OR OUTSTANDING DURING THE REPORTING PERIOD

* You are not required to report loans from a commercial lending institution, or any indebtedness created as part of a retail installment or credit card transaction, made in the lender's regular course of business on terms available to members of the public without regard to your official status. Personal loans and loans received not in a lender's regular course of business must be disclosed as follows:

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

HIGHEST BALANCE DURING REPORTING PERIOD

☐ $500 - $1,000
☐ $1,001 - $10,000
☐ $10,001 - $100,000
☐ OVER $100,000

INTEREST RATE

_____% ☐ None

TERM (Months/Years)

_____

SECURITY FOR LOAN

☐ None ☐ Personal residence

☐ Real Property _____ *Street address*

_____ *City*

☐ Guarantor _____

☐ Other _____ *(Describe)*

Comments: _____

Print Clear

CALIFORNIA FORM **700**
FAIR POLITICAL PRACTICES COMMISSION

Name ______________________

SCHEDULE D
Income – Gifts

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$________	____________
___/___/___	$________	____________
___/___/___	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$________	____________
___/___/___	$________	____________
___/___/___	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$________	____________
___/___/___	$________	____________
___/___/___	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$________	____________
___/___/___	$________	____________
___/___/___	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$________	____________
___/___/___	$________	____________
___/___/___	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$________	____________
___/___/___	$________	____________
___/___/___	$________	____________

Comments: ______________________________

Print **Clear**

CALIFORNIA FORM **700**
FAIR POLITICAL PRACTICES COMMISSION

Name

SCHEDULE E
Income – Gifts
Travel Payments, Advances, and Reimbursements

- **Mark either the gift or income box.**
- **Mark the "501(c)(3)" box for a travel payment received from a nonprofit 501(c)(3) organization or the "Speech" box if you made a speech or participated in a panel. Per Government Code Section 89506, these payments may not be subject to the gift limit. However, they may result in a disqualifying conflict of interest.**
- **For gifts of travel, provide the travel destination.**

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

☐ 501 (c)(3) or DESCRIBE BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S): ____/____/____ - ____/____/____ AMT: $ _____
(If gift)

► MUST CHECK ONE: ☐ Gift **-or-** ☐ Income

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

☐ 501 (c)(3) or DESCRIBE BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S): ____/____/____ - ____/____/____ AMT: $ _____
(If gift)

► MUST CHECK ONE: ☐ Gift **-or-** ☐ Income

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

☐ 501 (c)(3) or DESCRIBE BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S): ____/____/____ - ____/____/____ AMT: $ _____
(If gift)

► MUST CHECK ONE: ☐ Gift **-or-** ☐ Income

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

☐ 501 (c)(3) or DESCRIBE BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE(S): ____/____/____ - ____/____/____ AMT: $ _____
(If gift)

► MUST CHECK ONE: ☐ Gift **-or-** ☐ Income

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

Comments:

Print **Clear**

Item #11

Attachment 11.A

2021 Annual Quality Improvement Work Plan Evaluation Executive Summary

REPORT SUMMARY TO COMMITTEE

TO:	QI/UM Committee Members Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Amy Wittig, Quality Improvement Department
COMMITTEE DATE:	February 17, 2022
SUBJECT:	Quality Improvement End of Year Work Plan Evaluation Executive Summary 2021

Summary:
CalViva Health's 2021 Quality Improvement (QI) Program monitors improvement in clinical care and service using a range of indicators. These key performance indicators are found in service, clinical, and utilization reports from QI and various other departments. Based on these reports, areas of improvement are identified, and interventions implemented and monitored. In 2021, quality improvement initiatives are focused on (but not limited to) improving preventative care, disease management outcomes, continuity and coordination of patient care, patient safety metrics, member access to care, and supporting provider initiatives.

Purpose of Activity:
The QI Year-End Work Plan Evaluation Executive Report provides evidence of monitoring of the overall effectiveness of the QI activities and processes, and identifies barriers and opportunities for improvement.

Work Plan Initiatives:
Details for the outcomes are included in the 2021 QI Work Plan Evaluation. Key highlights include:

1. Access, Availability, and Service

1.1 Improve Access to Care: CalViva Health continued to monitor appointment access annually through the Provider Appointment Availability Survey (PAAS). After Hours Access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS). Sutherland Global conducted the MY 2020 surveys between September and December 2020. Results indicated a need for improvement in several areas.

When deficiencies were identified through analysis of the survey results, Corrective Action Plan (CAP) packets were distributed to Participating Provider Groups (PPGs) who failed one or more of the timely access or after-hours measures. For MY 2020, CalViva Health addressed non-compliance via a targeted PPG approach and a refined escalation process for non-responding PPGs. Targeted PPGs and Direct Network Providers (also known as Tier 1) were identified and CAP packets for MY 2020 PAAS & After-Hours results were sent out late August (for emailed packets) and mid-September (for mailed packets). A total of 19 Tier 1 CAPs were sent out with improvement plans due at the end of September thru mid-October.

All other noncompliant PPGs and Direct Network Providers were classified as Tier 2 and received education packets. Education packets were sent at the end of August to 42 PPGs and Direct Network providers.

To date, all improvement plans have been completed for Tier 1. Follow-up on missing documentation will continue with a close out on all CAPs expected in Q1 2022.

For 2021, there were 13 Timely Access webinars conducted with a total of 51 participants from the CalViva Health area. Due to the impacts of COVID 19, a self-study option was offered in 2021 to those PPGs and providers unable to attend one of the webinars. Data from the self-study option will be available in Q1 2022.

1.2 I**mprove Member Satisfaction**: The annual CalViva Health Access Survey was launched to members late March 2021. Root cause analysis on appeals and grievances data was conducted during the first half of the year to identify trends in member pain points, as well as areas for improvement. Findings were shared with internal stakeholders and teams to help guide future improvement initiatives. The CAHPS Team met regularly with partner departments to track progress of the various member experience improvement activities that were taking place across the organization. Examples of activities included: the Language Assistance Program, monitoring of C&L-related grievances, Timely Access Corrective Action Plans, and Access & Availability Webinars. These meeting spaces were also a platform to brainstorm any new ideas/projects to address any member issues that come up during the year. Keeping providers and office staff up-to-date and aware of the importance of CAHPS was completed via the annual CAHPS PPG Webinar Series, which held in September 2021.

2. Quality and Safety of Care

2.1 HEDIS® Minimum Performance Level (MPL) Default Measures (50th percentile) for MY 2020

Cervical Cancer Screening (CCS)	Kings and Madera counties exceeded MPL of 61.31%, and Fresno County (60.16%) fell below the MPL.
Childhood Immunization Combo 10 (CIS-10)	One county (Madera) exceeded MPL of 37.47%. Kings (29.93%) and Fresno (32.12%). counties fell below the MPL in MY 2020. A Performance Improvement Project (PIP) was implemented to improve rates in Fresno County.
Comprehensive Diabetes Care HbA1c Poor Control	Kings County met the 50th percentile (37.47%). Fresno (34.06%) and Madera (36.25%) Counties did not meet the MPL.
Controlling High Blood Pressure (CBP)	Kings & Madera counties exceeded MPL 61.80%. Fresno County (52.07%) fell below the MPL.
Timeliness of Prenatal Care (PPC-Pre)	All three counties exceeded MPL of 89.05%.

2.2 Non-Default HEDIS® Minimum Performance Level (MPL) Measures – Additional measures Below the MPL in MY 2020

Antidepressant Medication Management - Acute Phase (AMM)	All counties fell below the MPL of 53.57%.
Antidepressant Medication Management - Continuation Phase (AMM)	All counties fell below the MPL of 38.18%.
Breast Cancer Screening (BCS)	Madera County exceeded the MPL of 58.82%. Fresno (52.64%) and Kings (58.24%) Counties did not meet the MPL. A Disparity PIP was implemented in Fresno County and will continue in 2022.
Chlamydia Testing – TOTAL (CHL)	Kings County met the MPL of 58.44% in MY 2020. Fresno (57.81%)-and Madera (52.85%) Counties fell below the MPL.

3. Performance Improvement Projects

For 2021, two PIPs, targeted in Fresno County, were both in the intervention implementation phases.

- Breast Cancer Screening (BCS) disparity
- Childhood Immunizations, Combination 10 (CIS-10) project

3.1 Childhood Immunization (CIS-10):

In Q1 to Q4 2021, CalViva Health Medical Management staff continued the CIS-10 Performance Improvement Project in collaboration with one high volume, low compliance clinic in Fresno County. The team determined that an intervention focused on education was needed to improve the immunization completion rates. In Q3, an educational text messaging campaign was implemented with the clinic. Results are being analyzed and a second intervention is under consideration. Simple single level text messages may be more effective. CalViva Health will continue to offer health education materials to members and help parents understand the importance of childhood immunizations.

Modules 1,2, and 3 were submitted and approved by HSAG/DHCS.

3.2 Breast Cancer Screening (BCS) Disparity

In Q1 to Q4 2021, CalViva Health Medical Management staff continued a Breast Cancer Screening (BCS) Performance Improvement Project in collaboration with one high volume, low compliance clinic, a women's imaging center, and a community-based organization that supports the Hmong population in Fresno County. In Q3, a Hmong Sisters Educational Event was held at the cultural center, which included a video in the Hmong language to address health literacy barriers among the Hmong population, and included testimonials by breast cancer survivors, transportation presentation, and raffle items. The imaging center was present to inform members regarding how to make an appointment for their mammogram.
Data is being analyzed regarding the success of the event to encourage mammogram completion at the imaging center and an additional event is being planned. CalViva Health will continue to implement a member friendly approach by having a warm welcoming atmosphere at the events that addresses cultural and language issues, and other potential barriers.

Modules 1, 2, and 3 were submitted and approved by HSAG/DHCS.

Item #11

Attachment 11.B

2021 Annual Quality Improvement Work Plan Year End Evaluation

CalViva Health
Quality Improvement
End of Year Work Plan 2021

February 17, 2022

Table of Contents

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

PURPOSE

The purpose of the CalViva Health's Quality Improvement Program Year End Work Plan is to recap the established 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.

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.

SCOPE

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

Glossary of Abbreviations/Acronyms

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

I. ACCESS, AVAILABILITY, & SERVICE

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

Rationale and Aim(s) of Initiative

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

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

Timely Appointment Access to Primary Care Physicians and Specialists is measured through 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	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• MY 2021 PAAS & PAHAS Surveys – slated to begin in September and being conducted by Sutherland • Provider Updates ○ MY 2020 PAAS & After-Hours Survey Results – DRAFT currently in process (June). • Provider Webinars – two sessions held in Q1 (March) and two sessions held in Q2 (June). Total of 11 attendees. • Telephone Access Survey – decision made to move from quarterly to annually to alleviate provider survey abrasion. Survey will be conducted in Q4 by Sutherland. • Appointment Access P&P Updates – updates made to P&P in Q2 regarding Telephone Access Survey changes and other minor edits. Will be brought to CalViva Health Access workgroup for review in Q3 (September meeting).	• MY 2021 PAAS & PAHAS surveys completed December 24th. Auditing currently underway with final report generation at the end of January 2022. • Provider Updates – MY 2020 PAAS & After-Hours published July 30th. • Provider Webinars – 13 webinars conducted in 2021 with 51 attendees from the CalViva health area. Self-study packet option available to those unable to attend a webinar in 2021. • Telephone Access: survey conducted in Q4 2021 and ended on December 24th with final report generation at the end of January 2022. • Appointment Access P&P: updates reviewed at September 28th Access Work Group meeting.

• DHCS Medi-Cal Managed Care Timely Access Report – DHCS has not resumed surveys yet and no ETA on when they will resume.
• MY 2020 PAAS & After-Hours Results & CAP – survey results shared with CalViva at June Access WG Ad-hoc meeting. MY 2020 CAP will be presented at July Access WG meeting.
  ○ Tier 2 groups or Direct Network providers found to be non-compliant two or more years in a row will be moved to a Tier 1 CAP and will be required to complete and Improvement Plan.
• Resources Update
  ○ Timely Access Webinar Flyer: minor updates; finalized February
  ○ Timely Appointment Access Flyer: minor updates; finalized June
  ○ Timely Appointment Access & After-Hours: Understand Your Survey Results – title change (formerly known as Timely Appointment Access & After-Hours Report Card) and other minor updates; finalized June
  ○ After-Hours Scripts – reviewed Q2; no changes needed
  ○ Improve Health Outcomes – Provider Toolkit – under review.
• After-Hours Physician Callback Rate
  ○ In MY 2019, a new survey vendor was used (Sutherland) to conduct the After-Hours survey. Drop in rate in MY 2020 is likely attributed to a survey administration change, which was a slight modification to the survey tool. MY 2020 results are more consistent with results seen in MY 2018.
	• DHCS Medi-Cal Managed Care Timely Access Report: DHCS confirmed they will resume surveys January 2022.
	• MY 2020 PAAS & After-Hours CAP:
	  ○ Presented MY 2020 CAP at the July 27th Access Work Group meeting.
	  ○ A total of 19 Tier 1 CAP (PPG & Direct Network) packets were sent late August and mid-September via email and USPS. Improvement Plans were due September 30th for emailed CAP packets and October 15th for mailed CAP packets.
	  ○ A total of 42 Tier 2 Ed packets (PPG and Direct Network) were sent out August 24th.
	  ○ Both Tier 1 & Tier 2 PPGs were required to complete an Attestation form and return it within 30 days of receiving the CAP.
	  ○ All Improvement Plans received from PPGs. Follow-up on missing documentation required to close out CAPs continues. Delays due to COVID issues and/or staffing resources.
	
	Resource Updates: Improve Health Outcomes – Provider Toolkit rebrand/refresh delayed until Q2 2022.

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 2021)

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 = 55.9 (-4.4) Non-Urgent = 81.9 (3.2) Prenatal = 85.3 (-4.8)	Urgent = 60.3 Non-Urgent = 78.7 Prenatal = 90.1	CVH Performance MY 2018	Urgent = 65.6 Non-Urgent = 72.4 Prenatal = 89.6

Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request	90%	Overall= 68.9 (-2.0) Fresno= 71.3 Kings= 58.9 Madera= 67.7	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=44.4↓ (-7.8) Fresno= 47.0 Kings= 38.5 Madera= 39.0	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**
Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	90%	Overall= 85.9 (1.2) Fresno= 83.7 Kings= 91.1 Madera= 93.9	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= 78.4 (3.0) Fresno= 78.1 Kings= 82.5 Madera= 77.5	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**
First Prenatal Visit (PCP) – Within 2 weeks of request	90%	Overall= 87.1 (-1.3) Fresno= 86.7 Kings= 94.7 Madera= 71.4*	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= 80.9 (-10.3) Fresno= 81.8 Kings= 57.1* Madera= 100*	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= 80.9 (4.0) Fresno= 77.1 Kings= 97.1↑ Madera= 87.5	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= 89.0 (1.2) Fresno= 86.7 Kings= 94.4 Madera= 100	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 –	90%	Overall= 100 (6.7) Fresno= 100	Overall=93.3 Fresno=90.9	CVH Performance	Overall=66.7 Fresno=60.0

Appointment within 15 business days of request		Kings= 100* Madera=100*	Kings=100* Madera=100*	MY 2018	Kings=100 Madera= NR
Appropriate After-Hours (AH) emergency instructions	90%	Overall=96.0↓ (-1.9) Fresno= 95.0↓ Kings= 99.1 Madera= 100	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= 84.2↓ (-15.2) Fresno= 85.4↓ Kings= 70.9↓ Madera=95.6	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 2020 vs RY 2019, 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	Overall Effectiveness: • PAAS & After-Hours Surveys: o Urgent Care – PCP overall scores reflected a decrease of 2.0 percentage points (PP) compared to MY 2019. Overall Specialists scores continue to be low with a notable decline in MY 2020 of 7.8 PP. o Non-Urgent Care – PCP overall scores improved slightly as compared to MY 2019 with Kings and Madera County scores reflecting increases. Specialist overall scores also increased slightly (3.0 PP) as compared to the previous measurement year. All three counties demonstrated improvement in the Specialist scores with Kings County having the highest score at 82.5%. o After-Hours: Statistically significant decrease was noted for overall and county level scores in MY 2020 for the After-Hours Physician Callback metric. In MY 2019, a new survey vendor was used (Sutherland) to conduct the After-Hours survey. The decline in the rate in MY 2020 is likely attributed to a survey administration change, which was a slight modification to the survey tool. MY 2020 results are more consistent with results seen in MY 2018. • Provider Training: o A total of 13 Timely Access provider webinars were conducted for 2021 with 51 attendees from the CalViva area. This is similar to last year's attendance although more webinars were offered in 2020. A self-study option was offered upon request. Only a small number of participants chose this option and those numbers are not included in the 51 attendees referenced above.

	Barriers: • PAAS & After-ours Surveys: DMHC methodology makes it difficult to truly assess provider timely access, as it did not reflect real-life scenarios (other providers within the same group who may be able to see the patient sooner, part-time providers, use of extenders, etc.). Ongoing COVID-19 impacts likely attributed to the decline in Urgent care appointment scores. • Provider Training: Ability to track accurate CalViva attendance at Timely Access provider webinars continues to be challenging due to registration template restrictions. COVID-19 continued to affect attendance at webinars.
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 MY 2019 Result Rates: October 2019 – April 2020
        ii. Look-back Period for MY 2020 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 MY 2019 Result Rates: August 2018 – May 2019
    ii. Look-back Period for MY 2021 Result Rates: August 2020 – May 2021
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) ^. This measure was removed from the MY 2021 CAHPS Survey.

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	Q4 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	P	Quarterly basis	CVH/HN

these results and recommendations with Medical Management leadership at least quarterly.			

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

• The Provider Tool Kit was reviewed and updated for 2021. The following Member experience articles were included in the 2021 version: Appointment Scheduling Tip Sheet and Quick Reference Guide, Talking with my Doctor, Interpreter Services and the Nurse Advice Line. Due to the re-branding efforts, the launch of the 2021 tool kit had to be pushed back to Q4 2021. In addition, because of delay to in-person engagement, the Tool Kit will only be available in an e-version that will be sent to providers and staff.
• Content for the annual Member Newsletter was reviewed for edits and updated. The 2021 Member Newsletter will include articles on the following topics: Questions to Ask Your Health Care Provider, Interpreter Services, Access Standards, and the nurse advice line. The Member Newsletter launched on 7/22/2021.
• The annual CalViva Access Survey was launched late March and was fielded for 1.5 weeks until the target number of respondents was met. Results will be presented at the July 2021 CVH Access Workgroup Call.
  ○ There were no statistically significant changes in any of the measures rates in comparison to last year.
  ○ The following measures saw percentage rate decreases in comparison to last year: Getting Urgent Care As Soon As Needed; Getting Routine Care As Soon As Needed, and Easy of Getting Tests, Care, Treatment.
  ○ Ease of Getting Specialist Appointment increased from 2020, seeing a 6-percentage point increase.
  ○ Based on the 2021 results, areas of focus will continue to revolve around improving members' access to routine, urgent, and overall care.
• The 2021 PPG CAHPS Webinar is slated to be held in late September across 2 sessions (AM, PM).
 	
The Q1 root cause analysis on member pain points was completed and shared internally with the appropriate stakeholders. Based on review and analysis of the results, the following areas of opportunity have been identified:
	• Provider Tool Kit was updated earlier in the year but its launch date was pushed out. The e-version of the kit was distributed in Q4 to providers and staff.
	• The CAHPS PPG Webinar was held across two sessions in September 2021 (one AM, one PM session). The webinar reviewed the importance of CAHPS and member experience, highlighted the measures impacted directly by providers and staff, as well as stressed the importance of provider communication. New in 2021, the webinar was recorded and sent out to attendees (via URL link) after the webinar for future viewing.
	• The quarterly analysis of member pain points was put on hold for the second half of 2021 and will resume in Q1 2022 (using Q4 2021 data).

Transportation, appointment availability, and referral approvals. The member pain points data will also be brought into the QI-MCAL 2022 planning discussions as a way to take a more holistic view into members' care experience and help identify future improvement activities.	

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 2021)

CalViva Access Survey Measure(s)	**Specific Goal**	**MY 2019**	**MY 2020**	**Baseline Source** (Source: Previous Year CalViva Access Survey)	**Baseline Value**
Got urgent care as soon as needed	Improve YOY	78%	77%	MY 2018 Rate	76%
Got routine care as soon as needed	Improve YOY	67%	62%	MY 2018 Rate	65%
Ease to get specialist appointment	Improve YOY	59%	65%	MY 2018 Rate	59%
Ease of getting care/test/treatment	Improve YOY	76%	69%	MY 2018 Rate	77%
DHCS CAHPS Survey Measure(s)	**Specific Goal**	**MY 2019**	**MY 2021**	**Baseline Source** (Source: Quality Compass Percentiles)	**Baseline Value**
Getting Needed Care	Meet or Exceed Quality Compass 50th Percentile	69.10%	79.9%	MY 2021 50th Percentile	83.0%
Getting Care Quickly	Meet or Exceed Quality Compass 50th Percentile	73.31%	76.1%	MY 2021 50th Percentile	82.3%

How Well Doctors Communicate	Meet or Exceed Quality Compass 50th Percentile	86.52%	85.8%	MY 2021 50th Percentile	93.2%
Customer Service	Meet or Exceed Quality Compass 50th Percentile	NA	NA	MY 2021 50th Percentile	89.3%
Shared Decision Making^	Meet or Exceed Quality Compass 50th Percentile	77.00%	^	MY 2021 50th Percentile	79.84%
Rating of All Health Care	Meet or Exceed Quality Compass 50th Percentile	63.41%	72.2%	MY 2021 50th Percentile	76.4%
Rating of Personal Doctor	Meet or Exceed Quality Compass 50th Percentile	75.46%	77.8%	MY 2021 50th Percentile	83.5%
Rating of Health Plan	Meet or Exceed Quality Compass 50th Percentile	73.35%	75.9%	MY 2021 50th Percentile	78.5%
Rating of Specialist	Meet or Exceed Quality Compass 50th Percentile	74.44%	NA	MY 2021 50th Percentile	83.9%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness With Barrier Analysis	Results from the MY 2021 CAHPS Survey via DHCS showed improvement in 5 of the measures since the last survey fielded (MY 2019): Getting Needed Care, Getting Care Quickly, Rating of All Health Care, Rating of Personal Doctor and Rating of Health Plan. Although improvement has been seen, there is still room for improvement since all measures are still below the QC 50th percentile. CAHPS exposure and awareness continues to be one of the main priority areas since so many stakeholder teams and departments can potentially impact CAHPS. Quarterly CAHPS workgroups will remain in place as a platform to brainstorm new projects and collaboration opportunities within the organization. Due to the high influence of provider-member communication on CAHPS scores, the CAHPS Team plans to add more training/education opportunities specifically targeted for providers via the Provider Training Series Program estimated to launch in late March 2022. Internal and external member feedback will be routinely monitored to help guide where improvement efforts should be focused on throughout the year.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

II. QUALITY AND 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
Incentive gift cards upon completion of CHL Screenings.	M	Q2-Q3	CVH/HN
Initiate an electronic health record (her) 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)**

• In Q1 and Q2 2021, CalViva Health led a Chlamydia Screening (CHL) Performance Improvement Team in collaboration with one high volume, low compliance clinic in Madera County.
• The partner organization and CalViva Health established a multidisciplinary CHL improvement Team that met bi-weekly to determine the current process, identify potential barriers, and establish a plan for improvement to address potential barriers with the project.
• In Q1 2021, CalViva Health developed a provider profile to target non-complaint members. The team focused initially on the 21-to-24 year-old age band; this group had a larger population to impact our rates. The clinic implemented the EMR Flag alert and a Daily Huddle report to facilitate collaboration with the MA and MD. These PDSA interventions were successful with the 21-24 year old age band.
• In Q2, the PDSA added the members in the 17-20 year-old age band to the cohort, to determine the effectiveness of the approach across a wider age range and learn if there are new barriers to address. The PDSA is also testing for sustainability and reproducibility with this younger population.
	• In Q3, CalViva Health continued to work with one high volume, low compliance clinic in Madera County. The multi-disciplinary team continued the established bi-weekly meetings with the clinic. The CHL PDSA improvement team will review progress with the activities, address new barriers, and make modifications to the project as needed.
	• In Q1 and Q2, CalViva Health developed a Provider Profile in collaboration with the clinic/staff and identified members that required screenings.
	  ○ The main barrier was that both clinic staff and patients were not educated that the CHL Screening test is a urine test and can be ordered anytime. It does not need to wait for the Annual Women's Exam or Pap test. They also identified a lack of education on the importance of the CHL Screening. A booklet from the CDC website was printed and clinic staff shared the information with members via the telephone when contacting them to schedule an appointment.
	  ○ The intervention of the EHR/flag and Daily Huddle was successful, and the team considered opportunities for overall sustainability in other CalViva counties.

• The primary barrier identified by the clinic is that patients are not being screened when they are seen by their PCP or other clinic provider. The PCP's were deferring to the "Annual Women's Exam" for this type of screening, though a CHL screen can be ordered and completed at any visit, by collecting a urine specimen. • The intervention identified the patient on the Daily Huddle report for all visits and the medical assistant is responsible for facilitating this type of testing in collaboration with the provider. • The team is investigating opportunities in the CHL Screening process to improve the overall sustainability and performance of the health plan.	○ The intervention was adopted and maintained using an incentive -VISA gift card. • In Q3, this PDSA Improvement Project was completed after review by DHCS.

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%	Madera: 52.85%	MY 2019 HEDIS Data	55.42%
HEDIS Chlamydia Screening in Women (CHL) – Provider Goal	By 6/28/2021 increase the Screening Rate by 15% (60/402)	N/A	43.53%	58.33%	MY 2019 Provider Results	43.53%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • Strong collaboration between motivated staff and a proactive provider resulted in members completing CHL screenings. Supporting activities included bi-weekly meetings with staff, the clinic's participation in Daily Huddles, and the use of EHR flags to identify members who had an appointment that day. • The implementation of the Provider Profile and detailed documentation by the clinic staff displayed a significant improvement in the number of CHL screenings completed. **Barriers:** • Members did not always understand the significance of the CHL screenings. • Because of COVID-19 restrictions, members were afraid to come to the clinic. **Lessons Learned:** • A clinic champion and the support of the clinic's Quality Improvement leadership improved the success of implementation.

	• Obtaining staff feedback is crucial to successful intervention implementation. CalViva Health Medical Management staff scheduled bi-weekly meetings to hear staff successes, challenges, and implement solutions to barriers to maximize improvement efforts.
Initiative 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]

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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)
• In Q1 and Q2 2021, CalViva Health led a Breast Cancer Screening (BCS) Performance Improvement Team in collaboration with one clinic with 2 sites at Greater Fresno Health Organization (GFHO), which is a high volume, low compliance clinic; an imaging center; and a Hmong cultural center in Fresno County. • The partner organizations and CalViva Health established a multidisciplinary BCS improvement Team that met bi-weekly to	• In Q3 and Q4, CalViva Health Medical Management team continued to collaborate with BCS Improvement Team comprised of the Greater Fresno Health Organization (GFHO), a high volume/low compliance clinic, a breast imaging center, and a Hmong cultural center in Fresno County. • In Q3 and Q4, CalViva Medical Management staff continued the multidisciplinary meetings.

determine the current process, identify potential barriers, and establish a plan for improvement to address potential barriers with the project. • In Q2, the team completed the Key Driver, Process Map, and FMEA Tables; to be submitted to HSAG in Q3. • Through a barrier identification process, an Education Event which includes a video in Hmong language was developed to address health literacy barriers among the Hmong population. CalViva will use a member friendly approach that addresses cultural and language issues, along with transportation needs and other potential barriers. A member incentive will be offered to event attendees for completion of breast cancer screening. Modules 1 was submitted to HSAG and approved. Module 2 is submitted to HSAG and awaiting approval. • Provider Tip Sheets were developed in Q2 2021 and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended screening guidelines. • All Providers in Fresno County will be offered an incentive to encourage outreach to members for completion of their breast cancer screening.	• In Q2, Module 2, Intervention Determination, which includes the Key Driver Diagram, Process Map, and FMEA Tables were submitted and approved by HSAG. • In Q3, Module 3, Intervention Testing, was submitted and approved by HSAG. • In Q3, a Hmong Sister's Health Educational Event was held at the cultural center. The Event included a video on the importance of breast cancer screening (in Hmong) and presentations by a Hmong obstetrician-gynecologist, GFHO staff, imaging center representatives, testimonials, and transportation services. 15 out of the 35 scheduled members attended. • In Q4, upon completion of the breast cancer screening, member incentives were provided via GFHO clinic staff. • In Q4, CalViva Health Medical Management team started planning for the next event at the cultural center in Q1 2022.

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 2021)

Measure(s)	Specific Goal	Rate MY 2018	Rate MY 2019	Rate MY 2020	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%	52.64%	MY 2019 HEDIS Data	55.26%
HEDIS Breast Cancer Screening – Provider Goal	Meet or Exceed SMART Aim Goal of 47.8%	18.5%	28.46%	38.4%	MY 2019 Provider Results	28.46%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • Effective collaboration with clinic partners. • Multidisciplinary teams continue to be critical to the success of the project. • It is critical to offer health education materials to the members and offer interpreter services in various settings. • A demo video of a BCS exam was played at the event, and testimonials of breast cancer survivors in the Hmong community. **Barriers:** • COVID-19 restrictions. • Language barriers exist and it may require several attempts to fully communicate to a member what a mammogram is and why it is important. **Lessons Learned:** • It is critical to include Culture & Linguistic, Health Education, and Provider Relations on our team to address potential barriers in advance of the event. • Flexibility is important, often members do not arrive at their scheduled time and the clinic team needs to be prepared to adjust the schedule to fit them in. • Explore ways to engage members who refuse exams in dialogue to help them understand the importance of BCS and how it is done.
Initiative 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]

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)**
• In Q1 and Q2 2021, CalViva Health led a Childhood Immunizations (CIS-10) Performance Improvement Team in collaboration with one high volume, low compliance clinic in Fresno County. • Based upon Module 2 quality improvement activities (i.e., Process Mapping, Failure Modes and Effects Analysis, Failure Mode Priority Ranking, and a Key Driver Diagram activities), the team determined that an intervention focused on education was needed to improve immunization completion rates. A large number of parents admit to having concerns and questions about childhood vaccinations. A provider based educational texting campaign with the clinic is in the planning phases. • The clinic is working in collaboration with CVH Health Education Department to develop content for the text messaging campaign Modules 1 and 2 were submitted to and approved by HSAG; Module 3 is in development.	• In Q3 and Q4, CalViva Medical Management continued to collaborate with a high volume, low compliance FQHC through the Childhood Immunization Improvement Team and conducted regular bi-weekly meetings. • In Q3, Module 3, Intervention Testing, was submitted and approved by HSAG. • In Q3, the clinic collaborated with CVH Health Education Department to develop content and went live with a text messaging campaign • CalViva Health distributed a member newsletter, “Whole You”, including information on the importance of childhood immunizations. • The provider incentive continued throughout Q3 and Q4. • In Q3, Provider Tip Sheets were developed and made available through the Provider Portal. The tip sheet outlined HEDIS specifications, best practices, and childhood immunization guidelines.

• The member newsletter will be distributed to members in Q3 of 2021 to educate on the importance of childhood immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations. • Provider Tip Sheets were developed in Q3 2020 and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines.	

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 2021)

Measure(s)	Specific Goal	Rate MY 2018	Rate MY 2019	Rate MY 2020	Baseline Source	Baseline Value
Childhood Immunization Combo 10 – County Goal	Meet or Exceed the MPL (50^{th} Percentile) 34.79%	Fresno: 32.16%	Fresno 33.82%	Fresno 32.12%	MY 2019 HEDIS Results	33.82%
Childhood Immunization Combo 10 – Provider Goal	Meet or Exceed SMART Aim Goal of 34.82%	N/A	27.58%	20.97%	MY 2019 Provider Results	27.58%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • Effective collaboration and clinic engagement contributed to the success of the project thus far. • The clinic is well-established with sufficient staff to engage and participate on the project. • Text messaging may be an effective engagement tool. • Brief single level messages may be more effective. **Barriers:** • Text message campaigns have a number of limitations such as, bad contact information, no cell phone or inability to receive text messages. Few caregivers/parents responded to our text messages, but simpler messages may be more effective. • Some appointments were scheduled in follow up to our messages, but many were not attended or data gaps made it difficult assess whether the appointment was attended.

	Lessons Learned: • Additional interventions should be employed in follow up to a text message campaign.
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?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	Health Education	The PSG is being sent to CalViva Health members as part of the New Members Packet, and will be submitted to CalViva's QI/UM Committee on 11/18/2021.	☒	12/31/2021	Completed. Ongoing.
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	Clinical Practice Guidelines were disseminated March 2021, and was submitted to CalViva's QI/UM Committee on 7/15/2021.	☒	11/21	Completed. The CPG grid was approved by Health Net's Medical Advisory Council in November and posted on the website in November. Providers were notified of CPGs via the provider update: 21-466, *Help Your Patients Achieve Better Health Outcomes.*
3. Monitor CalViva Pregnancy Program and identify high risk members via Case Management	Case Management	The CalViva Pregnancy Program remains in place. 2021 YTD through May, 298 members have been managed in this program. Outcomes continue to demonstrate greater compliance with prenatal and postpartum visits and fewer preterm deliveries of members managed vs those not managed.	☒	12/20/21	The CalViva Pregnancy Program remains in place. For 2021 Jan through Nov, 603 members were managed in this program. Outcomes continue to demonstrate greater compliance with prenatal and postpartum visits and fewer preterm deliveries of members managed versus those not managed.
4. Promote Kick It California (formerly known as CA Smokers' Helpline) to smokers	Health Education	Propose a collaboration with CA Smokers' Helpline to do	☒	12/1/2021	Proposal with DHCS continues to be under review.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
		direct outreach to smokers. Program needs DHCS approval before implementation.			It was resubmitted in December to align with final inquiries. In the interim, preparations continue exploring new data sources to identify members who smoke or have nicotine dependence.
5. Launch a Diabetes Prevention Program	Health Education	DPP program implementation pending submission to DHCS.	☒	11/1/2021	Received DHCS approval on 11/1/21. Released a Provider Communication on 12/10. Conducted an outreach mailing to 9,854 members.
6. Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016.	Quality Improvement	Lead Screening for Children (LSC) measure added to performance trackers to monitor county and provider level performance. Monthly provider care gap reports with customized LSC measure implemented to notify providers of missing lead screenings. Provider report cards for lead screening were also implemented.	☒	12/30/2021	Ongoing monitoring through performance trackers, provider care gap reports, and report cards. First report due to DHCS in Q1 2022.
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Chronic Conditions Management program for appropriate member outreach	Chronic Conditions Management	Telephonic outreach and education activities continue to help members manage their chronic health conditions. Chronic conditions addressed in this	☒	Ongoing	Activities continue in 2022.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
		program include Asthma, Diabetes and Heart Failure.			
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	Health Equity	Completed. The C&L LAP report and work plan update was presented to UM/QI committee on 5/20/2021. The Timely Access Report (TAR) was completed and submitted for filing during Q1.	☒	5/20/2021 10/21/2021	The Health Equity LAP Mid Year Report and Mid Year Work Plan updates were presented to UM/QI committee on 10/21/2021.
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	Access & Availability	Slated to begin in September and being conducted by Sutherland	☒	12/24/21	All MY 2021 surveys completed with final results available Q1 2022.
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date	Access & Availability	MY 2020 TAR submitted timely.	☒	3/31/21	Completed.
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	Access & Availability	MY 2020 survey results shared with CalViva at June Access Workgroup Ad-hoc meeting. MY 2020 CAP will be presented at July Access WG meeting. • Tier 2 groups or Direct Network providers found to be non-compliant two or more years in a row will be moved to a Tier 1 CAP and will be required to	☐		All improvement plans received with ongoing follow-up for missing documentation. Expected close out for CAPs in Q1 2022.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		complete and Improvement Plan.			
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars	Access & Availability	Two sessions held in Q1 (March) and two sessions held in Q2 (June) with a total of 11 attendees. Low turnout can be attributed to "off-season" for CAP activities. Sessions will be held in Q3 & Q4 and should generate a higher turnout since this will be held during MY 2020 CAP distribution. Webinar attendance is a required activity for Tier 1 non-compliant PPGs.	☒	12/31/2021	A total of 13 sessions with 51 participants was conducted in 2021. Data for self-study option will be available in Q1 2022.
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	Access & Availability	Decision made to move from quarterly to annually to reduce provider survey abrasion. Survey will be conducted in Q4 by Sutherland.	☒	12/24/21	Surveys completed with final results available at end of January 2022.
7. DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey.	Access & Availability	DHCS has not resumed surveys yet and no ETA on when they will resume.	☒	12/31/21	DHCS to resume surveys in January 2022.
8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	A&G	A&G has worked with providers and internal departments as needed to help resolve member appeals and grievances.	☒	1/1/2022	Throughout 2021 A&G continued to partner with internal departments and providers to resolve A&G issues and cases. Reports

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		Data is a consistent component of QI/UM and tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.			were sent out monthly and quarterly to track issues.
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.	Health Education	On track to be submitted by 8/2/2021.	☒	8/2/2021	Population Needs Assessment was completed.
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	Data collection and analysis in progress for GEO Access report. Report on track for completion in Q3. The findings will be shared with QI/UM Committee and Provider Network Management (PNM) in Q4.	☒	9/27/2021	GEO Access report was completed in Q3 and shared with QI/UM Committee and Provider Network Management in Q4.
11. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	Quality Improvement	CVH still under DHCS CAP for IHA. QI Project underway w/ high volume low performing clinic and determined that code 96156 is effective to document IHEBA completion. Implementation is planned for Q3 & Q4 2021. We will monitor for effectiveness.	☒	11/18/2021	DHCS CAP is still open. Reporting completed for Q1/Q2 2021.
12. Engage with CVH provider offices to complete MY 2021 MCAS training focused on best practices for closing care gaps.	Quality Improvement	Completed 15 HEDIS trainings with 13 high-volume provider offices in Fresno, Kings and Madera Counties in Q1-Q2.	☒	Q1 and Q2 2021	Completed in Q1 and Q2.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
13. Engage with high volume CVH provider offices to complete interventions addressing systemic barriers to HEDIS performance.	Quality Improvement	Launched 39 interventions with 13 provider organizations in Fresno, Kings and Madera Counties in Q2. Intervention areas of focus included coding training and review, clinical workflow training, telehealth training, and Well Woman clinics.	☒	Q1 and Q2 2021	Completed in Q1 and Q2.
14. Quality EDGE (Evaluate Data to Generate Excellence). The Quality team in collaboration with Provider Engagement and the Medical Affairs teams developed the Quality EDGE process with the mission to outperform all market competitors on quality metrics by providing unparalleled consultative services, innovative programs and actionable reports while improving health equity. Program Oversight includes: • Tracking provider performance for MCAS HEDS measures held to the MPL • Tracking provider engagement in collaboration with the provider-facing teams • Developed Quality EDGE funds to support provider/member engagement • Developed innovative quality playbook and Quality EDGE tools (Priority Provider Profile Report, RAVE Tool, SBIT/Readiness Assessment) to support the Quality EDGE process.	Quality Improvement	N/A	☒	12/31/2021	Completed activities.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
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	The ImpactPro data remains incorporated into the Population Health Management Report used to identify high risk members. Outcomes demonstrate lower readmission rates, ED utilization, and health care costs post CM vs pre CM for members managed. Overall members were satisfied with the help they received from the CM and reported improvement in ability to care for self/family post CM.	☒	12/20/21	The ImpactPro data remains incorporated into the Population Health Management Report used to identify high risk members. In 2021, CM managed 7,175 members, 40% being high risk and 48% medium risk. Outcomes demonstrate lower readmission rates, ED utilization, and health care costs post CM vs pre-CM for members managed. Overall, members were satisfied with the help they received from the CM and reported improvement in ability to care for self/family post CM.
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	Credentialing	On target to meet year end metrics 7/9/2021. Credentialing Oversight Audit in progress.	☒	12/31/21	Credentialing oversight audit not yet complete. Reports received timely.
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	Managed Health Network Services (MHNS) initiated the annual member and provider satisfaction surveys in Q2. The team will analyze the results, conduct barrier analysis, and make plans for improvements, where	☒	12/2/21	MHNS completed the CVH member satisfaction survey, CVH BH provider satisfaction survey and resulting barrier analysis and action plan for 2022. Fresno member satisfaction decreased significantly around urgent appointment access with a

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		necessary, by December 2021.			non-physician and Madera member satisfaction decreased significantly around providers being respectful of race, ethnicity and/or region. Conversely, Fresno member satisfaction increased significantly with travel time to and coordination of care discussions with BH providers. MHNS will present comprehensive reports to CVH in 2022.
QUALITY IMPROVEMENT					
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To 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.	FSR	Not on track due to pandemic- no onsite visits per APL2-011. This APL was rescinded. Onsite audits expected to resume July 26, 2021. Plan for catch up on missed reviews in development.	☐	12/31/21	Onsite audits resumed 7/26/21. Using a backlog strategy, approved by DHCS, to complete sites that were postponed due to pandemic with estimated completion in 2023.
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	Quality Improvement	Ongoing. QI continues to complete Work Plan evaluation at Mid-Year as well as annually. The 2021 QI Workplan was completed and approved on March 18, 2021.	☒	9/16/2021	The 2021 mid-year work plan and executive summary were submitted 9/15/2021. The 2021 year-end work plan and executive summary are on track for Q1 2022.

Item #12

Attachment 12.A

2021 Annual Utilization Management Case Management Workplan Evaluation Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Jennifer Lloyd, Vice President Medical Management
COMMITTEE DATE:	February 17, 2022
SUBJECT:	2021 CalViva Utilization Management/Case Management Work Plan End of Year Evaluation Executive Summary

Summary:

Utilization Management (UM) processes have been consistent and evaluation/monitoring of UM metrics continue to be a priority. Both Case Management and Disease Management continue to monitor the effectiveness of programs in order to better serve our members.

The metrics below were identified as not met objectives for the year end evaluation reporting period:

- 2.2 Timeliness of processing the authorization request
- 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance

Purpose of Activity:

CalViva Health has delegated responsibilities for utilization management and case management (UM/CM) activities to Health Net Community Solutions. CalViva Health's UM/CM activities are handled by qualified staff in Health Net's State Health Program (SHP) division.

The Utilization and Case Management Program is designed for all CalViva Health members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely and effective manner. CalViva Medical Management staff maintains clinical oversight of services provided through review/discussion of routine reports and regular oversight audits.

The End of Year Evaluation of the UMCM Work Plan encompasses a review of medical management activities through the documentation of current and future strategic initiatives and goals. The Work Plan tracks key performance metrics, regulatory compliance, provides for an assessment of our progress and identifies critical barriers.

This plan requires involvement from many areas such as Appeals & Grievances, Compliance, Information Technology, Medical Informatics, Member Services, Pharmacy, Provider Oversight, Provider Network Management, Provider Operations, Quality Improvement and Medical Management.

Analysis/Findings/Outcomes:

I. Compliance with Regulatory & Accreditation Requirements

All Compliance activities met objectives for this end of year evaluation. No barriers have been identified.

II. Monitoring the Utilization Management Process

Monitoring of the utilization management process activities met objectives in 2021 with the exception of work plan element 2.2 Timeliness of processing the authorization request.

a. **Timeliness of processing the authorization request** (Work plan element 2.2)

The Plan monitored turn-around-time (TAT) as planned throughout 2021. There was a dip in the Pre-Service Expedited with Extension/Deferral TAT category in the second quarter. The sample size was 4 and one authorization did not meet in May. The Referral specialist was coached and the pend process reviewed. Due to the extremely low sample size (4 authorizations), failures affected the percentage more strongly. There were no failures in June.

In the second half of 2021 the preservice TAT goal of 95% was not met in July and August. As a result the following next steps were implemented and subsequent months were within target:

1. Cross training of UM staff to support Prior Authorization functions
2. Weekly recruitment meetings to support external recruitment resources
3. Change staffing model to maximize productivity with current staff

III. Monitoring Utilization Metrics

Monitoring of Utilization Metrics activities met objectives in 2021 with the exception of work plan element 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance.

a. **Improve Medi-Cal shared risk and FFS UM acute in-patient performance** (Workplan element 3.1)

The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout 2021 including daily UM huddles and weekly huddles with key hospitals.

Results of our goals to reduce admissions and average length of stay (ALOS) by 10%, based on claims utilization reflect admissions were below (met) target for SPD but TANF and MCE populations increased. The ALOS was higher than goal (did not meet) for all populations.

Barriers included:

- Inability to execute on-site hospital strategy due to COVID-19.
- Length of COVID-19 State of Emergency
- Long stay COVID admissions

b. **Over/under utilization** (Workplan element 3.2)

Planned objectives related to over/under utilization were met in 2021, however identified barriers included:

- COVID-19 shifted both utilization patterns and PPG UM resources.
- Staffing for all PPG departments including UM departments had issued due to COVID sick leave and resignations in healthcare.

c. **PPG Profile** (Workplan element 3.3)

Planned objectives related to PPG profile reporting were met in 2021, however identified barriers included:

- Due to COVID-19, some PPGs experienced staff turnover and shortage, which caused Decision TAT to drop below the 97%, required benchmark however stayed above 93%. Delegation oversight is working closely to improve the TAT to meet 100%.
- Some PPGs experienced issues with denial notification compliance due to new member notification templates issued by DHCS which included translation requirements that were not able to be implemented until late 2021.

IV. Monitoring Coordination with Other Programs and Vendor Oversight

All Coordination with Other Programs and Vendor Oversight activities met objectives in 2021.

a. **Case Management (CM) Program** (Work plan element 4.1)

Planned objectives related to Case Management were met in 2021, however identified barriers included:

- Decreased referrals from Concurrent Review to some programs due to COVID related complications for Members.
- Staffing constraints in Q3 and Q4.
- Changes in the Transition Care Management staffing and work process.

b. **Behavioral Health Performance Measures** (Work plan element 4.7)

Barriers were identified related to a not enough Psychiatrists in practice who are willing to treat the Medi-Cal population as well as provider dissatisfaction with current contract rates. Network availability and adequacy interventions were continued in 2021 to achieve desired results towards increasing adequacy and access to services.

V. Monitoring Activities for Special Populations

All Monitoring Activities for Special Populations activities met objectives in 2021.

a. **Monitor of California Children's Services (CCS) identification rate.** (Work plan element 5.1)

In 2021 teams exceeded the goal of minimum 5% CCS eligible identification rate and improved rate of referrals overall over 2020. CCS monitoring and identification process experienced the following barriers in 2021:

- The CA Central Valley CCS offices struggled with staffing and backlog of determinations for CCS which created additional pending cases for CVH.
- Additionally, some CA Central Valley CCS offices discontinued taking phone calls from the MCP plans to assist with issues and concerns.

Next Steps:

We are continuing monitoring of 2021 activities and will be continuing appropriate activities into 2022.

Item #12

Attachment 12.B

2021 Annual Utilization Management
Case Management Workplan
Year End Evaluation

CalViva Health
2021
Utilization Management (UM)/ Case Management (CM)
End of Year Work Plan Evaluation

Last updated: February 9, 2021

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in the first half of 2020 • Jan: COVID-19 Updates • February: Overview of Telehealth Services • March: Resuming Cancer Screening in COVID • April: Palliative Care: • May: Diabetes and CVD Best Practices • June: Addressing HPV hesitancy • June: Implicit Bias and Microaggression in Patient Care Interactions New hire overview training is offered monthly for all new hires. Medical management onboarding classes are offered and completion is monitored through our online learning management system. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform).	None identified	None	Ongoing

Annual Evaluation
 	
☒ **MET OBJECTIVES**
 	
☒ **CONTINUE ACTIVITY IN 2022**
	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in 2021
	
	• Jan: COVID-19 Updates
	• February: Overview of Telehealth Services
	• March: Resuming Cancer Screening in COVID
	• April: Palliative Care:
	• May: Diabetes and CVD Best Practices
	• June:
	  ○ Addressing HPV hesitancy
	  ○ Implicit Bias and Microaggression in Patient Care Interactions
	• August: Solving for Quality – HEDIS 2022
	• September: Health Care Teams Wellness in Challenging Times
	• October:
	  ○ Metastatic Triple Negative Breast Cancer
	  ○ Addressing Implicit Bias to Reduce Healthcare Disparities
		None identified	None	Ongoing

	• November: Alzheimer's Disease New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered and completion was monitored through our online learning management system. Training materials were reviewed and revised as needed. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform). IRR training and testing was completed.			

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, received from the Compliance Department and/or the Regulatory and Legislative Implementation committee. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner.	None identified	None	Ongoing Ongoing

☒ **CONTINUE ACTIVITY IN 2022**	Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.			Ongoing

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and annually thereafter through Cornerstone. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and annually thereafter. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Ongoing

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues of 30 sample size per metric. When a variance from compliance standards is identified, sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented Program Metrics Reporting (PMR) meeting.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards are identified, CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented to the Program Metrics Reporting (PMR) meeting and with CalViva Health.	None identified	None	Ongoing

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for the first two quarters in the year.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for all quarters in the year.	None	None	Ongoing

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2020 Year End UM/CM Work Plan Evaluation, 2021 UMCM Work Plan, 2021 UM Program Description and the 2021 CM Program Description were submitted and approved. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	The 2020 Year End UM/CM Work Plan Evaluation, 2021 UMCM Work Plan, 2021 UM Program Description and the 2021 CM Program Description were submitted and approved in Q1-2021. The 2021 UMCM Work Plan Mid-Year Evaluation was submitted and approved in Q3-2021. CalViva continues to monitor and revise policies and procedures based on DHCS, DMHC and other regulatory requirements.	None	None	Ongoing

2. Monitoring the UM Process

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

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>The leadership team meets daily to review reports to track turn-around times (TAT), current inventory and staffing resources. Daily goals, action plans, barriers are discussed and staffing adjustments are made in order to meet TAT goals.

Monthly Key Indicator (KIR) and Staffing reports are reviewed to track trends, results, opportunities and are discussed in the Medical Management Leadership Meetings. Action plans are developed/implemented as needed based on results/trends to mitigate risks with meeting requirements.

<table><tr><th></th><th colspan="3">Authorization Volume</th></tr><tr><th>Months</th><th>Approved</th><th>Modified</th><th>Denied</th></tr><tr><td>January</td><td>5,577</td><td>27</td><td>771</td></tr><tr><td>February</td><td>5,326</td><td>28</td><td>895</td></tr><tr><td>March</td><td>6,255</td><td>31</td><td>928</td></tr><tr><td>April</td><td>5,813</td><td>30</td><td>820</td></tr><tr><td>May</td><td>5,499</td><td>18</td><td>757</td></tr><tr><td>June</td><td>5,794</td><td>18</td><td>779</td></tr><tr><td>Totals</td><td>34,264</td><td>152</td><td>4,950</td></tr></table></td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2022</td><td>The leadership team meets daily to review reports to track turn-around times (TAT), current inventory and staffing resources. Daily goals, action plans, barriers are discussed and staffing adjustments are made in order to meet TAT goals.

Monthly Key Indicator (KIR) and Staffing reports are reviewed to track trends, results, opportunities and are discussed in the Medical Management Leadership Meetings. Action plans are developed/implemented as needed based on results/trends to mitigate risks with meeting requirements.</td><td>None identified</td><td>The authorization volume monitoring methodology was evaluated and changed in Q3 2021. It was restated to January 2021 to count authorizations by create date at the line level rolled up to one per create date. Historical counts were based on initial authorization create date only. The result of the change reflects a slight increase in the authorization counts which more accurately reflects productivity.</td><td>Ongoing</td></tr>
</table>

	Authorization Volume		
Months	**Approved**	**Modified**	**Denied**
January	6115	36	768
February	5864	38	938
March	7085	50	956
April	6578	48	832
May	6188	37	769
June	6707	37	803
July	6276	32	744
August	6256	38	857
September	6271	36	807
October	6620	38	870
November	6102	23	759
December	5939	50	733
2021 Totals	76001	463	9836

Prior year for comparison:

2020 Totals	**71,516**	**369**	**12,236**
2019 Totals	**75,473**	**506**	**15,073**

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

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

☐ ACTIVITY ON TARGET

☒ TOO SOON TO TELL</td>
<td>The plan met all TAT goals of 95% or better except for PreService Expedited with Extension/Deferral. For Q2 the sample size was 4 and one authorization did not meet in May 2021. The Referral specialist was coached and the pend process reviewed. There were no failures in June.

<table>
<tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th></tr>
<tr><td>Pre-Service Routine</td><td>99.09%</td><td>100%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>98.02%</td><td>100%</td></tr>
<tr><td>Pre-Service Expedited</td><td>97.69%</td><td>99.09%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>75%</td></tr>
<tr><td>Post Service</td><td>98.46%</td><td>100%</td></tr>
<tr><td>Post Service with Extension/Deferral</td><td>100%</td><td>100%</td></tr>
<tr><td>Concurrent</td><td>99.09%</td><td>100%</td></tr>
</table>
</td>
<td>Due to the extremely low sample size (4 authorizations), failures affect the percentage more strongly. The Referral Specialist mis-identified the pend request as standard and incorrect TAT dates were applied.</td>
<td>N/A</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2022</td>
<td>The Plan monitored TAT as planned throughout 2021. There was a dip in the TAT in May 2021 as explained in the Mid-Year report above. In the second half of 2021 the preservice TAT goal of 95% was not met in July and August. As a result the following next steps were implemented and subsequent months were within target:
1. Cross training of UM staff to support Prior Authorization functions
2. Weekly recruitment meetings to support external recruitment resources
3. Change staffing model to maximize productivity with current staff

<table>
<tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Pre-Service Routine</td><td>99%</td><td>100%</td><td>88%</td><td>98%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>98%</td><td>100%</td><td>86%</td><td>98%</td></tr>
<tr><td>Pre-Service Expedited</td><td>98%</td><td>99%</td><td>98%</td><td>98%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>75%</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service</td><td>98%</td><td>100%</td><td>99%</td><td>98%</td></tr>
<tr><td>Post Service with Extension/Deferral</td><td>100%</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Concurrent</td><td>99%</td><td>100%</td><td>100%</td><td>99%</td></tr>
</table>
</td>
<td>Turn Around times were impacted in July and August by the following:

1. Increase in Urgent referrals due to perceived urgency to perform procedures and diagnostic testing before potential lock down due to COVID surge in July. This required shifting of resources from processing Standard referrals and Routine deferral to support tight management of Urgent referrals.
2. Staffing impact:
a. absenteeism due to COVID (Staff contracting COVID or caring for family members with COVID)
b. Attrition of staff due to inability to recruit timely due lack of qualified applicants due to COVID impacts to hiring.</td>
<td>Teams addressed staffing gaps and improved recruitment strategies through weekly job fairs beginning in Q3.</td>
<td>Ongoing</td>
</tr>
</table>

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	IRR testing and training will be held Q3-4 2021	None identified	New optional annual training was developed in preparation for annual IRR testing.	12/31/2021
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Following InterQual IRR prep training, the Change Health (formerly McKesson) InterQual IRR modules were administered to the Physician Reviewers and the non-physician clinical staff requiring a minimum score of 90% to pass. Overall pass score was 96%	None identified	New optional annual training was developed in preparation for annual IRR testing.	12/31/2021

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 Quality Improvement / Utilization Management (QI/UM) committees and is aggregated and reviewed for additional actions and recommendations.	Ongoing

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Appeals data is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.

Turnaround Time Compliance for resolved expedited and standard appeals = 99.76% or 421 out of 422 cases.
<table>
<tr><th colspan="3">2021 Semi-Annual Count of Appeal Type</th></tr>
<tr><td>Appeal Type</td><td>Case Count</td><td>Percentage</td></tr>
<tr><td>Overturn</td><td>174</td><td>41.23%</td></tr>
<tr><td>Partial Uphold</td><td>6</td><td>1.42%</td></tr>
<tr><td>Uphold</td><td>237</td><td>56.16%</td></tr>
<tr><td>Withdrawal</td><td>5</td><td>1.18%</td></tr>
<tr><td>Case Total</td><td>422</td><td></td></tr>
</table>
</td>
<td>Pharmacy & NIA appeals remain two top trends during the review period. A barrier can be attributed due to insufficient documentation and records submitted by the providers requesting the services and triggering the initial denial.</td>
<td>A&G facilitates any needed member care during the review. Additionally, NIA and Pharmacy appeals are reviewed and reported on the monthly CVH A&G Dashboard and on the UMQI quarterly reports.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2022</td>
<td>Appeals data is a consistent component of UM/QI and is tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.

Appeals of UM Appeal determinations for time frame January – December 2021 Turnaround Time Compliance for Appeals = 99.76% or 826 out of 828 cases.
<table>
<tr><th colspan="3">2021 Annual Count of Appeal Type</th></tr>
<tr><td>Appeal Type</td><td>Case Count</td><td>Percentage</td></tr>
<tr><td>Overturn</td><td>361</td><td>43.6%</td></tr>
<tr><td>Partial Uphold</td><td>14</td><td>1.69%</td></tr>
<tr><td>Uphold</td><td>443</td><td>53.5%</td></tr>
<tr><td>Withdrawal</td><td>10</td><td>1.21%</td></tr>
<tr><td>Case Total</td><td>828</td><td></td></tr>
</table>
</td>
<td>None identified</td>
<td>A&G continued to facilitate any needed member care during the review period for care, services and pharmacy.</td>
<td>Ongoing</td>
</tr>
</table>

3. Monitoring Utilization Metrics

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

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

☐ ACTIVITY ON TARGET

☒ TOO SOON TO TELL</td>
<td>The Plan continued care management initiatives for all members. Interdisciplinary meetings occur weekly with CalViva Health and Daily with Case Management and Public Programs teams.</td>
<td>COVID-19 and the various states of emergency continue to impact utilization patterns and our target reduction of admissions and length of stay. The CalViva Health service has experienced the following impacts as of mid-year:
1. Central Valley Hospital surges beyond capacity requiring transfer of members beyond their service area for treatment.
2. Significant increase in ICU admissions which to an overall increase in length of stay.
3. Decreased available post-acute beds due to facility staffing being impacted by COVID-19.</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2022</td>
<td>The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout 2021 including daily UM huddles and weekly huddles with key hospitals.

Results of our goals to reduce admissions and average length of stay (ALOS) by 10%, based on claims utilization reflect admissions were below (met) target for SPD but TANF and MCE populations increased. The ALOS was higher than goal (did not meet) for all populations.

2021 Admissions PTMPY
<table>
<tr><th>Product</th><th>YTD</th><th>Annual Goal</th><th>% Diff</th></tr>
<tr><td>TANF</td><td>53.18</td><td>51.11</td><td>3.89%</td></tr>
<tr><td>SPD</td><td>154.71</td><td>175.94</td><td>-13.72%</td></tr>
<tr><td>MCE</td><td>137.85</td><td>88.54</td><td>35.77%</td></tr>
</table>
2021 Average Length of Stay
<table>
<tr><th>Product</th><th>YTD</th><th>Annual Goal</th><th>% Diff</th></tr>
<tr><td>TANF</td><td>4.10</td><td>3.81</td><td>7.14%</td></tr>
<tr><td>SPD</td><td>6.29</td><td>6.22</td><td>1.05%</td></tr>
<tr><td>MCE</td><td>5.31</td><td>4.85</td><td>8.59%</td></tr>
</table>
</td>
<td>Inability to execute on-site hospital strategy due to COVID-19.

Length of COVID-19 State of Emergency

Long stay COVID admissions</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Quarterly PPG UM data presented at CalViva Management Oversight Meetings. Quarterly JOMs with PPGs reviewed shifts in utilization.	COVID-19 has greatly shifted utilizations patterns and normal UM workflows.	ADT data feed made available to each PPG to allow for tracking of discharges. Population Health spreadsheets shared with PPGs with members stratified by acuity.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Quarterly PPG UM data presented at CalViva Management Oversight Meetings. Quarterly JOMs with PPGs review utilization patterns quarterly and compared with region. Central Valley had consistent COVID-19 related UM patterns of surges and ebbs.	COVID-19 shifted both utilization patterns and PPG UM resources. Staffing for all PPG departments including UM departments UM departments had issued due to COVID sick leave and resignations in healthcare.	Continued UM data presentation and analysis at monthly JOMs. New focus of real time population health metrics (stratification of members based on health conditions and acuity tiers, with outreach information and touch points documented) tied into the utilization metrics. This allowed the PPGs insight into their patient populations, and allows them real time insight that may benefit their internal UM efforts and case management outreach.	12/31/2021

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Q1 2021 PPG Profile and Narrative was provided 05/24/21 and reviewed at MOM on 06/08/21 PPG's profile reports are made available quarterly. Q2 - 8/30/21 Q3 - 11/29/21, Q4 - TBD Q1 & Q2 Annual Reviews - La Salle Medical Providers had 2 CAPs for Timeliness and Denial issues. - Central Valley Medical Providers had 2 CAPs for Denial and Accuracy issues. Pending Annual Reviews for Q3 & Q4 - Adventist Health Plan - First Choice Medical Group - Independence Medical Group - Santé Community Physicians Delegation oversight monitors CAPS to insure actions are implemented, documented and followed to completion. Both PPGs have implemented an action plan to ensure compliance with denial letters/template.	Due to COVID-19, some PPGs experienced staff turnover and shortage, which caused Decision TAT to drop below the 97%, required benchmark however stayed above 93%. Delegation oversight is working closely to improve the TAT to meet 100%. Some PPGs experienced denial issues. Due to a regulation change, PPGs also experienced accuracy issues, which resulted incorrect templates.	To address denial issues, Delegation Oversight provided La Salle and Central Valley with current denial templates. To address NOA issues Delegation Oversight developed a new training. La Salle, Central Valley, Adventist, First Choice, IMG and Santé will have completed the training in August 2021. Delegation Oversight launched a new Web based audit application that is interactive with the PPGs. The new application has expanded audit scope and new audit modalities such as inspection, evidence submission, interviews and, process walk through. Additionally, the new audit scope scores the delegates by focus areas: Program structure, Decision Criteria, Access to staff, Timeliness, Accuracy, Denials, Care Coordination, and Delegation. Issues identified during an audit are communicated via the tool to the PPG for awareness and opportunity to provide additional evidences. All issues non-remediated during the audit are transferred to an issue management module for tracking of corrective actions and retesting of areas that failed prior to closing the CAR. The New application also enables performance analysis across PPGs to identify improvement opportunities across all delegated groups.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Q3 2021 PPG Profile and Narrative was provided 11/29/2021 and will be reviewed at MOM. Data analysis for claims and authorizations reflected expected operation variations due to COVID. No major outliers were identified and trends demonstrate consistent results. CalViva PPG profile reports are made available quarterly. Q4 – 2/26/2022, Q1 2022 – 05/27/2022, Q2 2022 – 08/27/2022 CAPS are monitored by the Delegation Oversight team to ensure actions are implemented, documented and followed to completion. Q3 & Q4 Annual Reviews - Adventist Health Plan had 3 CAPs for Timeliness, Denials and Accuracy issues. - First Choice Medical Group had 2 CAPs for Timeliness and Denials issues. - Independence Medical Group had 3 CAPs for Timeliness, Denials and Accuracy issues. - Santé Community Physicians had 2 CAPs for Timeliness and Denials issues. Pending Annual Reviews for Q1 & Q2 2022 - Central Valley Medical Providers - La Salle Medical Associates	Due to COVID-19, some PPGs experienced staff turnover and shortage, which caused Decision TAT to drop below the 97% for Independence Medical Group and Santé Community Physicians. Delegation Oversight is working closely to improve the TAT to meet 100%. Some PPGs experienced issues with denial notification compliance due to new member notification templates issued by DHCS which included translation requirements that were not able to be implemented until late 2021.	None	Ongoing

4. Monitoring Coordination with Other Programs and Vendor Oversight

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 Emergency Department utilization o Overall health care costs o Member Satisfaction	Dedicated staff of Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs), Licensed Marriage Family Therapists (LMFTs), 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Number of Health Information Forms (HIFs) completed in January-June by member and returned or Envolve People Care outreach was 1,525 and 96 members subsequently referred to Case Management through June. Total members managed through Q2 across physical, behavioral health, and Transitional Case Management programs was 2,021. Outcome measures include: readmission rates, Emergency Department (ED) utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Physical Health, Behavioral Health, & Transitional Case Management & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2021 & 3/31/2021 & remained eligible 90 days after case open date. 463 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 9.3% difference • Volume of ED claims/1000/year decreased by 118 • Total health care costs reduction primarily related to reduction in inpatient costs, some decrease in outpatient services and increase in pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 98 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the Case Management and reported the goals they worked on improved understanding of their health Quality of Life Section 10.2% improvement in ability to care for self/family post CM (53.1%) vs pre Case Management (42.9%); 93.9% (92/98) of respondents reported Case Management exceed their expectations.	None	None identified	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Number of HIFs completed in January – December 2021 by member and returned or EPC outreach was 2,846; 807 members subsequently referred to CM. Total members managed through Q4 2021 across physical, behavioral health, and TCM programs was 2,625. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Results reported through Q3 include members with active or closed case on or between 1/1/2021 & 9/30/2021 & remained eligible 90 days after case open date. 1,079members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 9.3% decrease in readmission rate. • Volume of ED claims/1000/year decreased by 1,071 • Total health care costs reduction primarily related to reduction in inpatient costs, some decrease in outpatient services and increase in pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 175 members were successfully contacted Q1 through Q4 • Care Team Satisfaction - overall members were satisfied with the help they received from the CM and reported the goals they worked on improved understanding of their health • Quality of Life 9.1% increase in ability to care for self/family post CM (61.7%) vs pre-CM (52.6%); 94.9% (166/175) of respondents reported CM exceeded their expectations	Decreased referrals from Concurrent Review to some programs due to COVID related complications for Members. Staffing constraints in Q3 and Q4, as well as changes in the TCM staffing and work process.	Addressed staffing constraints with new position approvals.	Ongoing

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 (PCM)	☒ 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: ○ 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 Notice of Pregnancy (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

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

Mid-Year Report
 	
☒ **ACTIVITY ON TARGET**
 	
☐ **TOO SOON TO TELL**
	Referrals decreased from 555 in Q1 to 399 in Q2. Through Q2 449 members managed in PCM program. Quarterly average engagement rate increased from 23%in Q1 to 28% in Q2 with YTD average 25.5%.
	
	Texting portion of program on hold while texting policy under review.
	
	Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. In addition the rate of pre-term delivery of high risk members managed is compared to high risk members not managed. Results reported in Q1 for 2021 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed.
	
	• 1,421 members met the outcome inclusion criteria for visits; 442 members met preterm delivery criteria
	• Members enrolled in the High Risk Pregnancy Program demonstrated:
	  ○ 4.4% greater compliance in completing the first prenatal visit within their first trimester,
	  ○ 3.4% greater compliance in completing their post-partum visit
	  ○ 2.4% less pre-term deliveries in high risk members
		None identified	None	Ongoing

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

Annual Evaluation
 	
☒ **MET OBJECTIVES**
 	
☒ **CONTINUE ACTIVITY IN 2022**
	Referrals – 1,686 Q1-Q4 2021 with average engagement rate 23%. Through Q4 617 members managed in PCM program; Lower than number managed in 2020 (943).
	
	Texting portion of program on hold while texting policy under review.
	
	Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 7 & 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition the rate of pre-term delivery of high risk members managed is compared to high risk members not managed. Results reported through Q3 2021 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed.
	• 247 members met the outcome inclusion criteria for visits; 121 members met preterm delivery criteria
	• Members enrolled in the Pregnancy Program demonstrated:
	  ○ 5.3% greater compliance in completing the first prenatal visit within their first trimester
	  ○ 3.5% greater compliance in completing their post-partum visit
	  ○ 1.8% less pre-term deliveries in high risk members
	Pregnancy Program mailings: January through December
	• NOP mailings 9,458
	• Pregnancy mailings 1,715
	Post-delivery packets 758
		None identified	None	Ongoing

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 Emergency Department 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Data reported is a subset of information provided in 4.1.Referrals to behavioral health program increased from 254 in Q1 to 266 in Q2. Total members managed increased from 220 in Q1 to 236 in Q2. Total members managed through Q2 was 340. Calendar Year engagement rate 49%. Outcome measures include: readmission rates, Emergency Department utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Behavioral Health Case Management & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2021 & 3/31/2021 & remained eligible. Outcome results are consolidated across Physical Health, Behavioral Health, & Transitional Case Management programs and are reported in 4.1.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Data reported is a subset of information provided in 4.1.Referrals to behavioral health program Q1-Q4 2021 1,036. Total members managed increased in 2021 to 638 compared to 496 in 2020. Overall engagement rate 47.4%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Results reported through Q3 include members with active or closed case on or between 1/1/2021 & 9/30/2021 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	None identified	None	Ongoing

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Disease Management program continues for asthma, diabetes and heart failure. Ongoing program monitoring is conducted to assure that member needs are met. Program elements include: • educational materials and information about the program are sent to enrolled CVH members. • outbound telephonic interventions are conducted • referrals to case management and other programs as needed. Disease management member facing materials transitioned to pre-approved Krames materials. This refreshed the educational information and assured that members receive up-to-date, clinically validated information. Review of prevalence data to affirm selection of Disease Management conditions is in progress.	None identified	None	Ongoing Completed 05/07/2021 On Track
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Disease Management program continues for asthma, diabetes and heart failure: • educational materials and information about the program sent • outbound telephonic interventions continue • referral processes continue Ongoing program monitoring continues to assure that member needs are met. Review of prevalence data to affirm selection of Disease Management conditions is in progress.	None identified	None	Ongoing Ongoing Completed

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly PA statistics are tracked and reported quarterly in the UM/QI meeting. Active engagement with Pharmacy and existing narcotic prior authorization requirements continue as planned. Key SHP Quarterly meeting topics include • New Medi-Cal Rx go live date announced as 1/1/22. Workgroup has reinitiated and all deliverables are being reassessed. • AB1114 on hold by DHCS, no ETA on restart date. • A&G trends and concerns reviewed at SHP meeting and tracking is continued. Some improvement seen in some providers. • IRR results for q1 and q2 2021 presented and Envolve met goal of 95% for both quarters.	None identified	Narcotic Limits enacted 10/2019 based on CDC guidelines	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	• Medi-Cal RX Go-live activities completed and program launched 1/1/22. • AB1114 - Still no final APL or restart date but some activities were incorporated into Medi-Cal RX program. More information from DHCS likely in 2022 to refine this program. • A&G trends tracked in 2021with some improvement seen in some providers. • IRR results met standard in all quarters of 2021 with 95% or better except Q3 which missed target with a score of 94.17%. Q4 results are pending LAGS closure and transition/care of patients to new providers completed with success (Opioid/Chronic Pain)	None	• Medi-Cal RX issues will be tracked post go-live 1/1/22 to assess impact on patient care • DUR programs in 2022 based on data from Medi-Cal RX • Revised UMQI reporting for pharmacy data starting in Q1 2022 will be required due to the Medi-Cal RX transition. • A&G and PA related issues will be based on medical benefit in 2022 • IRR will be based on medical benefit drugs in 2022	Ongoing in 2022 with some program modifications due to Medi-Cal Rx implementation.

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. During the period January through July 2021, MHN received 261 referrals from Fresno, Kings and Madera counties. MHN referred 7 members to the county for Specialty Mental Health or Substance Abuse Services.	None Identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	The bidirectional referral process for CalViva counties continued to serve members in 2021, both via fax using the clinical screening tool and telephonically. Clinical rounds with MHN psychiatrists as well as HN medical physicians occurred weekly to ensure that members were receiving good coordinated and integrated care. PCPs continue to be offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. 907 calls were received from members 1/1/21–12/31/21. There was a 15% increase in volume of calls. Of those calls, 203 were sent to clinical care managers. Of those, 10were referred to County Specialty Mental Health Services. The remainder were assisted with referrals to MHN providers or case management services. Behavioral health care managers continue to attend medical concurrent review rounds to ensure that	None Identified	None	Ongoing

	member mental health and substance abuse needs are met. BHCMs also conduct rounds with plan psychiatrists to obtain clinical consultation on complex cases as well as decisions regarding denials and modifications.			

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	In Q1 2021, 15 of the 15 metrics met or exceeded their targets. In Q2 2021, 15 of the 15 metrics with targets met or exceeded their targets. The ABA authorization timeliness metric result was slightly under 100%, but it rounded to 100% and exceeded the threshold for action of 95%.	None identified	N/A	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	In Q3 2021, 15 of the 15 metrics with targets met or exceeded their targets.	• Psychiatry is an underserved specialty in California, particularly for the Medi-Cal population. There are not enough Psychiatrists in practice who are willing to treat this population. • Provider dissatisfaction with current contract rates.	Network availability and adequacy interventions identified in 2021, continue in order to achieve desired results by increasing adequacy and access to services.	Ongoing

5. Monitoring Activities for Special Populations

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

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The CCS identification rates for the CVH under 21 population continue to trend above 5%.

2021 Monthly CCS Identification Rates
<table>
<tr><th></th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>8.39%</td><td>7.32%</td><td>7.34%</td><td>7.68%</td></tr>
<tr><td>Feb</td><td>8.51%</td><td>7.40%</td><td>7.48%</td><td>7.80%</td></tr>
<tr><td>Mar</td><td>8.47%</td><td>7.37%</td><td>7.43%</td><td>7.76%</td></tr>
<tr><td>Apr</td><td>8.42%</td><td>7.35%</td><td>7.41%</td><td>7.72%</td></tr>
<tr><td>May</td><td>8.38%</td><td>7.29%</td><td>7.38%</td><td>7.68%</td></tr>
<tr><td>Jun</td><td>8.53%</td><td>7.47%</td><td>7.61%</td><td>7.87%</td></tr>
</table></td>
<td>No barriers identified</td>
<td>N/A</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2022</td>
<td>PPS continued efforts to identify and refer cases to CCS in collaboration with supporting departments such as UM and Pharmacy. The team exceeded goal of minimum 5% identification rate for the year.

2021 Monthly CCS Identification Rates
<table>
<tr><th>Quarter</th><th>2020</th><th>2021</th></tr>
<tr><td>Q1</td><td>8.34%</td><td>8.35%</td></tr>
<tr><td>Q2</td><td>8.23%</td><td>8.38%</td></tr>
<tr><td>Q3</td><td>8.22%</td><td>8.46%</td></tr>
<tr><td>Q4</td><td>8.27%</td><td>8.50%</td></tr>
</table></td>
<td>The CA Central Valley CCS offices struggled with staffing and backlog of determinations for CCS which created additional pending cases for CVH. Additionally, some CA Central Valley CCS offices discontinued taking phone calls from the MCP plans to assist with issues and concerns.</td>
<td>1. Provider communication was provided in effort to improve provider self referrals to CCS.
2. Plan leadership engaged conversations with multiple CCS offices to establish a plan for issues and concerns as well as updates on pending cases.
3. Plan leadership also identified an opportunity to engage the large facilities in the area to assist with communication on pending cases.</td>
<td>On-going</td>
</tr>
</table>

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 419 SPD members (SSI Dual and Non-Dual) have been managed 2020 through Q2. This includes PH CM, BH CM, TCM & OB CM, as well as both complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members for Q1 and Q2 (100% on time).	None identified.	N/A	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2022**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 1028 SPD members (SSI Dual and Non Dual) have been managed Q1-Q4 2021. This includes PH CM, BH CM, TCM & OB CM, as well as both co 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 complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members YTD 2021: 100%	None None	None None	Ongoing Ongoing

Item #12

Attachment 12.C

2022 Utilization Management Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Marianne Armstrong Utilization Management

COMMITTEE DATE: February 17, 2022

SUBJECT: Utilization Management Program Description Change Summary

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Header	Updated Health Net Logo
Throughout	Multiple	Updated year from 2021 to 2022
ii-iii	Table of Contents	Page numbering and section headers updated to align with content
5	Mission	Health Net mission updated. Centene mission removed.
5	UM Purpose	"Vision" and "mission" changed to "purpose"
6	Goals and Objectives	Hospital added to the CM and discharge planning evaluation coordination.
10, 13, 16, 17, 27, 28, 29	Multiple	Added chronic condition management to statements referencing disease management.
15	Pharmacy	Revised section to only apply to medical benefit medications per pharmacy benefit medications management shift to Medi-Cal Rx
24	Evaluation of Medical Technologies and Procedures	Section re-written
24	Satisfaction with UM Process	Format correction to separate the section – no content change
28	Senior VPPHCO	Title change from Senior Vice President Medical Management to Senior Vice President Population Health and Clinical Operations
28 35 38	VPPHCO, UM/CM Program Work Plan Approval	Title change from Vice President Medical Management to Vice President Population Health and Clinical Operations
30	HN Community Solutions Committee	Updated reporting review from biannually to quarterly and removed reference to the Dental QIC reporting into HNCS

~~2021~~2022

Health Net Community Solutions, Inc.
CalViva Health
Utilization Management (UM) Program Description

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

The CalViva Health Utilization Management (UM) Program Description summarizes the policies, processes and standards that govern UM programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization Management staff in the program execution of both delegated and non-delegated models.

The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence or concerns for the plan's fiscal performance.

The Utilization Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net or CalViva Health.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, medical records and claims functions, where appropriate.

Confidentiality

Health Net 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. Health Net 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 UM Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information is regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, are available to all HN staff via the corporate intranet website, “Centene University”.

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net’s Information Systems consist of various integrated subsystem databases, which support UM. The major sources of data utilized for UM activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Medical Management
- Customer Service
- Appeals and Grievance
- Case Management

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, Medical

Advisory Council, Customer Service and Claims. Additional sources of information include member and provider feedback.

Section 2

Mission

~~Centene Corporation~~

~~"Transforming the health of the community one person at a time by offering unique, cost-effective coverage solutions for low-income populations through locally based health plans and a wide range of specialty services."~~

Health Net Mission ~~and Purpose~~

Transforming the health of the community one person at a time by offering unique, cost-effective coverage solutions for low-income populations through locally based health plans and a wide range of specialty services.~~The mission of Health Net is:~~

~~"Better health outcomes at lower costs."~~

~~The purpose of Health Net is:~~

~~"Transforming the health of our communities, one person at a time"~~

State Health Programs UM ~~Vision~~Purpose

The ~~mission~~ purpose of Health Net's State Health Programs Utilization Management Program is to design and implement programs that facilitate the highest level of the member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the Health Net Medi-Cal Contract, and State and Federal regulations.

The Utilization Management Program identifies and manages members who are currently accessing health care services.

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address access and timeliness of care
- Initiate documentation to support investigation of potential quality of care issues
- Identify and resolve problems that result in excessive resource utilization and inefficient delivery of health care services
- Identify and resolve problems that result in under or over utilization

- Assess the effects of cost containment activities on the quality of care delivered
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of members through coordination with Case Management and Public Health Programs
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs

Goals and Objectives

The Program has the following specific objectives:

- Monitor consistency in application of all UM functions for members
- Review and evaluate health care services for quality, medical necessity and appropriate levels of care
- Identify actual and potential quality issues through this review process and refer to the appropriate quality management personnel
- Evaluate the need for case management and discharge planning in coordination with the hospital and the PCP
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Case Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Provider Oversight to determine delegation status for UM activities
- Evaluate the UM Program on a regular basis to respond to changes in the health care environment
- Collaborate with county Public Health-Linked Programs

Section 3

Description of Program

Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed for all State Health Program members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program is under the clinical supervision of the Health Net Chief Medical Officer who has substantial involvement in developing and implementing the Program.

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities includes timely, direct referrals, preauthorization's, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code 1367.01.

Through Health Net's Provider Oversight Process, Participating Provider Groups (PPGs) may be delegated the responsibility for the aforementioned UM activities.

Health Net has developed, implemented, and continuously updates and improves the UM Program to ensure appropriate processes are in place to review and approve the provision of medically necessary covered services. The plan has qualified staff who are responsible for the UM Program. The plan separates its medical decisions from fiscal and administrative management to assure the medical decisions are not unduly influenced by fiscal and administrative management. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 17, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) Policy Letters. Additionally, Health Net's State Health Programs Utilization Management Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and MRMIB for Utilization Management and Care Coordination activities.

The Program is conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq.

Prior authorization is not required for emergency and sensitive services, family planning services, annual preventive care visits to an OB/GYN, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective pregnancy termination, basic obstetrical care, minor consent services, and

immunizations at the Local Health Department (LHD). Utilization Management policies and procedures are available to members and providers upon request.

Health Net Utilization Management nurses provide decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources to support the plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Health Net and its delegated PPGs do not require prior authorization for emergency and sensitive services as outlined under the Scope of Utilization Management section of the UM Program Description. Direct referrals enhance the member's ability to directly access specialists such as dermatologists, podiatrists, ophthalmologists and OB/GYNs.

Preauthorization / Prior Authorization

Health Net requires delegated PPGs to create and maintain programs, policies and procedures, which at a minimum, meet Health Net's established standards. Health Net Utilization Management staff determines pre-service decisions for request types that are not delegated.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuity of care services. Pre-service decisions are required for elective inpatient admissions, referrals for selected ambulatory surgery, durable medical equipment, home IV infusion, and selected diagnostic and radiology procedures. The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are medically necessary, covered by the member's benefit plan, the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health appropriateness that are based on sound clinical evidence, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

Health Net has established a referral tracking process to track and monitor referrals requiring prior authorization. Health Net's referral tracking system includes authorized, denied, deferred and/or modified referrals. Finally, the process of referral tracking includes monitoring of timeliness.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for hospitalized patients. Any review for continued benefit coverage and provision of an approved ongoing course of treatment over a period of time or number of treatments. Concurrent review is a member-centric process that includes medical necessity review, discharge and transitional care planning and coordination of care.

A goal of CCR is to support the Member and Member's healthcare team to optimize health outcomes in the event the Member experiences a health status change. This is done through CCR work and advocacy with the PPG, Member and the Interdisciplinary Care Team to:

1) Ensure services are accessed timely,
2) Educate the Member's healthcare team on the Member's benefit structure and resources,
3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate referrals to appropriate Member resources, such as Managed Health Network, Inc. (MHN), case management, and community resources.

The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and Member care management support programs. Health Net nurses, Medical Directors and delegated partners conduct onsite or telephonic concurrent review of patients admitted to hospitals, rehabilitation units, or skilled nursing facilities. HN may monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status. The inpatient review process occurs within 1 business day from the day of hospital admission or within 1 business day of notification of admission and continues throughout the patient's hospital stay. The review process includes application of standardized nationally recognized criteria for medical appropriateness review, levels of care, discharge planning, and transitional care management including assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses use nationally recognized criteria, which includes InterQual® criteria, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy Policy to assess the appropriateness of the admission, level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the capacity of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

Health Net non-clinical staff supports pre-service and concurrent review with data entry, receipt and documentation of notification, and receipt and attachment of clinical content.

Reviews of requests that do not meet guidelines or criteria for certification are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess for member specific case management and disease/ chronic condition management needs and refer such cases to case management for evaluation. Concurrent Review Nurses collaborate with Case Managers on all members identified in active case management.

CCR goals include supporting the member and member's healthcare team to optimize health outcomes in the event the member experiences a health status change. This is done through work and advocacy with the PPG, member and/or the interdisciplinary care team to 1) ensure services are accessed timely, 2) educate to the member's healthcare team on the member's benefit structure and resources, 3) facilitate expeditious authorization of services when appropriate, and 4) facilitate referrals to appropriate member resources, where appropriate, such as MHN, case management, and community resources. The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and member care management support programs.

Discharge Planning

HN and/ or delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care in conjunction with the practitioner, member, and member's family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the member's admission, whenever possible. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to, home health care, durable medical equipment and/or transfers to a lower level of care (e.g., skilled nursing facility or acute rehabilitation).

HN Concurrent Review nurses identify potential case management cases and refer such cases to Case Management and other outpatient programs for post discharge evaluation and/or services

The criteria used for evaluating and guiding timely discharge planning is nationally recognized criteria including InterQual®, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy policy. Discharge planning is part of the Utilization/Care Management Program and includes, but is not limited to:

- Assessment of continuity of care needs.

- Assessment of member's support system to determine necessary services and support needs.
- Development of a discharge plan of care based on short-term medical/psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

Retrospective Review

Delegated PPGs conduct retrospective review activities in compliance with Health Net standards. Conversely, Health Net performs this activity for non-delegated providers.

Health Net and its delegated partners perform post-service review of medical records when services rendered have not been authorized. Any services failing to meet criteria are forwarded to Health Net and delegated partners' medical directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization against documented medical record evidence that the member received the services and that services meet the criteria for medical necessity. Post-service review determinations are processed within the timeframes specific to the product line after obtaining all necessary information required to review the request.

Second Opinion

A member, member's authorized representative or provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned members who request a second opinion to a participating physician within their medical group. If a member requests a second opinion about specialty care from a participating specialist physician who practices outside of the member's PCP's medical group, the request will be forwarded to Health Net medical management for review. Health Net does not routinely require prior authorization for such services given that the second opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. There is no cost to the member for second opinion either in network, or authorized out of network.

Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, Health Net will arrange for the member to obtain a second opinion out-of-network at no cost to the member.

Management of Information Systems

Health Net utilizes automated documentation systems to enter, view, and audit medical management information.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver quality, cost effective medical services to members and their dependents. Selection of a Primary Care Physician (PCP) and establishment of a relationship with that physician is the foundation for members obtaining appropriate health care services. PCPs include Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access / Availability to Health Care Services

An ongoing review of the Health Plan's network is conducted to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to members' needs. Site and medical record reviews are also conducted to ensure that access to care and services, and the confidentiality of member records are met. Recruitment will take place in areas where unmet needs are identified.

Coordination with Quality Improvement Programs

The Health Net State Health Programs Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the appropriate committees. Corrective actions, as appropriate, are required to continually improve care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate members for Public Health and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers
- Identifies and refers appropriate members for Health Education Services, including tobacco cessation and obesity prevention programs.

- Identifies and refers appropriate members for Cultural and Linguistic Services, including members needing translation of documents or interpreter service for office visits
- Offers dDisease/chronic condition mManagement (DM) Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. Disease/chronic condition managementDM activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

MHN Services is the behavioral health subsidiary of HNCS and HNCA that administers the Medi-Cal mild to moderate mental health services carved in to the Managed Care Plans.

MHN provides early and periodic screening, diagnosis and treatment services for members ages 0 to 21. These services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum practicable, the functioning of the members diagnosed with Autism Spectrum Disorder (ASD) as well as other disorders that result in behavioral disturbances.

MHN will manage specified mental health benefits to adults and children who are diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment as well as members seeking other services not provided by MHN, will be referred to the County Specialty MHP.

MHN's utilization management decisions are based on Change Healthcare's InterQual Level of Care Criteria; MHN's evidence-based internal criteria; and the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). MHN's evidence-based internal criteria guidelines are based on a variety of clinical sources such as the evidence-based American Psychiatric Association Practice Guidelines.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). MHN and Health Net do not impose Quantitative (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a

network mental health provider. CalViva will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered a ~~Non-Quantitative Treatment Limitation (~~NQTL~~)~~ under the definitions of the federal rules. MHN may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by MHN and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental health and substance use disorder benefits. Factors considered in the determination process will be supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

The core objective of utilization management at MHN is to manage available behavioral health care benefits to achieve the best possible clinical outcomes for members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, MHN has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The MHN utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by MHN do not require authorization. All MHN staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors. MHN staff providing services to CalViva members are located at MHN offices in California.

MHN coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, LLC Health Net Pharmac~~y~~eutical ~~Services~~Department, administers and manages the ~~prescription~~ medical drug benefit ~~including select injectable~~ for Health Net's Medi-Cal membership. Programs are

developed to ensure appropriate utilization of medications: ~~Pharmacy~~ Medical Benefit Drug Prior Authorization, ~~Recommended Drug List/formulary management,~~ Education programs for physicians~~, pharmacies~~ and members, and Pharmaceutical Safety.

~~The basic Medi-Cal "formulary" is prescribed by the state; however managed care organizations have latitude within each drug class for equivalent substitution.~~ A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered ~~for placement on the formulary~~under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

Continuity and Coordination of Care

Several mechanisms are implemented to monitor, evaluate and facilitate continuity and coordination of care among its members served by delegated and non-delegated providers. These activities include:

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating members and their families to implement a smooth and coordinated plan of care.

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers. Care Managers are patient advocates who ensure that these members receive timely and uninterrupted medical care during the transition process.

- Implementation of specific population-based, ~~disease~~ chronic condition management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal case management, asthma or diabetes.

Primary Care Physician responsibility:

The Primary Care Physician is responsible for the management and coordination of a member's complete medical care including initial and primary care, initiating specialty referral, and maintaining continuity of care to include coordination of specialty care, emergency services, and inpatient services.

Health Net supports the medical home model of primary care, and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours per week and have availability for urgent and emergent member needs 24 hours a day, 7 days a week.

As an additional aid to the primary care provider, Health Net provides nurse advice line 24 x 7. Health Net strives continually to meet the access and availability standards through our network relationships, member and provider education and triage services.

Health Promotion Programs

Be In Charge! ℠ Programs

CalViva Health provides the *Be In Charge!*℠ Programs for Medi-Cal members to help manage their health. These programs provide specific interventions to facilitate the member's individual 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 goal of the *Be In Charge!*℠ *Programs is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to have member engagement and to have preventive wellness, and chronic* ~~*care disease*~~*condition* management in accordance with national peer-reviewed published guidelines. Preventive medicine services, achieved through proactive education and active engagement of the members, promotes optimal health.

The *Be In Charge!*℠ Programs include:

- Disease/ Chronic Condition Management
- Weight Management Programs
- Health education classes and programs are offered in specific counties to target issues identified for the Medi-Cal population, such as asthma, diabetes, nutrition, heart health, hypertension and healthy pregnancy.

Nurse Advice Line

In addition to *Be in Charge!*℠ programs, the nurse advice line provides immediate symptom assessment and member education 24 hours a day, seven days a week. In addition to educating members how to better manage their health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is available in English and Spanish with interpreter services for other languages. Only California-licensed nurses assess, evaluate, triage or advise regarding the condition of an enrollee.

~~Disease~~ Chronic Condition Management

The *Be In Charge!*℠ ~~Disease~~ Chronic Condition Management Program increases awareness of self-care strategies and empowers participants to better manage their disease. The program targets high-risk members identified with chronic asthma, diabetes and heart failure conditions and encourages them to participate in the ~~disease~~ chronic condition management program. 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~~ chronic condition management are multichannel and come through provider, Case Management and member self-referrals.

Weight Management Programs

Members have access to a comprehensive Fit Families for Life-*Be In Charge!*℠ suite of programs. The Fit Families for Life-Home Edition is a 5-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. 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 center, community based organizations and provider clinics located in areas where CalViva Health members reside. The community classes are free to all CalViva Health members and the community. Providers should complete and fax a copy of the Fit Families for Life - *Be In Charge!*℠ Program Referral Form to the CalViva Health's Health Education Department to refer members to the Home Edition program.

Health Education Programs, Services and Resources

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

- Pregnancy Program – Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. 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 Program - Members have access to a health heart prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to 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 encourage members in accessing timely preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with depression, anxiety, stress, substance use, pain management, and insomnia.
- Health Promotion Incentive Programs - The Health Education Department (HED) partners with Quality Improvement Department to offer incentive programs to encourage members to access HEDIS related preventive health care services.
- Know Your Numbers Community Class and Screening Events - The HED 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 educational resources are 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, dental health, prenatal care, exercise and more. These materials are available in threshold languages.

- Health Education Member Request Form – Members complete a pre-stamped form to request free health education materials 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 or view some materials online at www.CalVivaHealth.org. They can also get CalViva Health's print resources at contracted providers and health education classes.
- Health Education Programs and Services Flyer – This flyer contains information on all health education programs and services offered to members and information on how to access services.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in English, Spanish and Hmong.
- Member Newsletter – Newsletter is mailed to members on a regular basis and covers various health topics and the most up-to-date information on health education programs and services.

Over and Under Utilization

All providers are required to submit to Health Net claim/encounter data for all services. Multiple methodologies are utilized to monitor under and over utilization, referral timeliness, provider appeals, denials and member appeals and grievances. The types of methods include:

- Annual on-site evaluation of network-wide PPGs Medi-Cal utilization management programs
- Over/Under utilization identified through member complaints tracking
- Focused audits
- Analysis of medical group-specific inpatient utilization, ER usage, and pharmacology data
- Evaluation of individual direct contract physician practice patterns

Also through these monitoring efforts, Health Net's Utilization Management Department regularly tracks its performance.

Through these comprehensive monitors, Health Net's Utilization Management Department:

- Measures compliance to guidelines
- Tracks performance against established goals
- Educates and addresses variances from agreed upon clinical criteria
- Conducts provider outreach programs to modify performance

Finally, Health Net completes the Quality Management education process with its contracted providers through local interaction with the regional Medical Directors at the

Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

Health Net's State Health Programs Utilization Management Program use the following guidelines to make medical necessity decisions (numbered in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

A. State law/guidelines (Title 22 CCR, Title 17 CCR, Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters, and California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v))
B. Plan-specific clinical policy (including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria);
C. Centene clinical policy (including Centene clinical policies in InterQual as custom content);
D. If no Plan, or Centene specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;
E. In the case of no guidance from A-D, additional information that the applicable Health Plan Medical Director will consider, when available, includes:
    1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
    2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
    3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
    4. Medical association publications; such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.;
    5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
    6. Published expert opinions, including in UpToDate;
    7. Opinion of health professionals in the area of specialty involved;
    8. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:

A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage

When state Medicaid coverage provisions conflict with the coverage provisions in Plan- or Centene-specific clinical policy, state Medicaid coverage provisions take precedence. Refer to the state Medicaid manual for any coverage provisions. Clinical policies, benefit

provision, guideline, protocol or criteria are available upon request per Federal and State regulatory guidelines.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's UM Program, medical decisions made by Plan or PPG medical directors will not be unduly influenced by fiscal or administrative management. In order to accomplish this, Health Net affirms that:

- Utilization management decisions are based on medical necessity and medical appropriateness
- Health Net does not compensate physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and attention is paid to the risk of under-utilization
- Health Net and its delegates distribute to all practitioners, providers,
- and employees a statement describing Health Net's policies and restrictions on financial incentives
- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service
- Health Net Regional Medi-Cal Medical Directors and the Vice President Medical Director for State Health Programs do not report to Health Net's Chief Financial Officer or its Marketing Director

Consistency of Application of Utilization Decision Criteria

Health Net's Regional Medical Director, Care Managers and CalViva Health Chief Medical Officer participate in biweekly regional Utilization Management rounds. At these meetings, a selection of appropriate inpatient admissions and outpatient services are reviewed and summarized. Problematic cases are discussed in detail to promote staff education and appropriate utilization. Potential PPG management issues are identified and referred to the Provider Oversight Department.

Inter-rater Reliability Review Process:

Health Net's Medical Directors and Registered Nurses who perform UM and CM activities all participate annually in the InterQual® Products Group Interrater Reliability (IRR) Program. The Acute, Home Care, Imaging, and Procedures modules may all be required, in adult and pediatric versions, depending upon the reviewer's job description. A passing score must be achieved, or corrective action plans are developed. IRR results are reported annually at the Health Net State Health Programs UMQI Committee Meeting.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

- Annual PPG oversight audit, which requires a file audit of denial files using Health Net Provider Delegation Audit Tool with Medi-Cal Addendum
- Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed

Standards of Timeliness of UM Decision Making

Health Net follows established time frames for internal and delegated PPG decision making to minimize any disruption in the provision of health care. The established time frames regarding medical necessity and authorization depend on the urgency of the clinical situation. Turnaround Time (TAT) Standards for requests are based on current DHCS, DMHC, and/or State regulatory guidelines, whichever guideline maintains the most stringent standard, is applied.

Health Net's delegated providers are informed of the decision timeliness standards in the Provider Operations Manual. A Health Net Medical Programs Manager, assessing the compliance of each medical group, performs an annual evaluation including review of timeliness. All requests for determination are communicated back to the member and the provider within the timeframes and methods dictated by the DHCS, DMHC, and/or State regulatory guidelines, whichever is the most stringent requirement.

Denials

A member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. He/she may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial letters into "threshold languages" in collaboration with Industry Collaboration Effort (ICE).

Rationale contained in denial letters includes a *summary denial reason/rationale* that is easily understandable for the member. In addition, a *detailed denial reason/rationale* is included which outlines benefit provisions, guidelines, protocols or similar criteria on which the denial is based.

Appeals

A licensed physician reviews all member medical necessity appeals.

CalViva Health does not delegate the appeals process. CalViva Health has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CalViva Health, CalViva Health is responsible for appeals for their members. However, Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net State Health Programs Medical Director. The case is forwarded to the CalViva Health CMO for review and final determination.

CalViva Health maintains well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials issued by CalViva Health, MHN or its delegates.

Each denial letter that is sent to the member includes the member's right to appeal and/or fair hearing, independent medical review, and instructions on how to initiate a routine or expedited appeal.

The member's right of appeal is communicated to the practitioners in the Provider Operations Manual and to the members in the copies of denial notifications sent. The Member Handbook also delineates the appeals process describing how to initiate an appeal verbally by contacting the Member Services Department by phone. The Member Services representative then forwards requests for member appeals to the Appeals and Grievances Department.

Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a member for medical services that have not yet been provided are considered to be member appeals.

Health Net Medical Directors will utilize board certified physician consultants from appropriate specialty areas, including behavioral health, to determine medical necessity when specialty specific input is deemed necessary.

Evaluation of Medical Technology and Procedures

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new

applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the HAYES Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.~~Health Net performs technology assessment through formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages. Health Net's Medical Policy Department provides support in the development of technology statements in response to specific requests and for proactively assessing current medical literature for new technology that may be sought by members.~~

~~Health Net utilizes nationally recognized primary sources for evidence based information including the Hayes Medical Technology Directory, Change Healthcare's InterQual criteria and information from nationally recognized evidence-based medical journals, colleges and academies. Health Net may also perform a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness, as reported in peer-reviewed journals, seek opinions and assessments by relevant specialists, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations and use reports and publications of government agencies (for example, the Food and Drug Administration [FDA], Centers for Disease Control [CDC], National Institutes of Health [NIH]).~~

~~Health Net Medical Policies are developed to guide utilization management decision making when there is no InterQual criterion or the InterQual criteria need to be revised to meet the needs of the population. These policies are developed through the review of the peer reviewed evidence based medical literature.~~
~~Once approved, it becomes established Health Net medical management policy, and providers and members have access to the information on Health Net's website. The~~

~~clinical criteria are reviewed at least annually by the policy committees or more frequently as dictated by current medical literature.~~

Satisfaction with the Utilization Management Process

At least annually, Health Net surveys members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the Health Net UMQI Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the Health Net UMQI Committee.

Communication Services

The Plan, MHN and the delegated partners provide access to Utilization Management staff for members and practitioners seeking information about the utilization management process and the authorization of care. Staff within Health Net, MHN and delegated partners are available at least eight hours a day during normal business days to receive and respond to inbound inquiries. In addition, Medi-Cal members have 24/7 access to the nurse advice line. Inbound and outbound communication regarding utilization management issues are accomplished through the following:

- Toll-free member/provider services telephone number/fax or email.
- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CalViva Health members upon request

The Plan will notify contracting health care providers, as well as, members and potential enrollees upon request of all services that require prior authorization, concurrent authorization or post-service authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Emergency Services

Health Net and its delegated PPGs provide geographically accessible coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition. Emergency services are covered both inside and outside the plan or network and do not require pre-authorization.

Evaluation of the Health Net State Health Programs UM Program Description and the UM Policies and Procedures

After Health Net completes its internal review and approval process, the CalViva Health UM Program Description is forwarded to CalViva Health for review and approval.

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Health Net's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Health Net Organizational Structure and Resources

Medical Management Resources

Health Net Chief Medical Officer

The 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 Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

The Chief Medical Officer has decision-making responsibilities for Health Net medical matters. The Chief Medical Officer oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other medical management leadership team members. Medical Management departments for which he/she has clinical oversight responsibility to include: Quality Improvement, Utilization Management, Case Management, Appeals and Grievances, Compliance, Program Accreditation and Disease/ Chronic Condition Management.

The Chief Medical Officer's responsibilities include, but are not limited to: leading the health plan in national medical management initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

Vice President Medical Director, State Health Programs

The Vice President Medical Director, State Health Programs (SHP), is responsible for Utilization Management and Case Management activities for Medi-Cal. In addition, the Vice President Medical Director is responsible for QI activities for these programs. The Vice President Medical Director is the chair of the Health Net Community Solutions Committee and is actively involved in implementing the SHP UM Program. The State Health Programs Vice President Medical Director reports to HN's Chief Medical Officer.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and case management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization Management staff and other Health Net staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Senior Vice President of ~~Medical Management (VPMM)~~Population Health and Clinical Operations (VPPHCO)

The Senior ~~VPMM~~ VPPHCO is a registered nurse with experience in utilization management and case management activities. The Senior ~~VPMM~~ VPPHCO is responsible for overseeing the activities of the Plan's Utilization Management and Case Management Programs. The Senior ~~VPMM~~ VPPHCO reports to the Plan Chief Operating Officer. The Senior ~~VPMM~~VPPHCO, in collaboration with the Vice President Medical Director (SHP), assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Healthcare Services (UM/CM) Resources

Vice President, ~~Medical Management~~Population Health and Clinical Operations

The Vice Presidents are responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and case/~~disease~~ chronic condition management. This individual is responsible for the organization-wide implementation, assessment and measurement of utilization management activities in order to improve the quality of care and services provided to the membership.

Director, Medical Management

The Directors are responsible for statewide oversight of the UM Program and:

- Oversee the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the member's benefit structure.
- Emphasizes continuity of transition of care, assisting members in obtaining access to care, and member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e. Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Case/~~Disease~~ Chronic Condition Management when appropriate,
- Management of out-of-area cases, and
- Monitoring effectiveness of delegated entities and contracted providers.
- All UM LVN, LCSW and RN staff is under the direct supervision of a Manager, HCS or UM, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of members to County CCS offices when eligible
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs

- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health

MHN Medical Director and MHN Medical Staff

The MHN Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of MHN behavioral health program and clinical policies, the MHN Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The MHN Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN members. The MHN Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the MHN QI Committee and to the Health Net Quality Improvement Committees. The MHN Medical Staff sits on the following committees: HN Quality Improvement Committee, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, the HN Medical Advisory Council, the MHN Quality Improvement Committee, and the MHN Utilization Management Committee. Additionally, Health Net's Medical Directors and UM/QI staff sits on MHN's QI and UM Committees.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Health Net Community Solutions Committee

The Health Net Community Solutions Committee reports directly to the Health Net Board of Directors. The committee is charged with the monitoring of the medical management and quality of care and services rendered to members within State Health Programs including identification and selection of opportunities for improvements, monitoring interventions and addressing UM and QI activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the Health Net Community Solutions Committee ~~biannually~~ quarterly reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI for this program. The Committee membership also includes practicing network physician representatives. The Health Net Community Solutions Committee is chaired by the Senior Medical Director for SHP and meets quarterly. ~~The SHP Dental UM/QI Committee reports to the Health Net Community Solutions Committee.~~

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs) and strategic partners (delegated partners).

Health Net has a thorough process in place to assess a potential delegate's readiness for delegation and to systematically monitor the performance. Health Net has designated Utilization Management (UM) Compliance Auditors to perform this evaluation. UM Compliance Auditors evaluate and monitor delegated partners annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities. Additionally, UM Compliance Auditors are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the Regional Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC).

Delegated partners are required to submit monthly/quarterly reports (for Medi-Cal) to Health Net. Reports are reviewed and assessed for content and feedback is given for reports submitted.

Responsibility of Delegation Oversight includes, but is not limited to:

A. Assessing and determining the appropriateness of delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

B. Performing ongoing monitoring of any open CAP items as requested by the Delegation Oversight Workgroup (DOW)/Delegation Oversight Committee (DOC). This may include additional file reviews, policy and procedure reviews, and educational sessions, on site meetings to ensure the delegated partner is meeting compliance.
C. Performing any additional delegation oversight activities as requested by the DOC.

Delegation Oversight Committee

A. Reviews Delegation Oversight activities and recommendations of the DOW and, as needed identifies corrective actions specific to delegated partner(s) that are not meeting compliance. The DOC will review the results of annual or focused audits, the corrective actions recommended and already undertaken by the delegate, minutes from the follow-up meetings or correspondence with the delegate, and results of follow-up audits, as appropriate.

B. As needed, initiates remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing monitoring/oversight.
- Freezing membership.
- Revoking delegation.
- Terminating the organization's contract with Health Net.
- Imposing financial penalties as allowed per contract.
- Removes sanctions, if appropriate.

Sub-delegation

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate's program.

A review of the contracted delegates shall be performed annually. More frequent assessments shall be performed, as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net's review upon request.

Section 6

Utilization and Case Management (UM/CM) Program Evaluation

UM/CM Program Evaluation

Health Net's Vice President of Medical Management annually prepares the CalViva Health Utilization/Care Management Program Evaluation and presents the evaluation to CalViva Health for review.

The annual evaluation of the CalViva Health Utilization/Care Management Program provides structure for the determination of program effectiveness and the impact of the program on members and providers. The process identifies program strengths and barriers, improvement opportunities and activities not completed, in addition to assessing demographics and effectiveness of the UM/CM Program initiatives.

The process of evaluation includes a comparison of the results of utilization/care management improvement activities against past year's performance. The evaluation documents evidence of resolution of identified problems or areas needing improvement.

Additional sources of data utilized to obtain feedback from providers and members on CalViva Health Utilization/Care Management Program and to identify opportunities for improvement include:

- Member grievances
- Member appeals
- Results of member satisfaction surveys
- Provider appeals
- Provider grievances
- Provider satisfaction surveys
- UM decision making timeliness
- Identification and referral of members eligible for carve-out programs
- HEDIS results
- Information from QI studies
- Joint Operation Meeting information
- PPG Report Cards
- Data and other feedback from Public Health-Linked Programs
- Over and under utilization
- Community Advisory Councils

UM/CM Program Work Plan

Health Net's SHP Senior Medical Director and Vice President ~~Medical Management~~Population Health and Clinical Operations annually develop the CalViva Health UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Fresno-Kings-Madera Regional Health Authority 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

Health Net Medi-Cal Utilization Management Program Approval

The Chief Medical Officer and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Jennifer Lloyd
Vice President of ~~Medical Management~~Population Health and Clinical Operations

Item #13

Attachment 13.A

2021 Annual Compliance Evaluation

CALVIVA HEALTH
2021 ANNUAL REGULATORY AFFAIRS & COMPLIANCE EVALUATION

I. EXECUTIVE SUMMARY

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

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

The Compliance Program is guided by the Plan's mission "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 Compliance Program is implemented by all Plan Departments: Compliance, Medical Management, Finance and Operations. Compliance Program results are the collective achievements of dedicated Plan staff members, the Plan's administrator, providers and community-based organizations working together to meet the needs of CalViva members and the community we serve. As will be presented below, in 2021, the Plan continued efforts to update its policies to be compliant with new regulations and guidance as well as improve its oversight of delegates/subdelegates, maintain its network adequacy, and timely access standards. Going forward, the Compliance Program will focus on meeting new regulatory challenges in 2022 and beyond, improving performance by addressing issues identified through Corrective Action Plans (CAPs) as well as maintaining overall operational effectiveness and regulatory compliance.

For the first half of 2021, several of Plan's operations and compliance activities continued to be impacted by the January 31, 2020 U. S. Secretary of Health and Humans Services (HHS) Secretary's declaration of a public health emergency (PHE), and the California Governor's March 4, 2020 declaration of a PHE due to the Novel Coronavirus Disease (COVID-19). However, by July 1, 2021, several temporary flexibilities that were issued pursuant to the Governor's April 22, 2020 Executive Order (EO N-55-20) were being terminated. As a result of the continued consequences of the COVID-19 pandemic, on October 15, 2021, the HHS

Secretary renewed the determination that a public health emergency still exists. This renewal was effective for 90 days (January 14, 2022).

II. Regulatory Affairs

A. Administrative and Operational Regulatory Reporting

As a licensed health plan, CalViva Health is required to submit a wide variety of information and data for review and approval to the DMHC in compliance with Knox-Keene regulations, and to the DHCS in compliance with its contract, Medi-Cal regulations and All Plan Letters. Regulatory filing activities include but are not limited to: material modification and amendment filings, annual timely access submissions, annual network certification, fraud waste and abuse case review and submissions, member-informing materials, new benefit-associated deliverables, changes in commission/committee members, key policies and procedures, etc. In 2021, CalViva Health made over 250 regulatory filings to DMHC and DHCS. These filings do not include the various "routine" monthly/quarterly data reports or audit-related information that are sent to the two agencies. In addition to regulatory filings and report submissions, the Plan undergoes annual audits by DHCS, triennial medical and financial audits by DMHC, annual HEDIS® audits and implements and addresses regulatory agency CAPs as needed.

B. Summary of State Audits, Corrective Actions, and Medi-Cal Contract Amendments

1. Department of Health Care Services (DHCS):

a. 2020 DHCS Audit - On 8/27/2021, the Plan submitted its final CAP Update to DHCS indicating that all corrective actions have been implemented, and that the results of the actions can be reviewed by DHCS at the next Medical Audit in 2022. The Plan has not yet received DHCS' acceptance of the Plan's CAP response.

b. 2021 DHCS Annual Audit – In consideration of the impact of the COVID-19 PHE, this audit was deferred until 2022 at the request of the Plan.

c. DHCS -2019-2020 Performance Evaluation – The final report issued in July 2021 identified three external quality review (EQR) improvement recommendations: one related to the 2020 DHCS Medical Survey finding, one related to HEDIS® data validation, one related to quality performance improvement projects. The Plan successfully implemented interventions addressing these areas.

d. DHCS 2020 - 2021 Encounter Data Validation (EDV) Study –The annual EDV study was postponed in 2021 due to the COVID-19 Public Health Emergency.

e. 2020 DHCS Annual Network Certification (ANC) – The Plan submitted the ANC in April of 2020. The DHCS issued a CAP on November 25, 2020 related to non-compliant time and distance standards. Accordingly, the Plan submitted its

responses on December 28, 2020. On March 11, 2021 DHCS informed the Plan that all ANC deficiencies were resolved and the CAP was closed.

f. 2021 DHCS Annual Network Certification (ANC) - The Plan submitted the ANC in April of 2021. On August 2, 2021, DHCS informed the Plan that it passed the 2021 ANC.

g. DHCS MOT Corrective Action Plan (CAP) – On December 10, 2021, the Plan received written notice of deficiencies related to the failure to CalAIM Benefit Standardization of Major Organ Transplants (MOT) network certification requirements. The Plan failed to demonstrate a minimum of one executed contract with a Center of Excellence (COE) for the following organ types: bone marrow, heart, kidney-pancreas, liver and lung. It should be noted that the DHCS issued CAPs to all Managed Care plans as this issue resulted from the DHCS' delay in establishing reimbursements rates for the COEs which are primarily California state universities. The Plan's Administrator, Health Net, is delegated for contracting with all COEs.

h. DHCS Contract Amendments - Several Medi-Cal contract amendments were executed between DHCS and CalViva Health in 2021.

- **Contract 10-8750 A15** – This amendment (retro-effective July 1, 2018) revises language for the Final Rule and Behavioral Health Treatment (BHT). It also adds 2018-2019 capitation rates.

- **Contract 10-8750 A16** ("The Bridge Amendment") – This amendment (retro-effective July 1, 2019) incorporates new Bridge language and adds the 2019-2020 capitation rates.

- **Contract 10-8750 A22** – This amendment (effective January 1, 2022) incorporates new Enhance Care Management (ECM) risk mitigation language.

h. COVID-19 – The Plan reported to DHCS as needed any COVID-19 related provider facility site changes.

2. Department of Managed Health Care (DMHC):

a. Measurement Year (MY) 2019 Timely Access Report (TAR): The Plan submitted its annual MY2019 TAR filing in May of 2020. The DMHC issued its findings on February 26, 2021 and the Plan submitted its response on May 27, 2021. An alternative access filing was subsequently filed.

b. Measurement Year (MY) 2020 Timely Access Report (TAR): The Plan submitted its annual MY2020 TAR filing in March of 2021 and is awaiting DMHC's final report.

c. March 2021 DMHC 18-Month Follow-Up Audit – On March 1, 2021, the DMHC conducted an 18-month follow-up audit of the outstanding deficiencies from the February 2019 DMHC Audit. The DMHC issued its Final Report on November 2, 2021.

The reported stated that one of the two deficiencies had been corrected. The second deficiency remains uncorrected and under DMHC review and will be assessed at the next triennial DMHC Audit scheduled for September 2022.

d. March 2022 DMHC Routine Financial Exam – On December 14, 2021, CalViva received written notice from DMHC of their intent to conduct the biennial financial audit on March 15, 2022.

C. DHCS Fraud, Waste and Abuse Required Reporting:

In 2021, the Plan and its delegate, Health Net's Special Investigations Unit (SIU), identified four (4) cases which were determined to reflect suspected fraud and/or abuse. All four cases were provider-related, one (1) of which was a pharmacy provider and one (1) was a non-contracted DME provider. The DHCS did not close any cases. All cases were promptly reported to DHCS within the ten (10) working days requirement. There were no cases referred to other law enforcement agencies by the Plan.

D. Privacy and Security Oversight

1. Regulatory and Contractual Obligations

CalViva Health continued to review and refine their practices and processes to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) contractual obligations and any other privacy and security related laws and regulations. The following key activities were completed for 2021:

- Breach Notifications and Assessments – Risk assessments were conducted on cases to determine the probability of compromise of protected health information in the event of a breach of unsecured protected health information.

- Periodic and Ongoing Training – The Plan conducted ad-hoc and annual privacy and security training to all employees. Educational newsletters were distributed quarterly.

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

In 2022, CalViva Health will continue assessing their practices and processes to ensure compliance with HIPAA and any applicable state regulations. These assessments could include, but are not limited to, reviewing operational business practices, completing the annual risk analysis with HIPAA One, engaging in ongoing risk management activities, and reviewing program documents related to HIPAA.

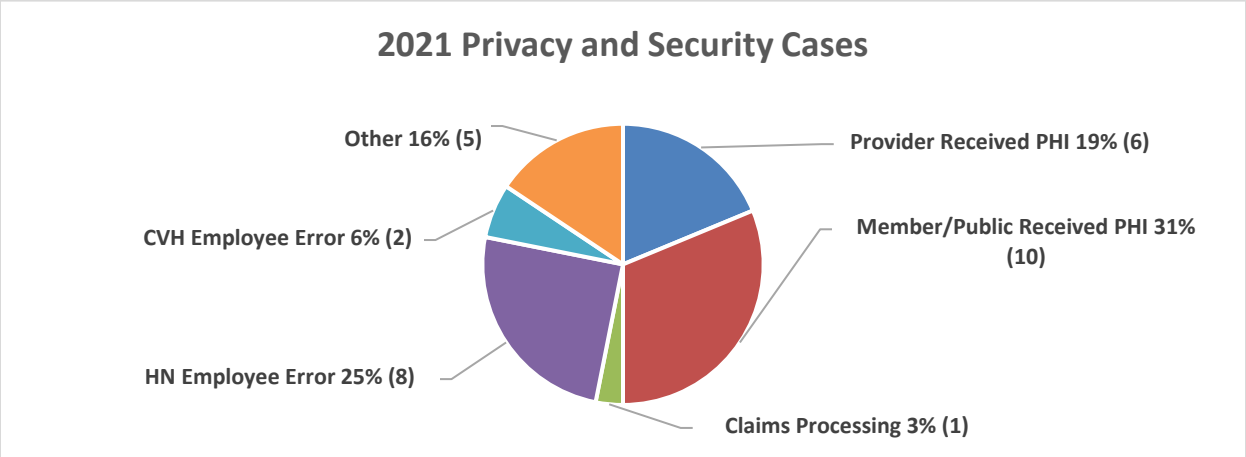
2. Reports of Possible Privacy and Security Incidents/Breaches

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

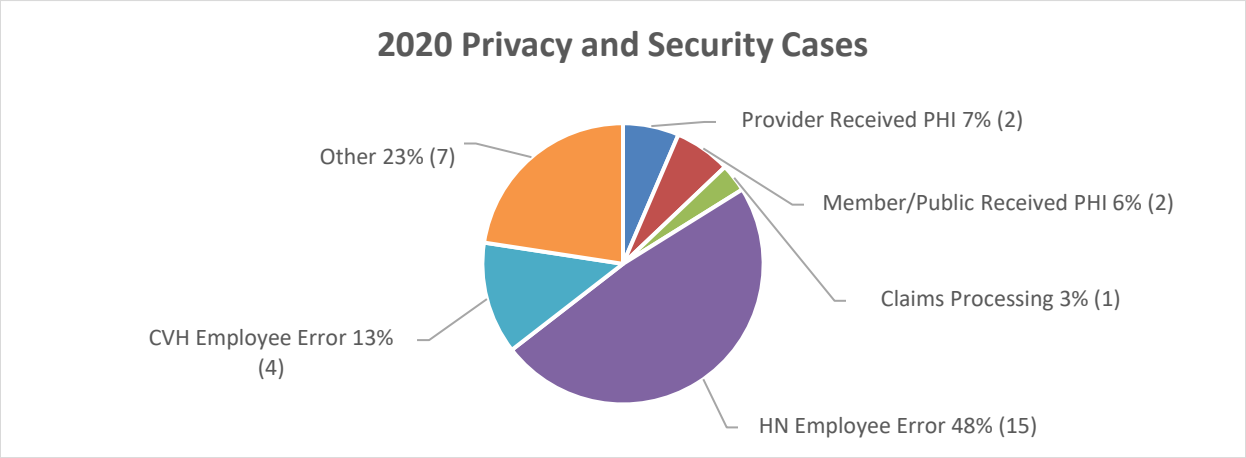
In 2021, thirty-two (32) privacy and security incidents were reported to the DHCS. Two (2) incidents occurred within CalViva Health. The remaining thirty (30) incidents involved the Plan's Administrator Health Net. Twenty (20) cases were deemed low risk or no risk after the completion of a risk assessment. Eight (8) cases did not require completion of a risk assessment as there were zero (0) individuals affected by the privacy incidents. Three (3) cases were deemed moderate-risk and one (1) case was deemed high-risk, which required notification to the affected individuals. There is one (1) case which is still pending DHCS case closure determination.

The first pie chart provides a high-level overview of the types of incidents which occurred in 2021. The second pie chart provides high-level overview of the types of incidents which occurred in 2020 for comparison purposes:

2021 Privacy and Security Cases



2020 Privacy and Security Cases



The pie charts reveal that the total number of privacy and security incidents have remained nearly consistent between 2021 (32 incidents) and 2020 (31 incidents), with only a 3% increase in 2021. The number of incidents involving claims processing had no change between 2021 and 2020. On the other hand, the number of incidents involving Member/Public Received PHI increased by 25%.

3. CalViva Health Internal Audits

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

In 2021, there was one (1) incident where an employee was subject to disciplinary action due to a privacy and security non-compliance issue.

E. DHCS New Benefits, Waivers and Other Programs:

1. On December 29, 2021, DHCS received federal approval from CMS to authorize the CalAIM Section 1115 and CalAIM Section 1915(b) waivers through December 31, 2026. CalAIM is a multi-year Department of Health Care Services (DHCS) initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program and payment reforms across the Medi-Cal program. The following are the initial key CalAIM initiatives approved under these waivers and were to become effective January 1, 2022:

   - Enhanced Care Management (ECM) and Community Supports (CS) - In 2021, the Plan submitted and received approval for its ECM/CS Model of Care which would become

effective in Kings County starting January 1, 2022. Fresno and Madera counties are planned for July 1, 2022 and the Plan will be working to deliver all MOC deliverables by February 15, 2022. ECM is a Medi-Cal managed care benefit and CS are optional, flexible wrap-around services provided as a substitute to, or avoid, other costly services such as hospital or skilled nursing facility admission.

- Major Organ Transplants (MOT) - Effective January 1, 2022, all major organ transplants are to be carved into Medi-Cal managed care. The Plan successfully submitted all deliverables for MOT and, as mentioned above, is working with Health Net to obtain contracts with all COEs.

- CalAIM Incentive Program (CalAIM IP)- Commensurate with the launch of ECM/CS on January 1, 2022, the DHCS will be implementing the CalAIM IP which is designed to complement/expand ECM/CS capacity building, investment in delivery system infrastructure and achieve improvements in quality. The Plan agreed to participate in the CalAIM Incentive Program with required deliverables to be submitted in January 2022.

2. Medi-Cal RX - Pursuant to the Governor's EO N-01-19 from January 7, 2019, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal Managed Care and transitioned to Medi-Cal FFS effective January 1, 2022. Prior to the effective date, the Plan submitted all required deliverables which were approved by the DHCS.

3. COVID-19 Vaccine Response Plan and Incentive Program – On September 1, 2021, the Plan submitted its vaccine response plan to DHCS which the DHCS approved on September 7, 2021. The Plan's vaccine strategy was later shared with other plans during a presentation given by CalViva's Chief Medical Officer during the December 1, 2021 Managed Care Plan Call. In conjunction with the vaccine response plan, the Plan agreed to participate in the Vaccine Incentive Program.

4. Behavioral Health Integration (BHI) Incentive Program – Pursuant to the Trailer Bill implementing the 2019 Budget Act, the Plan continues to participate in 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 for a 24-month period (January 1, 2021 through December 31, 2022). The goal of this program is to improve physical and behavioral health outcomes for Medi-Cal beneficiaries with co-morbid disorders by increasing rates of prevention, conducting early detection and interventions, and providing treatment that is clinically efficient, while being culturally and linguistically informed.

III. Compliance Program Activities

Due to the COVID-19 PHE and state and local emergency orders, CalViva Health had closed its

downtown and northeast Fresno Administrative offices to public visitors. In July 2021, the Plan reopened it Administrative offices to the public. A sign at the downtown office refers members, providers and the public to call the CalViva Health toll free Member Services number. The Member Services Call Center is open 24/7. CalViva employees are working at the northeast Fresno office and remotely as appropriate to their circumstances and the status of state and local emergency orders.

A. Program Document Reviews/Updates:

CalViva Health continued to operate a comprehensive Compliance Program in 2021. The Plan's Compliance Program includes the following written descriptions which were reviewed and updated as necessary in 2021.

- Compliance Program Description
- Code of Conduct
- Compliance Committee Charter
- Anti-Fraud Plan
- Privacy and Security Plan
- Compliance Policies and Procedures

B. Oversight and Monitoring of Delegated Activities:

The Plan continues to provide oversight and work closely with Health Net on an ongoing daily basis to ensure CalViva members have information and access to services during this time. Health Net anticipated continuing its remote based working environment through the first quarter of 2022.

1. Delegation Oversight Audits and CAPS

The table below lists the Plan's 2021 completed oversight audits of functions delegated to Health Net. Audits included desk reviews of any applicable functions subdelegated by Health Net, policies and procedures, reports, and evidence submitted to meet the required audit elements.

Access & Availability*	Claims*	FWA
Pharmacy	Provider Disputes	Emergency Services
Call Center	Utilization Management*	

* CAPs were required for the above functions and CAPs have been completed and approved.

2. Periodic Monitoring of Health Net

During 2021, CalViva Health staff continued a wide variety of activities to provide oversight and monitoring of the functions performed by Health Net and Health Net's delegated provider groups and subcontracted health plans on CalViva Health's behalf.

These activities included:

- Monthly management oversight meetings with Health Net key management staff to review reports, discuss issues and any improvement actions needed.
- Monthly/Quarterly monitoring and analysis of key performance measures and reports from delegated entities for timeliness, accuracy and issues.
- Ongoing workgroup collaborations with Health Net to ensure process integrity and contract deliverables in the following areas:
  - Grievance System
  - Quality Improvement, Utilization Management and Credentialing
  - Encounter Data Integrity
  - Access and Availability
- On-going oversight of subdelegated functions through report dashboards of comprehensive performance metrics accompanied by narrative reports explaining outlier data or issues.

C. 2021 CalViva Internal Audit

During 2021, the Compliance Department conducted an internal audit of employee, Commission and Committee member files to ensure completion of a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable. Records were also reviewed to ensure that no individual was listed on the Office of Inspector General ("OIG") exclusion list, the Medi-Cal suspended and ineligible provider lists, and licensing board sites. All files were found compliant and no CAP was issued.

D. CalViva Health Staff Trainings

A primary requirement of a successful Compliance Program is conducting ongoing education and training programs. Ongoing training helps CalViva Health staff to carry out daily Plan operations in an efficient and compliant manner. During 2021, the Plan conducted training for four new hires as well as the following mandatory annual staff trainings:

Compliance Program	Anti-Fraud and Abuse Program
Privacy and Security Program	Code of Conduct

Staff members also attested to having read and signed the following documents on an annual basis:

Drug Free Workplace Statement	Confidentiality Agreement
Conflict of Interest Statement	

All employees successfully completed all required trainings.

E. Member Communications

CalViva Health maintains a process for the review and approval of communications with members. In 2021, 43 communications were reviewed by CalViva Health. This included

member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2021 Annual Mailing, which included a flyer with instructions on how to download a copy of the 2021 EOC, was distributed to members by January 1, 2021. A 2022 Member Handbook/Evidence of Coverage (EOC) was being finalized in Q4 2021 and was in production by January 1, 2022.

F. Provider Communications

CalViva Health maintains a process for the review and approval of communications to contracted providers within the CalViva Health service area. In 2021, contracted providers were sent approximately 229 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 27 informational letter templates and 9 forms intended for provider use.

H. Provider Relations

CalViva Health continued productive relationships with participating providers. The following information reflects activities from January to December 2021. There were 1,952 provider "touches" and 3,376 training throughout Fresno, Kings, and Madera Counties. Plan staff conducted outreach, trainings and assisted providers with Medi-Cal guidelines and CalViva Health requirements in their day-to-day operations.

I. Appeal and Grievance (A&G) Resolution Summary

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

The following table summarizes the number and type of A&G cases received in 2021, and the percent resolved within the compliance turnaround times (TAT) standards. For instances of non-compliance, corrective action was implemented to ensure there would not be future similar occurrences.

	No. of Cases Received	No. of Cases Resolved †	% of Cases Resolved within TAT (No.)
Expedited Grievances	172	172	100 % (172)
Standard Grievances	1316	1312	99.77 % (1309)
Expedited Appeals	85	86	98.84% (85)
Standard Appeals	735	742	99.87 % (741)
Total:	**2308**	**2312**	**99.78% (2307)**

	No. of Cases Received	No. of Cases Resolved †	% of Cases Resolved within TAT (No.)
SPD Appeals & Grievances *	783	767	98 % (766)
Exempt Grievances #	3567	3567	100%

† Total will not match as some cases received in December 2021 may remain open at the start of 2022, and the resolved case number may include some cases received in December 2020 and resolved in 2021.

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

Exempt Grievance are grievances that can be resolved within one business day.

J. Independent Medical Reviews (IMRs) and State Hearings

The following table summarizes the number of DMHC IMR and DHCS State Hearing requests processed by the Plan in 2021. All cases were submitted within the required turnaround times.

Cases Received	2021 Total	% Cases Submitted w/in the TAT
DMHC Cases	**75**	**100%**
DHCS State Hearings	**17**	**100%**
Total:	**92**	**100%**

IV. 2022 Activities

In 2022, the Plan expects the California and Federal declarations of the COVID-19 PHE will continue to be renewed and have ongoing impacts on Plan activities. The DMHC and DHCS are requiring continued COVID-19 reporting related to any facility closures.

Regarding CalAIM initiatives, the Plan will continue its efforts to implement ECM/CS in Fresno and Madera counties by submitting updated Models of Care (MOCs), and begin planning activities for the January 1, 2023 carve-in of Long-Term Care.

As for non-CalAIM initiatives, effective May 1, 2022, full-scope Medi-Cal eligibility will be expanded to individuals 50 years of age and older, and who do not have satisfactory immigration status or are unable to establish immigration status. The Plan awaits DHCS guidance on any deliverables associated with this transition. Additionally, effective July 1, 2022, Doula Services will become a covered benefit, however in order to add these services DHCS must submit a State Plan Amendment (SPA) to CMS for approval.

In 2022, CalViva will once again be audited by both DHCS and DMHC. In 2021, CalViva continued its follow-up with both agencies to close out the remaining CAPs from the DHCS 2020 and DMHC 2021 audits before initiating the 2022 audit preparations.

The Plan anticipates developing new policies and implementing/revising existing processes as a

result of the initiatives described above, as well as new regulatory guidance and laws effective in 2021 and 2022.

Generally, the Plan expects increased regulatory oversight and monitoring of health plan activities, in the following areas:

- Provider network adequacy and certification requirements for direct and delegated networks
- Timely Access
- Encounter data quality and timeliness
- Clinical Quality Improvement (MCAS measures)
- Member Grievances/Appeals

The Compliance Department's efforts will focus on preparing for and monitoring the successful implementation of all new and current requirements.

APPROVAL:

		Date:	**February 17, 2022**
Name:	Mary Lourdes Leone		
Title:	Chief Compliance Officer		
		Date:	**February 17, 2022**
Name:	Jeffrey Nkansah		
Title:	Chief Executive Officer		
		Date:	**February 17, 2022**
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Item #14

Attachment 14.A

2022 Compliance Program Description

COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

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Chief Compliance Officer
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Fresno, CA 93711
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(559) 540-7856

CALVIVA HEALTH COMPLIANCE PROGRAM

I. CalViva Health Overview

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

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

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

II. Compliance Program Purpose and Objectives

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

Table 1 presents the primary objectives implicit in this purpose.

Table 1. Program Objectives

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

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

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

III. SCOPE

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

IV. AUTHORITY AND OVERSIGHT

A. GOVERNMENT AGENCIES

The following are some of the state and federal agencies that have legal authority to

regulate various aspects of health care and health care plans.

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

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

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

B. RHA COMMISSION

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

C. THE COMPLIANCE COMMITTEE

1. Oversees CalViva's Compliance Program and advises the CCO on Program adequacy.
2. Reviews the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct and recommends revisions as needed.
3. Analyzes CalViva's contractual, legal, and regulatory requirements and risk areas and consults with advisors and legal counsel as necessary.
4. Monitors reports of fraud, waste and abuse, and unauthorized use and/or disclosures of personal information ("PI"), including protected health information ("PHI").
5. Reviews and approves recommendations to modify or establish internal systems and controls necessary to carry out the Compliance Program.
6. Supports investigational activities performed by the CCO, and or state and federal officials, as they relate to violations of the federal False Claims Act, Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act (HIPAA).
7. Reviews and approves disciplinary and corrective actions related to non-compliance with the Compliance Program.

D. CHIEF COMPLIANCE OFFICER (CCO)

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

V. COMPLIANCE RISK AREAS

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

A. Access & Availability, and Quality of Care:

- Unavailable or inaccessible covered services to members;
- Inappropriate withholding or delay of covered services;
- Improper interference with health care professionals' advice to members regarding member's health status, medical care and treatment;
- Non-credentialed physicians or unlicensed/certified practitioners and providers;
- Discrimination on the basis of race, color, national origin, sex, age, religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identify or sexual orientation.

B. Data Collection and Submission:

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

C. Member Grievance and Appeal Procedures:

- Failure to ensure that members are properly notified of their grievance and appeal rights;

- Failure to respond and resolve member grievances and appeals within the required timeframes.

D. Emergency Services:

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

E. Kickbacks and Other Inducements:

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

F. False Claims:

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

G. Confidentiality:

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

H. Excluded Providers:

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

I. Member Dis-Enrollment:

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

J. Marketing

- Improper or misleading marketing materials

VI. COMPLIANCE PROGRAM ELEMENTS

A. POLICIES AND PROCEDURES

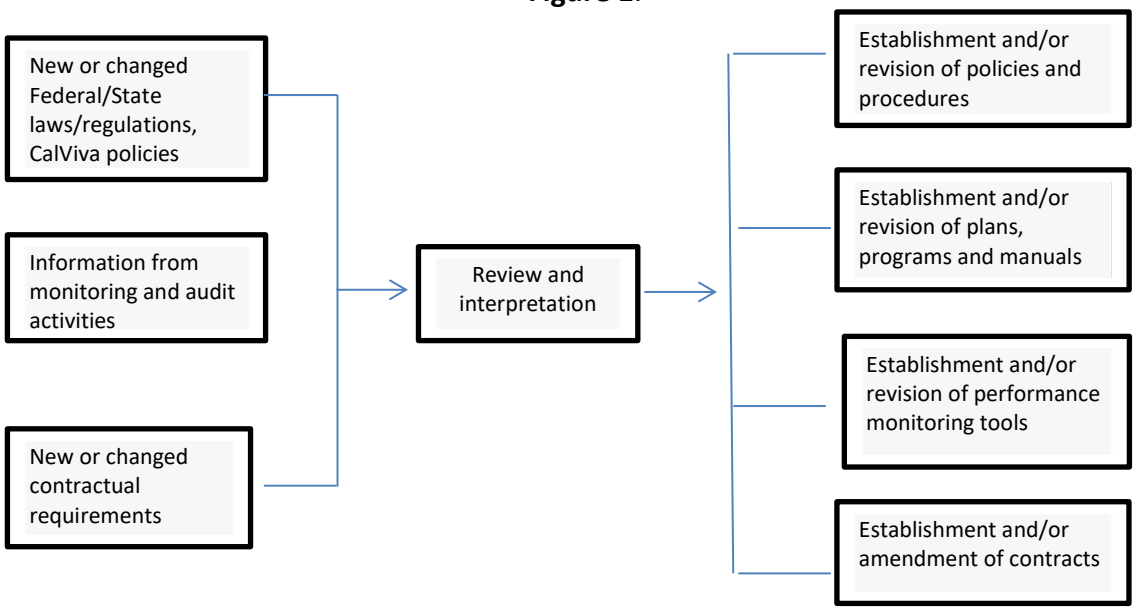
Prevention is the cornerstone to CalViva's Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from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

Table 2. Key Compliance-Related Policy Topics

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

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

Figure 1.



B. MONITORING

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

Table 3. Activities Monitored by CalViva

Provider Network Contracting and Updating	**Member Appeals and Grievances**	**Practitioner and Provider Credentialing**
Provider Access	**Facility Site Reviews & Medical Record Reviews**	**Encounter Data**
Member Rights and Services	**Cultural and Linguistic services**	**Claims Payment**
Marketing	**Provider Grievances and Disputes**	**Utilization Management & Case Management**
Health Education	**Mental Health & Behavioral Health Services**	**Quality Improvement**
Pharmaceutical Services	**Provider Training**	**Continuity of Care**
Fraud, Waste & Abuse		

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

C. EDUCATION AND TRAINING

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

Table 4. Program Documents

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

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

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

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

D. REPORTING NONCOMPLIANCE

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

1. **Criminal and Civil Violations of Law**: CalViva conducts fact-finding activities, and

reports to the proper authorities for further investigation and action, all credible, suspected occurrences of fraud, waste, abuse, kickbacks, and unauthorized uses and disclosures of protected information, including PHI.

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

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

E. Response and Corrective Action

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

VII. Summary

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

VIII. AUTHORITY

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

IX. Program Documents

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

X. APPROVAL

	_____	February 18, 2022 _____
Name:	Mary Lourdes Leone	Date
Title:	Chief Compliance Officer	
	_____	February 18, 2022 _____
Name:	Jeffrey Nkansah	Date
Title:	Chief Executive Officer	
	_____	February 18, 2022 _____
Name:	David S. Hodge, M.D.	Date
Title:	Chair, RHA Commission	

DOCUMENT HISTORY	
Date	**Comments**

03/01/2011	New Program Description
02/09/2012	Annual Update of Program Description
01/17/2013	Annual Update of Program Description
02/06/2014	Annual Review: Changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
01/26/2015	Annual Review: Changes to clarify monitoring and auditing activities
02/08/2016	Annual Review, added reference document
02/02/2017	Annual Review: Program Description is replaced in its entirety. Overall content is the same; reduced duplication with other program plans, formatting, editorial and organizational enhancements to all sections.
2/1/2018	Annual Review: Deleted "Privacy & Security Officer" from the CCO's responsibilities. CalViva's COO will now serve as the "Privacy & Security Officer", and this is reflected in the Privacy and Security Plan.
01/07/19	Annual Review: No changes.
01/21/20	Added additional Discrimination language to V. Compliance Risk areas, Section A.
10/22/20	Annual Review: Edited IV, D. (3.) to reflect current practice of preparing the annual Compliance Program Evaluation.
2/7/22	Annual Review: Updated CCO to Mary Lourdes Leone and CEO to Jeffrey Nkansah; added "Privacy Officer" to Section IV. D.; added Fraud, Waste & Abuse to Table 3.

Item #15

Attachment 15.A

2022 Code of Conduct

Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

Mary Lourdes Leone
Chief Compliance Officer
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7625 N. Palm Ave., Suite 109
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MLLeone@calvivahealth.org
Phone: 559-540-7856

Table of Contents

I. CalViva Health Overview:

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

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

II. Purpose:

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

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

III. Elements:

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

1. Member Services and Rights:

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

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

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

2. To be provided with free aids and services to communicate effectively with CalViva Health employees and providers and not be discriminated against on the basis of race, color, national origin, age, sex, religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

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

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

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

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

7. To complain about CalViva Health, the health plans and providers we work with, or the care provided without fear of losing their benefits. CalViva Health will help the member with the process. If a member doesn't agree with a decision, they have the right to appeal. Members have the right to disenroll from CalViva Health whenever they want.

8. To request a State Hearing and/or an Independent Medical Review (IMR).

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

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

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

2. Provider/Vendor Relations and Contracts:

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

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

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

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

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

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

4. For services that are not reasonable and necessary.

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

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

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

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

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

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

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

3. Business Operations and Accounting:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

U. CalViva Health, in cooperation with subcontractors and regulators, will make all reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violation occurs. Depending on the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If a subcontractor fails to remedy the circumstance, corrective action may include a range of disciplinary and corrective actions up to and including termination of the contract.

4. Medical Records:

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

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

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

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

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

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

C. CalViva Health retains records in accordance with a written policy which

incorporates Medicaid and all federal, state and local regulatory guidelines.

5. Medical Management and Claims:

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

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

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

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

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

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

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

6. Employee Relations:

A. CalViva Health encourages all employees and contractors to respect the rights and

cultural differences of other individuals.

B. CalViva Health does not discriminate on the basis of age, religion, color, race, sex, national origin, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation in personnel policies and procedures.

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

7. Avoiding Potential Conflict of Interest or Retribution

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

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

APPROVAL:

February 17, 2022

_____ Date: _____

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

February 17, 2022

_____ Date: _____

Name: Jeffery Nkansah
Title: Chief Executive Officer

February 17, 2022

_____ Date: _____

Name: David S. Hodge
Title: RHA Commission Chairperson

Item #16

Attachment 16.A

2022 Anti-Fraud Plan

ANTI-FRAUD PLAN

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

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
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Fresno, CA 93711
MLLeone@calvivahealth.org
Phone: 559-540-7856

Table of Contents

I. CalViva Health Overview

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

RHA has an Administrative Services Agreement ("ASA") with Health Net Community Solutions ("Health Net") to provide certain administrative services on the Plan's behalf. RHA also has a Capitated Provider Services Agreement ("CPSA") with Health Net for the provision of health care services to CalViva Health members through Health Net's network of contracted providers. Health Net is contracted to provide a broad range of administrative and operational services on CalViva Health's behalf, including but not limited to: enrollment processing, provider contracting and credentialing, utilization management, claims processing, member and provider services and maintaining the systems for most CalViva Health operations.

Under the term of the ASA and CPSA, Health Net is responsible for fraud and abuse investigations related to potential fraud cases involving CalViva Health members, providers, Health Net employees and subcontractors performing functions on behalf of CalViva Health. CalViva Health maintains overall responsibility for anti-fraud and abuse activities, and performs oversight and monitoring of Health Net and their Special Investigations Unit ("SIU"). The Plan also retains responsibility for investigating and addressing any potential incidents of fraud and abuse involving CalViva Health employees and consultants.

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

1. Statement of Purpose:

The purpose of the RHA/CalViva Health ("CalViva" or the "Plan") Anti-Fraud Plan is to organize and implement an anti-fraud strategy to identify and reduce costs to the Plan, providers, members, and others caused by fraudulent and abusive activities, and to protect members and the public in the delivery of health care services through the timely

detection, investigation, and prosecution of suspected fraud. Through the Anti-Fraud Plan, CalViva also seeks to prevent violations of the Federal False Claims Act, as codified in Section 3729 of Title 31 of the United States Code. The Plan's Anti-Fraud Program will also comply with the federal Medicaid managed care requirements in 42 CFR 438.608, Health & Safety Code Section 1348 and the Department of Health Care Services Medi-Cal Contract requirements in Exhibit E, Attachment 2, Provision 26.

2. Definitions:

A. **Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2; W&I Code Section14043.1(i).)

Health care fraud is a crime. Any person convicted of health care fraud faces imprisonment and substantial fines. Health care fraud could be committed by dishonest health care providers such as doctors, laboratories, medical equipment suppliers, by health plan members, Plan staff, and Plan subcontractors.

Some examples of fraud include:

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

See Appendix A for a more extensive set of examples.

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

Some examples of abuse include:

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

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

II. Scope of Anti-Fraud Plan:

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

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

A. the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations;
B. training of plan personnel and contractors concerning the detection of health care fraud;
C. the plan's procedure for managing incidents of suspected fraud; and
D. the internal procedure for referring suspected fraud to the appropriate government agency.

1. Responsibilities for Anti-Fraud Plan:

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

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

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

1. Receive information (formal and informal) on cases of suspected fraud
2. Provide oversight of activities and investigations carried out on CalViva's behalf by Health Net and other delegated entities.
3. Receive information from Health Net and other delegated entities on cases of suspected fraud and abuse related to CalViva and investigated by the delegated entities' SIU.
4. Provide oversight and receive information from delegated organizations on cases of suspected fraud and abuse related to CalViva

5. Report to the CEO on suspected cases of fraud, plan of investigation, timelines, and resources required
6. Maintain logs to assure timely investigations and reporting
7. Review and approve training and other anti-fraud materials sent to participating providers on CalViva's behalf.
8. When directed by the CEO or legal counsel, make referrals to appropriate law enforcement agencies

2. General Anti-Fraud Oversight Mechanisms:

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

1. CalViva Health will conduct background checks on all employees, which includes staff designated to handle funds and prepare financial statements.
2. Policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program.
3. Development and implementation of corrective actions addressing fraud and abuse issues as appropriate.
4. Ongoing monitoring and oversight by the CalViva Compliance Committee.
5. Provide contracted providers with anti-fraud information including how to report suspected fraud incidents.
6. Provide members with information on how to report suspected fraud incidents such as in the CalViva Health EOC/Member Handbook.
7. Investigate cases of suspected fraud with the most appropriate internal or external resources, appropriate to the problem.
8. Assure that conflicts of interest are not present in the investigation of suspected fraud cases.
9. Ensure that findings from independent audits and regulatory audits and surveys are followed up promptly by both the Plan as well as the subcontractors who may be cited; and identify any recurring trends.
10. Monitor member and provider issues, tracking and trending types of grievances and settings; and implementing corrective action when necessary.
11. Perform an annual file audit of a sample of contracted providers credentialed by Health Net and their delegated entities which have delegated credentialing responsibilities.
12. Monitor and review fraud cases/issues reported by delegated

organizations

13. Conduct formal and informal ongoing monitoring of the administrative services contracted to Health Net and delegated entities through the review of performance reports, annual audits, and quarterly member service verification reports; and developing corrective action plans, when appropriate.
14. Review the Anti-Fraud Plan annually and, if revised, maintain documentation that approval has been received from the Department of Managed Health Care (DMHC).
15. Review Health Net's annual anti-fraud report to the DMHC.
16. Assure that Medicaid/Medi-Cal or Medicare terminated or suspended providers do not receive program funds.

3. Procedures for Investigating Suspected Fraud:

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

1. The procedure for undertaking an investigation includes:
    A. A review of all identified related documents;
    B. Consultation, if necessary, with internal or external resources with knowledge of applicable law, regulations or policies, procedures or standards; and
    C. Interviews with persons with knowledge of the alleged activity.
2. A description of the investigation process is included in Plan policies and procedures. The policies and procedures are reviewed annually and revised as needed.
3. The Compliance Committee reviews reports of fraud, waste and abuse cases investigated and any corrective actions implemented.
4. All cases of suspected fraud, waste and/or abuse where there is reason to believe that an incident of fraud, waste and/or abuse has occurred by subcontractors, members, providers, or employees will be reported to the DHCS.
5. In addition, in situations where fraud is confirmed, disciplinary action may be taken and reports to appropriate third parties may be made, including the following:
    A. For employees, incidents may be grounds for immediate dismissal, and, if appropriate, referral to law enforcement agencies.
    B. For contracted providers, disciplinary action may include terminating any contracted relationship between the Plan and the provider or, in the case of a group or institutional provider, removal of the provider's subcontractor or employee from providing services with respect to CalViva members.

C. For Medi-Cal members, disciplinary action will include referral to the Department of Health Care Services and, if appropriate, the initiation of procedures to disenroll the member from CalViva, according to provisions of the Medi-Cal managed care contract.

6. Appropriate local, State or Federal authorities will be notified as necessary.
7. A summary report of cases and outcomes is provided quarterly to the Compliance Committee and summary reports are included in the regular compliance reports to the RHA Commission.
8. To prevent repeat offenses, the CCO, and if applicable, in consultation with Health Net, may create new policies, procedures and employee training programs to address new issues regarding the Anti-Fraud Plan's implementation as they arise.

4. Use of External Resources for Special Investigations:

The following external resources are utilized by the Plan:

1. CalViva Employee, Consultant and Contractor Investigations - CalViva has retained Epperson Law Group, PC to provide its General Counsel services. The law firm has municipal and litigation attorneys experienced in matters involving public agency ethics rules, restrictions on self-dealing, and prohibited financial transactions. Cases involving alleged fraud and improprieties by CalViva employees, officers, directors, consultants or contractors will be referred to Epperson Law Group, PC for investigation as needed.
2. CalViva Member and Provider Investigations - As described in Section I, *CalViva Health Overview*, in accordance with the ASA and CPSA between CalViva and Health Net, the Special Investigations Unit (SIU) for Health Net performs fraud and abuse investigations (i.e. prepay reviews; retrospective reviews, etc.) related to potential fraud cases involving CalViva members or providers. Health Net also conducts routine reviews of provider's billing/coding practices to ensure compliance with state and federal regulations. In addition, Health Net will review claim reports to ensure that codes and practices used in billing are correct and that the Plan has paid health care providers appropriately. The SIU team has a diverse range of qualifications that stem from the legal, healthcare, loss prevention, law enforcement, medical and other experience/educational backgrounds. Several members of the team are also credentialed as Accredited Health Care Fraud Investigators ("AHFI"), Certified Professional Coders ("CPC"), and Certified Fraud Examiners ("CFE").

5. Additional Internal and External Resources:

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

1. The Plan's Chief Medical Officer, Chief Financial Officer and other Plan staff.
2. The Plan's independent financial audit firm
3. DHCS audits and surveys
4. DMHC audits and surveys

6. Freedom from Retaliation and Avoiding Conflicts of Interest:

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

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

7. Referrals to or from Appropriate Outside Agencies:

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

1. Fraud, Waste and Abuse Reporting to DHCS - CalViva will comply with the DHCS contractual requirements for prompt referral of any potential Fraud, Waste, or Abuse that the Plan identifies to the DHCS Audits and Investigations Intake Unit. The Plan shall conduct, complete, and promptly report to DHCS, the results of a substantiated preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.

   On CalViva's behalf, the Health Net SIU will investigate and provide the Plan with a report of the results. CalViva retains the discretion to determine if potential fraud and abuse claims are reportable to DHCS. The Plan's CCO will review the report with other Plan executives as appropriate to determine if the results involve a matter of suspected Fraud, Waste or Abuse. The CCO or

designated Compliance staff will submit reports of suspected Fraud, Waste or Abuse to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. The report will be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;
b. E-fax at (916) 440-5287; or
c. U.S. Mail at:
Department of Health Care Services
Audits & Investigations Division
Attention: Chief, Intake Unit1500 Capitol Avenue
Sacramento, CA 95814

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

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

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

removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;
b. E-fax at (916) 440-5287; or
c. U.S. Mail at:
   Department of Health Care Services
   Managed Care Division
   Attention: Chief, Program Integrity Unit
   MS 4417
   P.O. Box 997413
   Sacramento, CA 95899-7413

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

5. Prosecution - In the event of fraud, the CEO or the RHA Commission will evaluate the appropriateness of pursuing civil prosecution. The Plan will consult with legal counsel, as described in section II.4.1.

8. Staff Training and Education:

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

The CEO and CCO, in consultation with the RHA Commission, and other executive

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

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

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

9. Public Awareness:

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

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

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

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

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

Medi-Cal anti-fraud information resources are also available on the Department of Health Care Services website: dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

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

10. Participating Health Care Providers:

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

11. Location:

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

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

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

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

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

Authority

- DHCS Contract, Exhibit E, Attachment 2, Provision 26
- Health & Safety Code Section 1348
- Code of Federal Regulations, 42 CFR 438.608, 42 CFR 438.610 and 42 CFR 455.2
- United States Code, 31 U.S.C. Section 3729 and 42 USC Section 1396a(a)(68)
- Welfare & Institutions Code Section 14043.1(a) and (i), and Section 14115.75
- DHCS All Plan Letters 08-007, 15-026, 16-001

References

- CalViva Health Compliance Program
- CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation

APPENDIX A

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

I. Types of Fraudulent Acts

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

A. Fabrication of Claims

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

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

B. Falsification of Claims

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

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

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

II. Examples of Indicators of Potential Fraud

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

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

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

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

16. Any confirmed cases based on Service Verification (SV) member reporting.

APPENDIX B

CalViva Health Referral Form for Incident of Suspected Fraud

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

Name: _____ Contact Phone: _____

Department: _____

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

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

INFORMATION ABOUT THE SUSPECTED INDIVIDUAL/ENTITY

Name of Individual or Provider or Other: _____

Address: _____

Phone: _____

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

Please describe how you were informed of the incident: _____

_____

_____

Please provide a description of the suspect incident: _____

_____

_____

_____

_____

Signed: _____ Date: _____

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

APPROVAL:

February 17, 2022

Date: _____

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

February 17, 2022

Date: _____

Name: Jeffery Nkansah
Title: Chief Executive Officer

February 17, 2022

Date: _____

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

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

2-18-16	Section 11 and office address throughout	Updated office address and phone numbers and added information from APL15-026
2-17-17	Various	Clarified the overview and operational structure of CalViva Health. Removed reference to Optum as Health Net no longer uses Optum in their SIU activity.
2-15-18	Various	Annual Review, minor grammatical changes and added a reference to the COO and Operations Department staff.
01/07/19	Section II 7.	Inserted PIU e-mail address.
2-20-20	Overview; Sections II.4.1; II.7, 1 & 4	Clarified contractual relationships related to anti-fraud activity; updated external resources information; added revisions to reflect new requirements specified in DHCS–CalViva Contract (10-87050 A12) and made other minor editorial changes (grammar, regulatory citations, clarification to reflect current activities, etc.).
7/8/20	Section II # 9	Updated the DHCS website URL. Deleted an obsolete DHCS URL.
10/20/20	Section II, 2(6. And 13.); Section II, 6; Section II, 7(1. And 3); and Appendix A. II (16.)	Section II, 2(6. And 13.) added reference to EOC, and new Service Verification (SV) language; Section II, 7(1.) deleted typo and added “Promptly” reported and “Substantiated” preliminary to paragraph. Section II, 7(3.) added correct department name for mailing, “Managed Care Operations Division.” Appendix A, II, #16 added reference to Service Verification (SV) reporting.
1/17/22	Cover Page and throughout	Updated the CCO to Mary Lourdes Leone and the CEO to Jeffery Nkansah; Under References, specifically added the name of CalViva’s policy (CO-005).

Item #17

Attachment 17.A

2022 Privacy and Security Plan

PRIVACY AND SECURITY PLAN

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

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mlleone@calvivahealth.org
Phone: 559-540-7856

Table of Contents

I. CalViva Health Overview

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

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

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

1. Statement of Purpose:

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

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

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

2. **Confidentiality Guideline:**

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

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

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

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

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

II. OVERSIGHT AND EVALUATION OF PLAN

1. Designation of Privacy and Security Officer:

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

The CCO responsibilities include:

A. Serving as the Privacy and Security Officer

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

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

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

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

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

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

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

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

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

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

laws; and

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

2. CalViva Health's Compliance Committee:

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

The Committee's responsibilities include:

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

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

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

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

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

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

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

H. Overseeing development of resolutions to Breach issues.

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

recurrence in the future.

3. CalViva Health Management:

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

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

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

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

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

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

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

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

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

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

III. DEFINITIONS, MISSION, AND GOALS AND OBJECTIVES

1. Definitions:

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

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

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

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

a. "Breach" excludes three scenarios:

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

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

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

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

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

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

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

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

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

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

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

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

N. **Vulnerability** – Weakness in an information system, system Security procedures, internal controls, or implementation that could be exploited by a threat source and lead to a compromise in the integrity of that system.

2. **Mission:**

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

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

The elements of the mission allow CalViva Health to:

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

requests for restrictions and accounting of disclosures.

C. Protect the public's health and well-being.
D. Adhere to the HIPAA General Administrative Privacy Rule Requirements as published in the final rule on December 28, 2000 and amended on March 27, 2002 and August 14, 2002. These requirements are found in 45 C.F.R. Part 160 and Part 164, sections 101 through 106 (otherwise known as Subparts A, B and C).
E. Adhere to the HIPAA General Administrative Security Rule as published in the final rule on February 20, 2003. These requirements are found in 45 C.F.R. Part 160, 162 and 164.
F. Adhere to the HIPAA Omnibus Rule as published on January 25, 2013.
G. Comply with the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
H. Comply with the California Civil Code sections 1798.29(a) and 1798.82(a), California Confidentiality of Medical Information Act, Civil Code 56 et seq. and California Health and Safety Code sections 1364.5 and 1386 (b) (15) requirements and the California information Practices Act of 1977.
I. Comply with the California Department of Health Care Services (DHCS) contract requirements Exhibit G; Department of Managed Health Care (DMHC), California Civil Code section 1798.82, Center for Medicare and Medicaid Services (CMS); and, the HITECH Act Breach reporting requirements.
J. Ensure privacy and Security training is provided to CalViva Health employees, management and business associates.
K. Ensure Risk Analyses and Risk Mitigation Implementation Plans are conducted and implemented.

3. **Goals and Objectives:**

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

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

A. Provides oversight and monitoring of responsibilities delegated to contracted and sub- contracted entities.
B. Implement corrective action plans to address deficiencies in the safeguard or use of Protected Health Information.
C. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.
D. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.
E. Conduct internal monitoring and auditing of CalViva Health operations and functions to assess compliance with state and federal requirements.
F. Identify and investigate potential privacy and Security Breaches. Take appropriate

action(s) to resolve and report Breaches.

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

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

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

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

IV. SCOPE OF PLAN

1. Policy and Procedures:

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

A. How PHI is used and disclosed
B. The individual's rights to PHI
C. CalViva Health's relationship with contractors and sub-contractors
D. CalViva Health's response plan for complaints and privacy Breaches
E. CalViva Health's training programs
F. CalViva Health's Risk Analyses and Risk Mitigation measures
G. CalViva Health's contingency plans
H. CalViva Health's utilization of technology to communicate with members, providers, consumers, and employees.

2. Permitted Uses and Disclosures:

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

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

3. CalViva Health Responsibilities:

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

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

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

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

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

3. **Use of Paper Document Controls –** CalViva Health's paper document controls includes protection of data by making sure PHI in paper form is locked in a file cabinet rather than left unattended. CalViva Health also escorts visitors to areas in which PHI is housed. CalViva Health confidentially shreds and destroys PHI in paper form and never removes PHI from the premises except for routine business purposes or with the express written permission of a state and/or federal agency. Faxes containing PHI are never left unattended and outgoing faxes include a confidentiality statement notifying the recipient receiving to destroy faxes received in error. PHI is mailed using secure means and for large volume mailings of PHI, CalViva Health uses a bonded courier with signature required on receipt.

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

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

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

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

4. Education and Training Programs:

CalViva Health will ensure that training is provided to all employees and business associates. All

employees with access to Protected Health Information are required to attend and participate in privacy and security training sessions. Adherence to the provisions of this plan, such as attending training sessions, will be a factor in the annual evaluation of each employee. All new employees will be provided training within a reasonable period after orientation.

5. Risk Analysis and Risk Management:

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

CalViva Health implements these steps when conducting a Risk Analysis:

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

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

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

APPROVAL:

Date: **February 17, 2022**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

Date: **February 17, 2022**

Name: Jeffrey Nkansah
Title: Chief Executive Officer

Date: **February 17, 2022**

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

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

2/16/2017		Annual Review; Updated overview clarify current contractual relationships and activities. Updated the name of document from Privacy and Security Program to Privacy and Security Plan.
2/15/2018		Annual Review; Updated the officer responsible for the Privacy and Security Plan, added a reference to comply with California's Data Breach Security Reporting Requirements, Updated the Department Responsible for the Plan and the reference to the name of the report which would be provided to the RHA Commission. Re-arranged sections for readability.
2/21/2019		Annual Review; No Changes Needed
2/20/2020		Annual Review; Added language referencing new policy HI-031 Member Communications under Telephone Consumer Protections Act (TCPA). Clarified a definition and a publishing date for a previously released regulatory law.
2/18/2021		Annual Review; No Changes Needed
2/3/2022		Annual Review; Updated the CCO to Mary Lourdes Leone and the CEO to Jeffery Nkansah

Item #18

Attachment 18.A

Financials as of December 31, 2021

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of December 31, 2021

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	184,268,121.75
5	Total Bank Accounts	$ 184,268,121.75
6	Accounts Receivable	
7	Accounts Receivable	187,387,804.13
8	Total Accounts Receivable	$ 187,387,804.13
9	Other Current Assets	
10	Interest Receivable	2,649.39
11	Investments - CDs	0.00
12	Prepaid Expenses	672,498.29
13	Security Deposit	0.00
14	Total Other Current Assets	$ 675,147.68
15	Total Current Assets	$ 372,331,073.56
16	Fixed Assets	
17	Buildings	6,315,257.92
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	87,137.68
21	Total Fixed Assets	$ 9,563,814.70
22	Other Assets	
23	Investment -Restricted	301,525.77
24	Lease Receivable	3,192,798.94
25	Total Other Assets	$ 3,494,324.71
26	TOTAL ASSETS	$ 385,389,212.97
27	LIABILITIES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	140,478.36
32	Accrued Admin Service Fee	4,316,202.00
33	Capitation Payable	202,563,886.46
34	Claims Payable	14,004.77
35	Directed Payment Payable	3,455,426.56
36	Total Accounts Payable	$ 210,489,998.15
37	Other Current Liabilities	
38	Accrued Expenses	1,035,892.89
39	Accrued Payroll	201,194.01
40	Accrued Vacation Pay	370,762.59
41	Amt Due to DHCS	0.00
42	IBNR	49,890.52
43	Loan Payable-Current	0.00
44	Premium Tax Payable	0.00
45	Premium Tax Payable to BOE	6,052,350.70
46	Premium Tax Payable to DHCS	41,562,500.00
47	Total Other Current Liabilities	$ 49,272,590.71
48	Total Current Liabilities	$ 259,762,588.86
49	Long-Term Liabilities	
50	Renters' Security Deposit	25,906.79
51	Subordinated Loan Payable	0.00
52	Total Long-Term Liabilities	$ 25,906.79
53	Total Liabilities	$ 259,788,495.65
54	Deferred Inflows of Resources	$ 3,280,149.10
55	Equity	
56	Retained Earnings	119,072,374.53
57	Net Income	3,248,193.69
58	Total Equity	$ 122,320,568.22
59	TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND EQUITY	$ 385,389,212.97

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2021 - December 2021

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	Interest Income	132,953.46	48,000.00	84,953.46
3	Premium/Capitation Income	694,615,959.43	682,680,662.00	11,935,297.43
4	**Total Income**	**694,748,912.89**	**682,728,662.00**	**12,020,250.89**
5	**Cost of Medical Care**			
6	Capitation - Medical Costs	576,461,059.57	566,828,399.00	9,632,660.57
7	Medical Claim Costs	510,729.20	540,000.00	(29,270.80)
8	**Total Cost of Medical Care**	**576,971,788.77**	**567,368,399.00**	**9,603,389.77**
9	**Gross Margin**	**117,777,124.12**	**115,360,263.00**	**2,416,861.12**
10	**Expenses**			
11	Admin Service Agreement Fees	25,725,304.00	25,160,300.00	565,004.00
12	Bank Charges	119.35	3,600.00	(3,480.65)
13	Computer/IT Services	91,684.91	94,998.00	(3,313.09)
14	Consulting Fees	0.00	150,000.00	(150,000.00)
15	Depreciation Expense	143,142.87	153,000.00	(9,857.13)
16	Dues & Subscriptions	83,248.70	90,096.00	(6,847.30)
17	Grants	2,356,818.20	2,356,818.20	0.00
18	Insurance	91,115.02	90,309.00	806.02
19	Labor	1,917,191.88	1,933,869.00	(16,677.12)
20	Legal & Professional Fees	40,592.02	95,400.00	(54,807.98)
21	License Expense	398,537.58	427,830.00	(29,292.42)
22	Marketing	631,829.78	835,000.00	(203,170.22)
23	Meals and Entertainment	14,156.09	14,850.00	(693.91)
24	Office Expenses	29,812.95	42,000.00	(12,187.05)
25	Parking	206.95	750.00	(543.05)
26	Postage & Delivery	1,602.05	1,680.00	(77.95)
27	Printing & Reproduction	1,138.02	2,400.00	(1,261.98)
28	Recruitment Expense	1,698.65	18,000.00	(16,301.35)
29	Rent	0.00	6,000.00	(6,000.00)
30	Seminars and Training	9,448.88	13,000.00	(3,551.12)
31	Supplies	4,594.34	5,400.00	(805.66)
32	Taxes	83,125,000.00	83,125,002.00	(2.00)
33	Telephone/Internet	17,365.18	17,940.00	(574.82)
34	Travel	7,704.46	11,500.00	(3,795.54)
35	**Total Expenses**	**114,692,311.88**	**114,649,742.20**	**42,569.68**
36	**Net Operating Income/ (Loss)**	**3,084,812.24**	**710,520.80**	**2,374,291.44**
37	**Other Income**			
38	Other Income	163,381.45	259,998.00	(96,616.55)
39	**Total Other Income**	**163,381.45**	**259,998.00**	**(96,616.55)**
40	**Net Other Income**	**163,381.45**	**259,998.00**	**(96,616.55)**
41	**Net Income/ (Loss)**	**3,248,193.69**	**970,518.80**	**2,277,674.89**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2022 vs FY 2021

		Total	
		July 2021 - Dec 2021 (FY 2022)	July 2020 - Dec 2020 (FY 2021)
1	Income		
2	Interest Income	132,953.46	83,250.09
3	Premium/Capitation Income	694,615,959.43	647,654,615.42
4	Total Income	**694,748,912.89**	**647,737,865.51**
5	Cost of Medical Care		
6	Capitation - Medical Costs	576,461,059.57	543,925,249.96
7	Medical Claim Costs	510,729.20	369,256.69
8	Total Cost of Medical Care	**576,971,788.77**	**544,294,506.65**
9	Gross Margin	**117,777,124.12**	**103,443,358.86**
10	Expenses		
11	Admin Service Agreement Fees	25,725,304.00	24,434,597.00
12	Bank Charges	119.35	993.77
13	Computer/IT Services	91,684.91	91,485.80
14	Depreciation Expense	143,142.87	143,178.36
15	Dues & Subscriptions	83,248.70	80,121.00
16	Grants	2,356,818.20	2,475,000.00
17	Insurance	91,115.02	87,699.04
18	Labor	1,917,191.88	1,798,923.94
19	Legal & Professional Fees	40,592.02	62,717.00
20	License Expense	398,537.58	379,663.67
21	Marketing	631,829.78	658,359.95
22	Meals and Entertainment	14,156.09	11,360.08
23	Office Expenses	29,812.95	31,376.24
24	Parking	206.95	0.00
25	Postage & Delivery	1,602.05	1,074.91
26	Printing & Reproduction	1,138.02	835.65
27	Recruitment Expense	1,698.65	1,573.98
28	Rent	0.00	0.00
29	Seminars and Training	9,448.88	946.04
30	Supplies	4,594.34	4,018.00
31	Taxes	83,125,000.00	74,811,403.50
32	Telephone/Internet	17,365.18	16,938.26
33	Travel	7,704.46	144.34
34	Total Expenses	**114,692,311.88**	**105,092,410.53**
35	Net Operating Income/ (Loss)	**3,084,812.24**	**(1,649,051.67)**
36	Other Income		
37	Other Income	163,381.45	311,633.37
38	Total Other Income	**163,381.45**	**311,633.37**
39	Net Other Income	**163,381.45**	**311,633.37**
40	Net Income/ (Loss)	**3,248,193.69**	**(1,337,418.30)**

Item #18

Attachment 18.B

A & G Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2021

Current as of End of the Month: December
Revised Date: 1/19/2022

CalViva - 2021																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2021 YTD**	**2020 YTD**
Expedited Grievances Received	8	15	14	37	9	16	17	42	19	11	14	44	22	13	14	49	172	110
Standard Grievances Received	91	102	130	323	119	117	140	376	137	98	128	363	104	67	83	254	1316	997
Total Grievances Received	**99**	**117**	**144**	**360**	**128**	**133**	**157**	**418**	**156**	**109**	**142**	**407**	**126**	**80**	**97**	**303**	**1488**	**1107**
Grievance Ack Letters Sent Noncompliant	0	2	0	2	0	0	0	0	0	1	0	1	1	0	0	1	4	3
Grievance Ack Letter Compliance Rate	**100.0%**	**98.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.0%**	**100.0%**	**99.7%**	**99.0%**	**100.0%**	**100.0%**	**99.6%**	**99.70%**	**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	14	14	36	10	16	13	39	23	11	12	46	23	12	16	51	172	111
Expedited Grievance Compliance rate	**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%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	1	1	1	0	1	2	3	0
Standard Grievances Resolved Compliant	68	88	122	278	112	125	134	371	125	136	99	360	115	110	75	300	1309	1033
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.0%**	**99.7%**	**99.1%**	**100.0%**	**98.7%**	**99.3%**	**99.77%**	**100.0%**
Total Grievances Resolved	**76**	**102**	**136**	**314**	**122**	**141**	**147**	**410**	**148**	**147**	**112**	**407**	**139**	**122**	**92**	**353**	**1484**	**1144**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**56**	**79**	**106**	**241**	**98**	**119**	**119**	**336**	**123**	**103**	**92**	**318**	**113**	**91**	**60**	**264**	**1159**	**878**
Access - Other - DMHC	6	17	21	44	23	24	18	65	27	25	20	72	26	19	15	60	241	63
Access - PCP - DHCS	3	12	9	24	4	6	11	21	12	6	6	24	11	7	11	29	98	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	3	9	19	6	8	10	24	12	6	6	24	11	7	2	20	87	48
Administrative	8	13	19	40	19	26	20	65	17	18	17	52	8	16	8	32	189	191
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	4	11	8	23	11	5	9	25	3	11	4	18	10	12	9	31	97	82
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	6	7	15	9	8	9	26	4	2	1	7	2	4	5	11	59	80
Pharmacy	1	2	3	6	2	3	1	6	3	5	7	15	2	5	2	9	36	51
Transportation - Access	13	5	16	34	8	25	18	51	25	10	15	50	19	13	7	39	174	116
Transportation - Behaviour	11	10	13	34	15	14	21	50	20	19	16	55	24	8	1	33	172	100
Transportation - Other	1	0	1	2	1	0	2	3	0	1	0	1	0	0	0	0	6	37
Quality Of Care Grievances	**20**	**23**	**30**	**73**	**24**	**22**	**28**	**74**	**25**	**44**	**20**	**89**	**26**	**31**	**32**	**89**	**325**	**266**
Access - Other - DMHC	0	0	0	0	3	0	0	3	0	0	0	0	0	0	1	1	4	4
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	1	2	0	0	0	0	2	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	2	1	4	0	0	0	0	0	1	0	1	0	1	0	1	6	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	6	8	19	5	2	6	13	7	10	5	22	2	7	2	11	65	56
PCP Care	5	5	7	17	4	5	7	16	3	6	1	10	5	2	8	15	58	95
PCP Delay	4	7	9	20	7	10	9	26	7	12	7	26	12	10	13	35	107	42
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0
Specialist Care	3	2	4	9	3	2	1	6	4	12	4	20	5	7	5	17	52	46
Specialist Delay	2	1	1	4	2	3	5	10	3	3	2	8	2	3	3	8	30	15
Exempt Grievances Received	229	255	325	**809**	335	285	238	**858**	320	392	393	**1105**	298	263	234	**795**	**3567**	2877
Access - Avail of Appt w/ PCP	3	3	3	**9**	3	2	7	**12**	0	3	0	**3**	7	4	6	**17**	**41**	93
Access - Avail of Appt w/ Specialist	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	1	0	**1**	**3**	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	6	**10**	7	2	7	**16**	3	4	9	**16**	0	0	0	**0**	**42**	35
Access - Wait Time - in office for appt	0	0	1	**1**	1	2	2	**5**	0	1	4	**5**	6	0	3	**9**	**20**	17
Access - Panel Disruption	5	11	9	**25**	6	3	3	**12**	3	5	1	**9**	3	1	1	**5**	**51**	57
Access - Shortage of Providers	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	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	1	1	**3**	0	1	0	**1**	1	3	0	**4**	2	0	0	**2**	**10**	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	2	0	**2**	0	1	2	**3**	0	1	1	**2**	**7**	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	1	1	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	0
Attitude/Service - Health Plan Staff	2	3	1	**6**	2	0	0	**2**	3	1	3	**7**	0	0	0	**0**	**15**	17
Attitude/Service - Provider	27	27	34	**88**	79	41	19	**139**	59	98	74	**231**	62	47	34	**143**	**601**	285
Attitude/Service - Office Staff	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	12
Attitude/Service - Vendor	3	0	0	**3**	1	2	1	**4**	3	2	0	**5**	2	0	2	**4**	**16**	11
Attitude/Service - Health Plan	1	0	0	**1**	4	0	0	**4**	0	2	1	**3**	3	0	0	**3**	**11**	11
Authorization - Authorization Related	0	1	0	**1**	3	1	3	**7**	2	4	2	**8**	5	1	2	**8**	**24**	25
Eligibility Issue - Member not eligible per Health Plan	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	6
Eligibility Issue - Member not eligible per Provider	4	2	5	**11**	5	5	3	**13**	7	2	3	**12**	3	3	1	**7**	**43**	37
Health Plan Materials - ID Cards-Not Received	28	56	46	**130**	40	36	26	**102**	32	38	43	**113**	33	35	34	**102**	**447**	235
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	3	**3**	1	1	2	**4**	0	1	2	**3**	0	0	1	**1**	**11**	7
Health Plan Materials - Other	0	1	2	**3**	0	1	0	**1**	0	0	1	**1**	2	0	0	**2**	**7**	3
PCP Assignment/Transfer - Health Plan Assignment - Change Request	93	99	138	**330**	133	89	75	**297**	53	86	92	**231**	71	61	56	**188**	**1046**	1162
PCP Assignment/Transfer - HCO Assignment - Change Request	11	20	22	**53**	4	49	41	**94**	52	51	68	**171**	30	37	36	**103**	**421**	156
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	0

CalViva Health Appeals and Grievances Dashboard 2021

PCP Assignment/Transfer - PCP Transfer not Processed	3	1	4	**8**	1	4	0	**5**	3	0	2	**5**	1	2	2	**5**	**23**	19
PCP Assignment/Transfer - Rollout of PPG	4	3	5	**12**	3	2	0	**5**	6	2	2	**10**	1	0	0	**1**	**28**	45
PCP Assignment/Transfer - Mileage Inconvenience	4	4	10	**18**	16	7	1	**24**	11	7	13	**31**	6	2	5	**13**	**86**	58
Pharmacy - Authorization Issue	2	0	0	**2**	0	0	0	**0**	0	4	1	**5**	0	0	1	**1**	**8**	5
Pharmacy - Authorization Issue-CalViva Error	0	1	0	**1**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**2**	1
Pharmacy - Eligibility Issue	8	5	8	**21**	10	10	14	**34**	20	25	23	**68**	17	16	5	**38**	**161**	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	2	2	**12**	4	2	6	**12**	6	7	4	**17**	2	3	3	**8**	**49**	45
Transportation - Access - Provider No Show	3	3	1	**7**	0	0	1	**1**	1	3	2	**6**	14	20	14	**48**	**62**	24
Transportation - Access - Provider Late	1	1	2	**4**	0	1	1	**2**	8	2	1	**11**	8	5	3	**16**	**33**	52
Transportation - Behaviour	4	4	1	**9**	0	4	9	**13**	11	13	14	**38**	13	16	12	**41**	**101**	119
Transportation - Other	1	0	0	**1**	0	0	1	**1**	2	1	3	**6**	0	0	0	**0**	**8**	12
OTHER - Other	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	7
OTHER - Balance Billing from Provider	8	4	16	**28**	12	15	16	**43**	34	24	23	**81**	7	8	12	**27**	**179**	161

CalViva Health Appeals and Grievances Dashboard 2021

Appeals	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**June**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**YTD**
Expedited Appeals Received	8	6	9	23	1	6	5	12	12	6	5	23	7	12	8	27	85	115
Standard Appeals Received	45	68	90	203	58	68	63	189	55	76	60	191	49	54	49	152	735	918
Total Appeals Received	**53**	**74**	**99**	**226**	**59**	**74**	**68**	**201**	**67**	**82**	**65**	**214**	**56**	**66**	**57**	**179**	820	**1033**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	1	3
Appeals Ack Letter Compliance Rate	**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%**	**98.1%**	**100.0%**	**99.3%**	**99.86%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Expedited Appeals Resolved Compliant	7	8	8	**23**	2	6	5	**13**	12	3	6	**21**	8	11	9	28	85	114
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**66.7%**	**100.0%**	**95.2%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.84%**	**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	45	76	172	84	55	74	213	74	54	65	193	67	54	42	163	741	916
Standard Appeals Compliance Rate	**98.0%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.87%**	**100.0%**
Total Appeals Resolved	**59**	**53**	**84**	**196**	**86**	**61**	**79**	**226**	**86**	**58**	**71**	**215**	**75**	**65**	**51**	**191**	**828**	**1031**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**59**	**53**	**84**	**196**	**86**	**61**	**79**	**226**	**86**	**58**	**71**	**215**	**75**	**65**	**51**	**191**	**828**	1029
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	1	4	5	1	1	2	4	3	0	2	5	0	0	1	1	15	17
DME	4	4	6	14	10	5	11	26	7	3	10	20	5	1	4	10	70	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	2	0	0	2	0	0	0	0	0	0	1	1	4	2
Advanced Imaging	22	18	34	74	37	21	36	94	29	22	22	73	35	16	13	64	305	488
Other	7	5	3	15	7	3	8	18	10	3	6	19	1	7	5	13	65	67
Pharmacy	20	24	33	77	24	26	19	69	33	26	26	85	30	39	26	95	326	362
Surgery	5	1	4	10	5	5	3	13	4	4	5	13	4	2	1	7	43	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**	**1**	**1**	**1**	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	1	1	1	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	35	33	47	**115**	53	32	37	122	42	22	45	109	42	39	16	97	443	577
Uphold Rate	**59.3%**	**62.3%**	**56.0%**	**58.7%**	**61.6%**	**52.5%**	**46.8%**	**54.0%**	**48.8%**	**37.9%**	**63.4%**	**50.7%**	**56.0%**	**60.0%**	**31.4%**	**50.8%**	**53.5%**	**56.0%**
Overturns - Full	22	17	35	**74**	31	28	41	**100**	43	34	23	**100**	32	25	30	**87**	361	432
Overturn Rate - Full	**37.3%**	**32.1%**	**41.7%**	**37.8%**	**36.0%**	**45.9%**	**51.9%**	**44.2%**	**50.0%**	**58.6%**	**32.4%**	**46.5%**	**42.7%**	**38.5%**	**58.8%**	**45.5%**	**43.6%**	**41.9%**
Overturns - Partials	1	2	2	**5**	0	1	0	**1**	0	2	1	**3**	1	0	3	**4**	13	12
Overturn Rate - Partial	**1.7%**	**3.8%**	**2.4%**	**2.6%**	**0.0%**	**1.6%**	**0.0%**	**0.4%**	**0.0%**	**3.4%**	**1.4%**	**1.4%**	**1.3%**	**0.0%**	**5.9%**	**2.09%**	**1.6%**	**1.2%**
Withdrawal	1	1	0	**2**	2	0	1	**3**	1	0	2	**3**	0	1	2	3	**11**	10
Withdrawal Rate	**1.7%**	**1.9%**	**0.0%**	**1.0%**	**2.3%**	**0.0%**	**1.3%**	**1.3%**	**1.2%**	**0.0%**	**2.8%**	**1.4%**	**0.0%**	**1.5%**	**3.9%**	**1.6%**	**1.3%**	**1.0%**
Membership	376,770	378,355	380,179		382,052	383,876	385,467		386,814	388,184	389,651		390,506	391,857	393,125			########
Appeals - PTMPM	0.16	0.14	0.22	0.17	0.23	0.16	0.20	0.20	0.22	0.15	0.18	0.18	0.19	0.17	0.13	0.16	0.18	0.24
Grievances - PTMPM	0.20	0.27	0.36	0.28	0.32	0.37	0.38	0.36	0.38	0.38	0.29	0.35	0.36	0.31	0.23	0.30	0.32	0.27

Fresno County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2021 YTD	2020 YTD
Expedited Grievances Received	7	12	13	32	4	16	14	34	14	7	13	34	21	13	8	42	142	92
Standard Grievances Received	77	79	118	274	96	109	115	320	117	86	110	313	86	61	69	216	1123	864
Total Grievances Received	**84**	**91**	**131**	**306**	**100**	**125**	**129**	**354**	**131**	**93**	**123**	**347**	**107**	**74**	**77**	**258**	**1265**	**956**
Grievance Ack Letters Sent Noncompliant	0	2	0	2	0	0	0	0	0	1	0	1	1	0	0	1	4	3
Grievance Ack Letter Compliance Rate	**100.0%**	**97.5%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.8%**	**100.0%**	**99.7%**	**98.8%**	**100.0%**	**100.0%**	**99.5%**	**99.6%**	**99.65%**
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	7	11	13	31	5	16	10	31	18	7	12	37	21	12	10	43	142	93
Expedited Grievance Compliance rate	**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%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	2	2	0
Standard Grievances Resolved Compliant	57	73	96	226	104	102	125	331	102	119	85	306	94	95	67	256	1119	894
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.9%**	**100.0%**	**98.5%**	**99.2%**	**99.8%**	**100.0%**
Total Grievances Resolved	**64**	**84**	**109**	**257**	**109**	**118**	**135**	**362**	**120**	**126**	**97**	**343**	**116**	**107**	**78**	**301**	**1263**	**987**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**47**	**64**	**86**	**197**	**85**	**100**	**107**	**292**	**98**	**87**	**79**	**264**	**94**	**79**	**51**	**224**	**977**	**758**
Access - Other - DMHC	6	15	21	42	19	21	17	57	22	16	18	56	25	18	12	55	210	56
Access - PCP - DHCS	3	10	9	22	3	5	10	18	7	6	6	19	9	7	9	25	84	98
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	5	2	6	13	4	7	7	18	10	5	4	19	9	6	1	16	66	38
Administrative	8	12	13	33	15	24	20	59	15	16	14	45	7	10	8	25	162	162
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	3	9	4	16	10	4	7	21	3	9	4	16	9	12	8	29	82	73
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	3	6	10	9	7	9	25	2	2	1	5	2	4	5	11	51	61
Pharmacy	1	2	3	6	2	1	1	4	2	5	6	13	2	4	2	8	31	40
Transportation - Access	11	3	14	28	7	20	15	42	24	9	13	46	14	12	5	31	147	104
Transportation - Behaviour	8	8	9	25	15	11	19	45	13	18	13	44	17	6	1	24	138	90
Transportation - Other	1	0	1	2	1	0	2	3	0	1	0	1	0	0	0	0	6	33
Quality Of Care Grievances	**17**	**20**	**23**	**60**	**24**	**18**	**28**	**70**	**22**	**39**	**18**	**79**	**22**	**28**	**27**	**77**	**286**	**229**
Access - Other - DMHC	0	0	0	0	3	0	0	3	0	0	0	0	0	0	1	1	4	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	1	2	0	0	0	0	2	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	2	1	4	0	0	0	0	0	1	0	1	0	1	0	1	6	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	5	7	16	5	1	6	12	5	8	4	17	2	7	1	10	55	48
PCP Care	4	4	4	12	4	4	7	15	3	6	1	10	3	0	5	8	45	83
PCP Delay	4	6	7	17	7	9	9	25	7	10	7	24	10	9	13	32	98	37
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0
Specialist Care	3	2	3	8	3	1	1	5	3	11	3	17	5	7	5	17	47	38
Specialist Delay	1	1	1	3	2	3	5	10	3	3	2	8	2	3	2	7	28	12

CalViva Health Appeals and Grievances Dashboard 2021 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	6	4	9	19	1	4	5	10	11	5	2	18	5	7	6	18	65	96
Standard Appeals Received	37	49	80	166	45	59	53	157	43	59	48	150	44	48	41	133	606	789
Total Appeals Received	**43**	**53**	**89**	**185**	**46**	**63**	**58**	**167**	**54**	**64**	**50**	**168**	**49**	**55**	**47**	**151**	671	**885**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	2
Appeals Ack Letter Compliance Rate	**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%**	**97.9%**	**100.0%**	**99.2%**	**99.8%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Expedited Appeals Resolved Compliant	5	6	8	19	2	4	5	11	11	3	3	17	5	7	6	18	65	95
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**66.7%**	**100.0%**	**94.1%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.5%**	**98.9%**
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	46	38	53	137	76	43	63	**182**	62	38	55	**155**	54	49	36	**139**	613	785
Standard Appeals Compliance Rate	**97.8%**	**100.0%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**
Total Appeals Resolved	**52**	**44**	**61**	**157**	**78**	**47**	**68**	**193**	**73**	**42**	**58**	**173**	**59**	**56**	**42**	**157**	**680**	**881**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**52**	**44**	**61**	**157**	**78**	**47**	**68**	**193**	**73**	**42**	**58**	**173**	**59**	**56**	**42**	**157**	**680**	**880**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	2	2	1	1	2	4	2	0	2	4	0	0	0	0	10	15
DME	4	4	6	14	10	3	8	21	7	1	9	17	5	0	4	9	61	38
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	2	0	0	2	0	0	0	0	0	0	1	1	4	2
Advanced Imaging	20	17	26	63	34	18	30	82	25	14	17	56	27	14	11	52	253	436
Other	7	5	3	15	5	2	8	15	10	3	5	18	1	6	3	10	58	58
Pharmacy	16	17	21	54	21	18	17	56	26	20	21	67	23	34	22	79	256	291
Surgery	4	1	3	8	5	5	3	13	3	4	4	11	3	2	1	6	38	40
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**	**1**	**1**	**1**	**1**
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	1	1	1	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	29	27	37	**93**	47	25	33	**105**	35	15	33	**83**	31	33	14	**78**	359	497
Uphold Rate	**55.8%**	**61.4%**	**60.0%**	**59.2%**	**60.3%**	**53.2%**	**48.5%**	**54.4%**	**47.9%**	**35.7%**	**56.9%**	**48.0%**	**52.5%**	**58.9%**	**33.3%**	**49.7%**	**52.8%**	**56.4%**
Overturns - Full	21	15	22	**58**	30	22	35	**87**	37	26	23	**86**	28	22	23	**73**	304	364
Overturn Rate - Full	**40.4%**	**34.1%**	**36.7%**	**36.9%**	**38.5%**	**46.8%**	**51.5%**	**45.1%**	**50.7%**	**61.9%**	**39.7%**	**49.7%**	**47.5%**	**0.0%**	**0.0%**	**46.5%**	**44.7%**	**41.3%**
Overturns - Partials	1	1	2	**4**	0	0	0	**0**	0	1	1	**2**	0	0	3	**3**	9	12
Overturn Rate - Partial	**1.9%**	**2.3%**	**3.3%**	**2.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.4%**	**1.7%**	**1.2%**	**0.0%**	**0.0%**	**7.1%**	**1.9%**	**1.3%**	**1.4%**
Withdrawal	1	1	0	**2**	1	0	0	**1**	1	0	1	**2**	0	1	2	**3**	8	8
Withdrawal Rate	**1.9%**	**2.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**0.0%**	**0.5%**	**1.4%**	**0.0%**	**1.7%**	**1.2%**	**0.0%**	**1.8%**	**4.8%**	**1.9%**	**1.2%**	**0.9%**
Membership	304,759	305,990	307,463		308,852	310,191	311,420		312,453	313,499	314,657		315,334	316,422				**1700076**
Appeals - PTMPM	0.17	0.14	0.20	0.17	0.25	0.15	0.22	0.21	0.23	0.13	0.18	0.18	0.19	0.18	-	0.00	0.14	0.19
Grievances - PTMPM	0.21	0.27	0.36	0.28	0.35	0.38	0.43	0.39	0.38	0.40	0.31	0.36	0.37	0.34	-	0.00	0.26	0.21

Kings County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2021 YTD	2020 YTD
Expedited Grievances Received	1	1	0	2	4	0	1	5	2	1	0	3	1	0	4	5	15	10
Standard Grievances Received	5	9	4	18	14	2	14	30	6	4	10	20	7	1	8	16	84	58
Total Grievances Received	**6**	**10**	**4**	**20**	**18**	**2**	**15**	**35**	**8**	**5**	**10**	**23**	**8**	**1**	**12**	**21**	**99**	**68**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**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%**
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	1	1	0	2	4	0	1	5	2	1	0	3	1	0	4	5	15	10
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**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	4	7	8	19	2	15	3	20	10	6	4	20	12	7	2	21	80	57
Standard Grievance Compliance rate	**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%**	**100.0%**
Total Grievances Resolved	**5**	**8**	**8**	**21**	**6**	**15**	**4**	**25**	**12**	**7**	**4**	**23**	**13**	**7**	**6**	**26**	95	**67**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**4**	**7**	**6**	**17**	**6**	**13**	**4**	**23**	**11**	**5**	**3**	**19**	**11**	**6**	**6**	**23**	**82**	**56**
Access - Other - DMHC	0	0	0	0	2	1	0	3	3	4	1	8	1	1	1	3	14	3
Access - PCP - DHCS	0	1	0	1	1	0	0	1	3	0	0	3	1	0	2	3	8	2
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	2	1	0	3	2	1	1	4	0	0	0	0	1	0	0	1	8	4
Administrative	0	0	1	1	1	2	0	3	1	1	0	2	0	2	0	2	8	13
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	0	2	2	0	0	1	1	0	0	0	0	0	0	1	1	4	1
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	2	1	3	0	1	0	1	1	0	0	1	0	0	0	0	5	12
Pharmacy	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	2	8
Transportation - Access	0	1	1	2	0	5	0	5	0	0	2	2	4	1	2	7	16	5
Transportation - Behaviour	2	2	1	5	0	2	2	4	2	0	0	2	4	2	0	6	17	6
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Quality Of Care Grievances	**1**	**1**	**2**	**4**	**0**	**2**	**0**	**2**	**1**	**2**	**1**	**4**	**2**	**1**	**0**	**3**	**13**	**11**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	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	1	1	1	3	0	0	0	0	3	3
PCP Care	0	0	1	1	0	1	0	1	0	0	0	0	0	1	0	1	3	5
PCP Delay	0	1	0	1	0	0	0	0	0	1	0	1	2	0	0	2	4	1
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	2
Specialist Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0

CalViva Health Appeals and Grievances Dashboard 2021 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	1	0	0	1	0	0	0	0	1	0	2	3	0	2	1	0	4	6
Standard Appeals Received	3	3	5	11	4	5	5	14	6	8	5	19	0	2	2	0	44	41
Total Appeals Received	**4**	**3**	**5**	**12**	**4**	**5**	**5**	**14**	**7**	**8**	**7**	**22**	**0**	**4**	**3**	**0**	48	**47**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	1	0	0	1	0	0	0	0	1	0	2	3	0	2	1	3	7	6
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	1	3	5	9	3	4	6	13	7	6	6	19	3	1	2	6	47	45
Standard Appeals Compliance Rate	**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%**	**100.0%**
Total Appeals Resolved	**2**	**3**	**5**	**10**	**3**	**4**	**6**	**13**	**8**	**6**	**8**	**22**	**3**	**3**	**3**	**9**	**54**	**51**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**3**	**5**	**10**	**3**	**4**	**6**	**13**	**8**	**6**	**8**	**22**	**3**	**3**	**3**	**9**	**54**	**51**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	1	2	3	0	0	0	0	1	0	0	1	0	0	1	1	5	1
DME	0	0	0	0	0	0	2	2	0	0	1	1	0	1	0	1	4	3
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
Advanced Imaging	1	0	0	1	1	0	3	4	2	3	2	7	1	0	0	1	13	21
Other	0	0	0	0	1	0	0	1	0	0	1	1	0	1	1	2	4	4
Pharmacy	1	2	3	6	1	4	1	6	4	3	4	11	1	1	1	3	26	20
Surgery	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	1	2	2
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**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	1	2	1	**4**	2	2	2	**6**	4	1	7	**12**	3	2	0	**5**	27	26
Uphold Rate	**50.0%**	**66.7%**	**20.0%**	**40.0%**	**66.7%**	**50.0%**	**33.3%**	**46.2%**	**50.0%**	**16.7%**	**87.5%**	**54.5%**	**100.0%**	**66.7%**	**0.0%**	**55.6%**	**50.0%**	**51.0%**
Overturns - Full	1	0	4	**5**	0	1	4	**5**	4	5	0	**9**	0	1	3	**4**	23	24
Overturn Rate - Full	**50.0%**	**0.0%**	**80.0%**	**50.0%**	**0.0%**	**25.0%**	**66.7%**	**38.5%**	**50.0%**	**83.3%**	**0.0%**	**40.9%**	**0.0%**	**33.3%**	**100.0%**	**44.4%**	**42.6%**	**47.1%**
Overturns - Partials	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	2	0
Overturn Rate - Partial	**0.0%**	**33.3%**	**0.0%**	**10.0%**	**0.0%**	**25.0%**	**0.0%**	**7.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.7%**	**0.0%**
Withdrawal	0	0	0	**0**	1	0	0	**1**	0	0	1	**1**	0	0	0	**0**	2	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**33.3%**	**0.0%**	**0.0%**	**7.7%**	**0.0%**	**0.0%**	**12.5%**	**4.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.7%**	**2.0%**
Membership	31,802	31,984	32,109		32,332	32,512	32,645		32,699	32,883	33,043		33,114	33,260				**273008**
Appeals - PTMPM	0.06	0.09	0.16	0.10	0.09	0.12	0.18	0.13	0.24	0.18	0.24	0.22	0.09	0.09	-	0.14	0.15	0.14
Grievances - PTMPM	0.16	0.25	0.22	0.22	0.19	0.46	0.12	0.26	0.37	0.21	0.12	0.23	0.39	0.21	-	0.39	0.28	0.18

Madera County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2021 YTD**	**2020 YTD**
Expedited Grievances Received	0	2	1	3	1	0	2	3	3	3	1	7	0	0	2	2	15	8
Standard Grievances Received	9	14	8	31	9	6	11	26	14	8	8	30	11	5	6	22	109	75
Total Grievances Received	**9**	**16**	**9**	**34**	**10**	**6**	**13**	**29**	**17**	**11**	**9**	**37**	**11**	**5**	**8**	**24**	**124**	**83**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	**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%**	**97.3%**
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	0	2	1	3	1	0	2	3	3	3	0	6	1	0	2	3	15	8
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0
Standard Grievances Resolved Compliant	7	8	18	33	6	8	6	20	13	11	10	34	9	8	6	23	110	82
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**90.0%**	**97.1%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.1%**	**100.0%**
Total Grievances Resolved	**7**	**10**	**19**	**36**	**7**	**8**	**8**	**23**	**16**	**14**	**11**	**41**	**10**	**8**	**8**	**26**	**126**	**90**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**5**	**8**	**14**	**27**	**7**	**6**	**8**	**21**	**14**	**11**	**10**	**35**	**8**	**6**	**3**	**17**	**100**	**64**
Access - Other - DMHC	0	2	0	2	2	2	1	5	2	5	1	8	0	0	2	2	17	4
Access - PCP - DHCS	0	1	0	1	0	1	1	2	2	0	0	2	1	0	0	1	6	7
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	0	0	3	3	0	0	2	2	2	1	2	5	1	1	1	3	13	6
Administrative	0	1	5	6	3	0	0	3	1	1	3	5	1	4	0	5	19	16
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	2	2	5	1	1	1	3	0	2	0	2	1	0	0	1	11	8
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	1	0	2	0	0	0	0	1	0	0	1	0	0	0	0	3	7
Pharmacy	0	0	0	0	0	1	0	1	0	0	1	1	0	1	0	1	3	3
Transportation - Access	2	1	1	4	1	0	3	4	1	1	0	2	1	0	0	1	11	4
Transportation - Behaviour	1	0	3	4	0	1	0	1	5	1	3	9	3	0	0	3	17	7
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Quality Of Care Grievances	**2**	**2**	**5**	**9**	**0**	**2**	**0**	**2**	**2**	**3**	**1**	**6**	**2**	**2**	**5**	**9**	**26**	**26**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	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	1	1	1	3	0	1	0	1	1	1	0	2	0	0	1	1	7	5
PCP Care	1	1	2	4	0	0	0	0	0	0	0	0	2	1	3	6	10	7
PCP Delay	0	0	2	2	0	1	0	1	0	1	0	1	0	1	0	1	5	4
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	1	1	1	3	0	0	0	0	3	6
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	3

CalViva Health Appeals and Grievances Dashboard 2021 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	1	2	0	3	0	2	0	2	0	1	1	2	2	3	1	6	13	13
Standard Appeals Received	5	16	5	26	9	4	5	18	6	9	7	22	5	4	6	15	81	88
Total Appeals Received	**6**	**18**	**5**	**29**	**9**	**6**	**5**	**20**	**6**	**10**	**8**	**24**	**7**	**7**	**7**	**21**	94	**101**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**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%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	1	2	0	3	0	2	0	2	0	0	1	1	3	2	2	7	13	13
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	4	4	18	26	5	8	5	**18**	5	10	4	**19**	10	4	4	**18**	81	86
Standard Appeals Compliance Rate	**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%**	**100.0%**
Total Appeals Resolved	**5**	**6**	**18**	**29**	**5**	**10**	**5**	**20**	**5**	**10**	**5**	**20**	**13**	**6**	**6**	**25**	**94**	**99**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**5**	**6**	**18**	**29**	**5**	**10**	**5**	**20**	**5**	**10**	**5**	**20**	**13**	**6**	**6**	**25**	**94**	**98**
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	1
DME	0	0	0	0	0	2	1	3	0	2	0	2	0	0	0	0	5	6
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
Advanced Imaging	1	1	8	10	2	3	3	8	2	5	3	10	7	2	2	11	39	31
Other	0	0	0	0	1	1	0	2	0	0	0	0	0	0	1	1	3	5
Pharmacy	3	5	9	17	2	4	1	7	3	3	1	7	6	4	3	13	44	51
Surgery	1	0	1	2	0	0	0	0	0	0	1	1	0	0	0	0	3	4
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**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	5	4	9	**18**	4	5	2	**11**	3	6	5	**14**	8	4	2	**14**	57	54
Uphold Rate	**100.0%**	**66.7%**	**50.0%**	**62.1%**	**80.0%**	**50.0%**	**40.0%**	**55.0%**	**60.0%**	**60.0%**	**100.0%**	**70.0%**	**61.5%**	**66.7%**	**33.3%**	**56.0%**	**60.6%**	**54.5%**
Overturns - Full	0	2	9	**11**	1	5	2	**8**	2	3	0	**5**	4	2	4	**10**	34	44
Overturn Rate - Full	**0.0%**	**33.3%**	**50.0%**	**37.9%**	**20.0%**	**50.0%**	**40.0%**	**40.0%**	**40.0%**	**30.0%**	**0.0%**	**25.0%**	**30.8%**	**33.3%**	**66.7%**	**40.00%**	**36.2%**	**44.4%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	1	0	0	**1**	2	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**10.0%**	**0.0%**	**5.0%**	**7.7%**	**0.0%**	**0.0%**	**4.0%**	**2.1%**	**0.0%**
Withdrawal	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	1	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**20.0%**	**5.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.1%**	**1.0%**
Membership	40,209	40,381	40,607		40,868	41,173	41,402		41,662	41,802	41,951		42,058	42,175				**343989**
Appeals - PTMPM	0.12	0.15	0.45	0.24	0.12	0.24	0.12	0.16	0.12	0.24	0.12	0.16	0.31	0.14	-	0.30	0.21	0.21
Grievances - PTMPM	0.17	0.25	0.47	0.30	0.17	0.19	0.19	0.19	0.38	0.33	0.26	0.33	0.24	0.19	-	0.31	0.28	0.20

CalViva SPD only																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2021 YTD**	**2020 YTD**
Expedited Grievances Received	6	5	3	14	2	2	6	10	7	8	7	22	7	4	2	13	59	32
Standard Grievances Received	40	37	59	136	44	41	61	146	53	43	39	135	38	20	29	87	504	401
Total Grievances Received	**46**	**42**	**62**	150	**46**	**43**	**67**	**156**	**60**	**51**	**46**	**157**	**45**	**24**	**31**	**100**	**563**	**433**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.4%**	**100.0%**	**100.0%**	**98.9%**	**99.8%**	**99.50%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	6	4	4	14	2	2	6	10	7	8	6	21	8	3	3	14	59	28
Expedited Grievance Compliance rate	**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%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	37	36	46	119	51	51	42	144	57	57	33	147	34	41	20	95	505	394
Standard Grievance Compliance rate	**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%**	**100.0%**
Total Grievances Resolved	**43**	**40**	**50**	**133**	**53**	**53**	**48**	**154**	**64**	**65**	**39**	**168**	**42**	**44**	**23**	**109**	564	**422**
Grievance Descriptions - Resolved Cases	**43**	**40**	**50**	**133**	**53**	**53**	**48**	**154**	**64**	**65**	**39**	**168**	**42**	**44**	**23**	**109**	564	**422**
Access to primary care	1	2	4	7	0	1	4	5	3	2	5	10	5	1	4	10	32	35
Access to specialists	3	1	4	8	2	1	3	6	11	10	1	22	2	3	4	9	45	12
Continuity of Care	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	12	11	16	39	12	20	15	47	27	20	10	57	21	17	5	43	186	35
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	8	11	9	28	6	8	5	19	4	5	1	10	1	12	4	17	74	73
QOS Non Access	19	15	17	34	33	23	21	77	19	28	22	69	13	11	6	30	210	234
Exempt Grievances Received	10	5	9	**24**	12	9	4	**25**	0	8	3	**11**	3	5	10	**18**	**78**	113
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Specialist	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	3
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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	1	0	0	**1**	0	0	0	**0**	0	0	1	**1**	1	0	0	**1**	**3**	2
Attitude/Service - Provider	0	1	2	**3**	0	0	0	**0**	0	1	0	**1**	0	0	2	**2**	**6**	13
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Vendor	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	5
Attitude/Service - Health Plan	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
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**	1
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	**1**	2
Health Plan Materials - ID Cards-Not Received	2	1	0	**3**	4	1	0	**5**	0	3	0	**3**	0	3	2	**5**	**16**	12
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	1	0	**1**	0	0	1	**1**	1	0	0	**1**	**3**	0
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Health Plan Assignment - Change Request	4	1	3	**8**	5	1	2	**8**	0	0	0	**0**	0	1	3	**4**	**20**	24
PCP Assignment/Transfer - HCO Assignment - Change Request	2	1	0	**3**	0	0	0	**0**	0	0	1	**1**	1	0	1	**2**	**6**	7
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	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	2
PCP Assignment/Transfer - Rollout of PPG	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	2
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0

Pharmacy - Eligibility Issue	0	0	0	**0**	1	3	2	**6**	0	4	0	**4**	0	0	0	**0**	**10**	7
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	4
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
OTHER - Balance Billing from Provider	0	0	2	**2**	1	0	0	**1**	0	0	0	**0**	0	0	1	**1**	**4**	12

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	2	1	3	6	0	2	1	3	4	2	1	7	1	1	2	4	20	39
Standard Appeals Received	13	18	22	53	16	13	24	53	12	21	14	47	11	7	14	32	185	221
Total Appeals Received	**15**	**19**	**25**	**59**	**16**	**15**	**25**	**56**	**16**	**23**	**15**	**54**	**12**	**8**	**16**	**36**	205	**260**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**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%**	**99.5%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	2	5	1	2	1	4	4	1	1	6	1	1	2	4	19	34
Expedited Appeals Compliance Rate	**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%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	12	14	20	46	20	14	14	**48**	24	16	18	**58**	17	11	5	**33**	185	214
Standard Appeals Compliance Rate	**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%**	**100.0%**
Total Appeals Resolved	**14**	**15**	**21**	**50**	**21**	**16**	**15**	**52**	**28**	**17**	**19**	**64**	**18**	**12**	**7**	**37**	**203**	**248**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**14**	**15**	**21**	**51**	**21**	**16**	**15**	**52**	**28**	**17**	**19**	**64**	**18**	**12**	**7**	**37**	**204**	**248**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	1	1	1	1	1	3	2	0	1	3	0	0	0	0	7	4
DME	2	2	1	5	5	1	6	12	4	2	6	12	4	0	2	6	35	24
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	1	0	0	1	0	0	0	0	0	0	1	1	2	0
Advanced Imaging	3	4	10	17	7	7	3	17	6	6	2	14	9	1	1	11	59	97
Other	1	2	0	3	2	0	3	5	1	1	1	3	0	2	0	2	13	14
Pharmacy	8	6	9	23	5	7	2	14	13	8	9	30	5	9	3	17	84	100
Surgery	0	1	1	2	0	0	0	0	2	0	0	2	0	0	0	0	4	9
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**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	7	9	12	**28**	9	7	8	**24**	10	6	9	**25**	11	7	1	**19**	96	123
Uphold Rate	**50.0%**	**60.0%**	**52.4%**	**56.0%**	**42.9%**	**43.8%**	**53.3%**	**46.2%**	**35.7%**	**35.3%**	**47.4%**	**39.1%**	**61.1%**	**58.3%**	**14.3%**	**51.4%**	**47.3%**	**49.6%**
Overturns - Full	6	6	8	**20**	11	9	6	**26**	18	10	9	**37**	7	5	4	**16**	99	116
Overturn Rate - Full	**42.9%**	**40.0%**	**38.1%**	**40.0%**	**52.4%**	**56.3%**	**40.0%**	**50.0%**	**64.3%**	**58.8%**	**47.4%**	**57.8%**	**38.9%**	**41.7%**	**57.1%**	**43.2%**	**48.8%**	**46.77%**
Overturns - Partials	0	0	2	**2**	0	0	0	**0**	0	1	1	**2**	0	0	2	**2**	6	7
Overturn Rate - Partial	**0.0%**	**0.0%**	**9.5%**	**4.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**5.9%**	**5.3%**	**3.1%**	**0.0%**	**0.0%**	**28.6%**	**5.4%**	**3.0%**	**2.8%**
Withdrawal	1	0	0	**1**	1	0	1	**2**	0	0	0	**0**	0	0	0	**0**	3	2
Withdrawal Rate	**7.1%**	**0.0%**	**0.0%**	**2.0%**	**4.8%**	**0.0%**	**6.7%**	**3.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.5%**	**0.8%**
Membership	33,854	33,850	33,872		33,913	33,987	33,964		33,946	33,941	34,219		34,573	34,722				**101333**
Appeals - PTMPM	0.41	0.44	0.62	0.00	0.62	0.47	0.44	0.00	0.82	0.50	0.56	0.63	0.52	0.35	-	0.53	0.29	0.30
Grievances - PTMPM	1.27	1.18	1.45	0.00	1.56	1.56	1.41	0.00	1.89	1.92	1.14	1.65	1.21	1.27	-	1.57	0.80	0.52

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 #18

Attachment 18.C

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 12/01/2021 to 12/31/2021

Report created 1/26/2022

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>

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 12/01/2021 to 12/31/2021
Report created 1/26/2022

ER utilization based on Claims data	2020-12	2020-Trend	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
																Quarterly Averages									Annual Averages		
Expansion Mbr Months	95,089		96,111	96,910	95,851	95,393	95,063	94,707	94,331	93,947	93,563	93,192	92,778	92,441		84,091	85,931	90,437	94,076	96,291	95,054	93,947	92,804		88,634	94,524	
Family/Adult/Other Mbr Mos	256,743		257,664	258,048	249,673	248,656	247,854	247,163	246,305	245,536	244,772	243,944	243,291	242,737		244,286	247,113	252,446	255,918	255,128	247,891	245,538	243,324		249,941	247,970	
SPD Mbr Months	34,757		34,715	34,577	34,021	33,817	33,635	33,463	33,269	33,097	32,915	32,718	32,535	32,406		34,607	34,667	34,783	34,800	34,438	33,638	33,094	32,553		34,714	33,431	
Admits - Count	2,019		2,051	1,837	2,185	2,059	2,082	2,114	2,082	2,103	1,971	1,967	2,027	1,971		2,204	1,782	2,135	2,073	2,024	2,085	2,052	1,988		2,049	2,037	
Expansion	587		577	544	693	667	665	697	700	714	644	651	644	678		653	566	683	650	605	676	686	658		638	656	
Family/Adult/Other	996		1,039	853	982	921	919	899	882	976	904	910	920	860		1,022	842	1,011	990	958	913	921	897		966	922	
SPD	432		428	434	499	463	494	514	500	410	421	404	463	433		526	372	440	429	454	490	444	433		442	455	
Admits Acute - Count	1,384		1,404	1,232	1,529	1,494	1,500	1,501	1,545	1,488	1,389	1,414	1,428	1,409		1,513	1,135	1,400	1,410	1,388	1,498	1,474	1,417		1,364	1,444	
Expansion	496		493	422	541	530	523	534	569	536	471	499	486	515		472	411	513	517	485	529	525	500		478	510	
Family/Adult/Other	481		507	416	536	531	507	496	520	569	531	535	518	492		554	375	475	490	486	511	540	515		474	513	
SPD	405		404	393	452	432	468	470	456	382	386	378	424	402		486	348	411	402	416	457	408	401		412	421	
Readmit 30 Day - Count	173		208	199	242	213	222	247	208	190	197	205	205	151		291	224	280	229	216	227	198	187		256	207	
Expansion	61		69	77	86	74	64	81	86	69	61	82	69	66		82	77	92	84	77	73	72	72		84	74	
Family/Adult/Other	41		53	39	53	38	38	52	46	53	46	48	43	22		84	64	81	59	48	43	48	38		72	44	
SPD	71		86	83	103	101	120	114	76	68	90	75	93	63		125	82	107	86	91	112	78	77		100	89	
**ER Visits - Count	9,873		9,473	9,374	11,112	12,129	13,744	13,379	14,404	14,828	12,913	12,666	11,885	5,713		16,643	9,262	11,466	10,478	9,986	13,084	14,048	10,088		11,962	11,802	
Expansion	3,214		2,986	2,891	3,156	3,358	3,538	3,609	3,829	3,709	3,000	3,056	2,678	1,611		3,771	2,919	3,631	3,301	3,011	3,502	3,513	2,448		3,406	3,118	
Family/Adult/Other	5,459		5,307	5,306	6,125	6,779	7,885	7,485	8,025	8,507	7,585	7,131	6,808	2,910		11,007	5,062	6,339	5,876	5,579	7,383	8,039	5,616		7,071	6,654	
SPD	1,185		1,160	1,115	1,331	1,337	1,488	1,403	1,492	1,427	1,156	1,220	1,049	551		1,841	1,265	1,380	1,271	1,202	1,409	1,358	940		1,439	1,227	
Admits Acute - PTMPY	42.9		43.3	37.9	46.9	45.7	45.7	45.6	46.8	45.0	42.0	42.7	43.2	42.7		50.0	37.0	44.4	43.9	42.7	45.6	44.6	42.9		43.8	44.0	
Expansion	62.6		61.6	52.3	67.7	66.7	66.0	67.7	72.4	68.5	60.4	64.3	62.9	66.9		67.4	57.4	68.1	65.9	60.5	66.8	67.1	64.7		64.8	64.7	
Family/Adult/Other	22.5		23.6	19.3	25.8	25.6	24.5	24.1	25.3	27.8	26.0	26.3	25.5	24.3		27.2	18.2	22.6	23.0	22.9	24.8	26.4	25.4		22.7	24.8	
SPD	139.8		139.7	136.4	159.4	153.3	167.0	168.5	164.5	138.5	140.7	138.6	156.4	148.9		168.4	120.6	141.7	138.5	145.1	162.9	147.9	147.9		142.3	151.0	
Bed Days Acute - PTMPY	321.2		285.0	210.5	233.2	225.1	224.7	229.4	239.8	247.2	249.8	219.1	243.9	220.2		246.0	202.3	257.5	289.9	242.9	226.4	245.6	227.7		249.5	235.6	
Expansion	509.6		429.3	307.8	371.7	352.0	339.3	342.6	387.7	399.3	397.8	337.1	401.2	350.6		348.1	315.0	407.0	451.9	369.4	344.6	394.9	363.0		382.7	367.9	
Family/Adult/Other	152.0		126.6	94.2	102.9	105.0	101.3	98.9	114.1	133.6	128.5	112.9	107.4	99.2		99.8	85.9	107.9	131.6	107.9	101.8	125.4	106.5		106.5	110.4	
SPD	1,056.1		1,064.7	809.3	881.5	848.1	925.5	1,007.0	909.7	838.3	927.1	838.8	1,026.8	949.8		1,030.3	754.1	956.0	1,017.0	918.9	926.6	891.7	938.3		939.4	918.8	
ALOS Acute	7.5		6.6	5.6	5.0	4.9	4.9	5.0	5.1	5.5	6.0	5.1	5.6	5.2		4.9	5.5	5.8	6.6	5.7	5.0	5.5	5.3		5.7	5.4	
Expansion	8.1		7.0	5.9	5.5	5.3	5.1	5.1	5.4	5.8	6.6	5.2	6.4	5.2		5.2	5.5	6.0	6.9	6.1	5.2	5.9	5.6		5.9	5.7	
Family/Adult/Other	6.8		5.4	4.9	4.0	4.1	4.1	4.1	4.5	4.8	4.9	4.3	4.2	4.1		3.7	4.7	4.8	5.7	4.7	4.1	4.8	4.2		4.7	4.4	
SPD	7.6		7.6	5.9	5.5	5.5	5.5	6.0	5.5	6.1	6.6	6.1	6.6	6.4		6.1	6.3	6.7	7.3	6.3	5.7	6.0	6.3		6.6	6.1	
Readmit % 30 Day	8.6%		10.1%	10.8%	11.1%	10.3%	10.7%	11.7%	10.0%	9.0%	10.0%	10.4%	10.1%	7.7%		13.2%	12.5%	13.1%	11.1%	10.7%	10.9%	9.7%	9.4%		12.5%	10.2%	
Expansion	10.4%		12.0%	14.2%	12.4%	11.1%	9.6%	11.6%	12.3%	9.7%	9.5%	12.6%	10.7%	9.7%		12.5%	13.7%	13.5%	12.9%	12.8%	10.8%	10.5%	11.0%		13.1%	11.2%	
Family/Adult/Other	4.1%		5.1%	4.6%	5.4%	4.1%	4.1%	5.8%	5.2%	5.4%	5.1%	5.3%	4.7%	2.6%		8.3%	7.6%	8.0%	6.0%	5.0%	4.7%	5.2%	4.2%		7.5%	4.8%	
SPD	16.4%		20.1%	19.1%	20.6%	21.8%	24.3%	22.2%	15.2%	16.6%	21.4%	18.6%	20.1%	14.5%		23.7%	22.0%	24.4%	20.0%	20.0%	22.8%	17.6%	17.8%		22.6%	19.6%	
**ER Visits - PTMPY	306.2		292.3	288.3	340.7	370.7	418.6	406.3	436.5	448.5	390.2	382.9	359.4	173.0		549.9	302.0	364.0	326.5	307.1	398.6	425.1	305.2		384.3	359.1	
Expansion	405.6		372.8	358.0	395.1	422.4	446.6	457.3	487.1	473.8	384.8	393.5	346.4	209.1		538.1	407.7	481.7	421.1	375.2	442.1	448.7	316.6		461.1	395.9	
Family/Adult/Other	255.2		247.2	246.7	294.4	327.2	381.8	363.4	391.0	415.8	371.9	350.8	335.8	143.9		540.7	245.8	301.3	275.5	262.4	357.4	392.9	277.0		339.5	322.0	
SPD	409.1		401.0	387.0	469.5	474.4	530.9	503.1	538.2	517.4	421.4	447.5	386.9	204.0		638.4	437.8	476.2	438.4	418.8	502.8	492.5	346.5		497.6	440.6	
Services	pliance Go		TAT Compliance Goal: 100%													TAT Compliance Goal: 100%									TAT Compliance Goal: 100%		
Preservice Routine	100.0%		100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	84.0%	82.0%	98.0%	98.0%	96.0%	100.0%		100.0%	100.0%	100.0%	100.0%	99.3%	100.0%	88.0%	98.0%				
Preservice Urgent	100.0%		96.0%	100.0%	98.0%	98.0%	100.0%	100.0%	100.0%	96.0%	100.0%	98.0%	98.0%	100.0%		98.7%	99.3%	100.0%	99.3%	98.0%	99.3%	98.7%	98.7%				
Postservice	100.0%		98.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	94.0%	100.0%	100.0%		100.0%	98.7%	100.0%	100.0%	98.7%	100.0%	99.3%	98.0%				
Concurrent (inpatient only)	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.3%				
Deferrals - Routine	100.0%		100.0%	95.4%	100.0%	100.0%	100.0%	100.0%	83.3%	78.6%	95.2%	95.2%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.5%	100.0%	85.7%	98.4%				
Deferrals - Urgent	100.0%		100.0%	Null	100.0%	null	50.0%	100.0%	N/A	100.0%	100.0%	N/A	100.0%	N/A		100.0%	99.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%				
Deferrals - Post Service	NA		null	null	null	null	null	null	null	null	null	null	null	null		null	null	null	null	null	null	null	null				
	CS ID RATI		CCS ID RATE																	CCS ID RATE						CCS ID RATE	
CCS %	8.25%		8.17%	8.29%	8.25%	8.21%	8.17%	8.33%	8.36%	8.37%	8.37%	8.37%	8.48%	8.33%		8.34%	8.23%	8.22%	8.27%	8.24%	8.24%	8.28%	8.40%		8.27%	8.31%	
	rinatal Case Manageme		Perinatal Case Management																	Perinatal Case Management						Perinatal Case Management	
Total Number Of Referrals	113		136	154	259	173	128	97	145	162	106	118	158	174		783	561	559	404	549	398	413	450		2,307	1,810	
Pending	2		0	0	0	0	0	0	0	0	2	2	3	2		1	0	0	5	0	0	2	7		6	9	
Ineligible	2		7	9	22	23	6	3	2	2	3	8	4	7		26	30	31	8	38	32	7	19		95	96	
Total Outreached	109		129	145	237	150	122	94	143	160	101	108	151	165		756	531	528	391	511	366	404	424		2,206	1,705	
Engaged	26		32	40	47	36	34	29	42	40	20	24	29	18		222	202	157	112	119	99	102	71		693	391	
Engagement Rate	24%		25%	28%	20%	24%	28%	31%	29%	25%	20%	22%	19%	11%		29%	38%	30%	29%	23%	27%	25%	17%		31%	23%	
New Cases Opened	26		32	40	47	36	34	29	42	40	20	24	29	18		222	202	157	112	119	99	102	71		693	391	
Total Cases Managed	271		257	251	281	286	274	263	278	291	274	262	251	237		465	472	485	413	344	354	336	307		943	621	
Total Cases Closed	51		46	17	32	46	36	32	30	39	35	38	33	47		151	169	193	189	95	114	104	118		702	431	
Cases Remained Open	205		212	215	225	217	158	115	193	160	166	188	204	180		291	319	267	205	225	115	166	180		205	180	
	egrated Case Managem		Integrated Case Management																	Integrated Case Management						Integrated Case Management	
Total Number Of Referrals	150		121	116	115	91	81	133	104	136	132	121	86	77		373	439	561	488	352	305	372	284		1,861	1,313	
Pending	14		0	0	0	0	0	0	0	0	2	2	4	6		1	1	0	20	0	0	2	12		22	14	
Ineligible	32		17	9	9	7	7	3	6	10	10	8	9	12		23	28	51	97	35	17	26	29		199	107	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 12/01/2021 to 12/31/2021
Report created 1/26/2022

ER utilization based on Claims data	2020-12	2020-Trend	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
Total Outreached	104		104	107	106	84	74	130	98	126	120	111	73	59		349	410	510	371	317	288	344	243		1,640	1,192	
Engaged	69		74	76	74	55	51	86	55	77	73	83	48	38		172	193	290	224	224	192	205	169		879	790	
Engagement Rate	66%		71%	71%	70%	65%	69%	66%	56%	61%	61%	75%	66%	64%		49%	47%	57%	60%	71%	67%	60%	70%		54%	66%	
Total Screened and Refused/Decline	10		8	9	11	8	9	17	12	15	12	12	11	3		55	65	72	49	28	34	39	26		241	127	
Unable to Reach	25		22	22	21	21	14	27	31	34	35	16	14	18		122	152	148	98	65	62	100	48		520	275	
New Cases Opened	69		74	76	74	55	51	86	55	77	73	83	48	38		172	193	290	224	224	192	205	169		879	790	
Total Cases Closed	63		60	60	51	48	51	85	57	84	81	82	78	78		105	142	196	240	171	184	222	238		683	815	
Cases Remained Open	292		310	322	330	327	253	166	271	230	224	292	301	258		184	289	314	292	330	166	224	258		292	258	
Total Cases Managed	357		378	394	406	408	409	445	416	435	432	431	395	354		279	367	533	541	526	537	566	516		990	1104	
Critical-Complex Acuity	55		60	58	60	58	50	56	56	57	48	46	44	40		42	65	77	73	74	64	61	53		130	120	
High/Moderate/Low Acuity	302		318	336	346	350	359	389	360	378	384	385	351	314		237	302	456	468	452	473	505	463		860	984	
	sitional Case Managen							**Transitional Case Management**												**Transitional Case Management**							**Transitional Case Management**
Total Number Of Referrals	204		143	201	229	250	212	201	115	138	101	94	105	80		421	479	740	688	573	663	354	279		2,328	1,869	
Pending	25		0	0	0	0	0	0	0	0	0	0	0	5		0	0	0	25	0	0	0	5		25	5	
Ineligible	22		23	21	26	40	23	21	21	10	10	7	13	8		27	33	74	69	70	84	41	28		203	223	
Total Outreached	157		120	180	203	210	189	180	94	128	91	87	92	67		394	446	666	594	503	579	313	246		2,100	1,641	
Engaged	79		57	102	116	128	132	148	73	97	66	63	70	45		214	218	343	303	275	408	236	178		1,078	1,097	
Engagement Rate	50%		48%	57%	57%	61%	70%	82%	78%	76%	73%	72%	76%	67%		54%	49%	52%	51%	55%	70%	75%	72%		51%	67%	
Total Screened and Refused/Decline	19		13	24	15	10	10	6	4	6	1	4	3	1		65	75	95	73	52	26	11	8		308	97	
Unable to Reach	59		50	54	72	72	47	26	17	25	24	20	19	21		115	153	228	218	176	145	66	60		714	447	
New Cases Opened	79		57	102	116	128	132	148	73	97	66	63	70	45		214	218	343	303	275	408	236	178		1,078	1,097	
Total Cases Closed	113		89	49	109	120	122	145	132	74	109	48	65	73		199	226	303	342	247	387	315	186		1,070	1,135	
Cases Remained Open	42		76	61	92	103	92	60	64	67	40	50	62	50		63	56	106	42	92	60	40	50		42	50	
Total Cases Managed	185		148	161	228	251	263	295	218	182	174	125	147	126		280	296	398	394	366	487	388	242		1136	1214	
High/Moderate/Low Acuity	185		148	161	228	251	263	295	218	182	174	125	147	126		280	296	398	394	366	487	388	242		1136	1214	
	Palliative Care							**Palliative Care**												**Palliative Care**							**Palliative Care**
Total Number Of Referrals	10		13	12	17	14	10	18	13	9	12	10	15	12		69	81	33	40	42	42	34	37		223	155	
Pending	0		0	0	0	0	0	0	0	0	0	0	0	3		0	1	0	7	0	0	0	3		4	3	
Ineligible	6		6	4	4	5	4	3	2	3	5	6	7	5		24	34	11	14	14	12	10	18		83	54	
Total Outreached	4		7	8	13	9	6	15	11	6	7	4	8	4		45	46	22	19	28	30	24	16		132	98	
Engaged	3		5	8	7	4	5	11	9	5	6	2	7	3		34	35	16	14	20	20	20	12		99	72	
Engagement Rate	75%		71%	100%	54%	44%	83%	73%	82%	83%	86%	50%	88%	75%		76%	76%	73%	74%	71%	67%	83%	75%		75%	73%	
Total Screened and Refused/Decline	0		2	0	4	2	1	3	2	1	0	2	1	0		8	9	4	4	6	6	3	3		25	18	
Unable to Reach	1		0	0	2	3	0	1	0	0	1	0	0	1		3	2	2	1	2	4	1	1		8	8	
New Cases Opened	3		5	8	7	4	5	11	9	5	6	2	7	3		36	33	16	14	20	20	20	12		99	72	
Total Cases Closed	11		5	2	8	2	8	9	9	5	6	14	4	3		23	25	22	28	15	19	20	21		98	75	
Cases Remained Open	87		92	91	91	94	68	46	79	66	71	76	84	83		88	96	91	87	91	46	71	83		87	83	
Total Cases Managed	105		102	103	107	104	108	108	110	104	105	101	94	93		107	122	126	122	114	116	118	111		262	166	
	oral Health Case Mana							**Behavioral Health Case Management**												**Behavioral Health Case Management**							**Behavioral Health Case Managemen**
Total Number Of Referrals	96		73	92	86	87	93	82	91	90	111	120	103	82		120	325	364	291	251	262	292	305		1,100	1,110	
Pending	6		0	0	0	0	0	0	0	0	0	0	1	13		0	0	0	6	0	0	0	14		6	14	
Ineligible	5		6	3	3	1	2	4	2	6	5	3	5	4		4	15	16	16	12	7	13	12		51	44	
Total Outreached	85		67	89	83	86	91	78	89	84	106	117	97	65		116	310	348	269	239	255	279	279		1,043	1,052	
Engaged	34		29	47	39	40	42	40	41	53	57	63	51	35		51	119	156	114	115	122	151	149		440	537	
Engagement Rate	40%		43.0%	53.0%	47.0%	47.0%	46.0%	51%	46%	63%	54%	54%	53%	54%		46%	38%	45%	42%	48%	48%	54%	53%		43%	51%	
Total Screened and Refused/Decline	3		0	2	3	0	1	0	1	0	0	0	1	1		0	6	16	8	5	1	1	2		30	9	
Unable to Reach	48		38	40	41	46	48	38	47	31	49	54	45	29		65	184	176	147	119	132	127	128		572	506	
New Cases Opened	34		29	47	39	40	42	40	41	53	57	63	51	35		51	119	156	114	115	122	151	149		440	537	
Total Cases Closed	51		52	28	25	33	34	40	50	45	53	53	51	51		52	65	125	140	105	107	148	155		382	515	
Cases Remained Open	78		75	92	101	104	80	80	90	84	91	116	128	116		65	189	241	234	101	80	91	116		729	116	
Total Cases Managed	149		133	129	140	154	161	163	170	173	182	192	191	176		122	299	521	492	220	236	280	278		1434	640	
Critical-Complex Acuity	7		7	6	6	9	9	8	9	7	9	12	10	11		16	34	46	22	11	15	12	14		118	28	
High/Moderate/Low Acuity	142		126	123	134	145	152	155	161	166	173	180	181	165		106	265	475	470	209	221	268	264		1316	612	

Item #18

Attachment 18.D

QIUM Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: February 17th, 2022

SUBJECT: CalViva Health QI & UM Update of Activities Quarter 4 2021 (February 2022)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health QI & UM performance, program and regulatory activities in Quarter 4 of 2021.

I. Meetings

Two meetings were held in Quarter 4, one on October 21st and one on November 18th. This report will summarize Quality Improvement, Utilization Management, Case Management and other activities carried out by the Medical Management Department in Quarter 4 2021.

The Program Documents that were approved were:

1. 2021 Culture & Linguistics Work Plan Mid-Year Evaluation & Executive Summary
2. 2021 Health Education Work Plan Mid-Year Evaluation & Executive Summary
3. Culture & Linguistics Language Assistance Program Mid-Year Report
4. Culture & Linguistics Geo Access Report
5. Preventive Health Guidelines

The General Documents approved were:

1. Pharmacy Formulary & Provider Updates
2. Medical Policies Update Q3
3. UMCM Policies & Procedures

II. QI Reports -

The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance (A & G) Dashboard** for September 2021 tracks volumes, turn-around times, and case classifications. Results demonstrate that the volume of grievances (QOS & QOC) in the third quarter remained relatively consistent with Q2 2021 with some variation noted. One (1) grievance acknowledgment letter and one (1) expedited appeal were noted to not meet turn-around times.
   a. Majority of grievances reported were in the Quality of Service and Exempt categories.
   b. Appeal volumes as of the end of Q3 have demonstrated variation quarter to quarter with the majority of cases related to Advanced Imaging and Pharmacy consistent with previous months.
   c. A & G Letter Monitoring continues. All errors are corrected prior to mailing. Follow up occurs with staff and physicians as indicated based upon the source of the errors.

2. **Potential Quality Issues (PQI) Report** provides a summary of the quarterly evaluation of cases/issues that may result in substantial harm to a 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.
   a. No cases were generated from Provider Preventable Conditions (PPCs).
   b. Member generated PQI's increased slightly compared to the previous three Quarters.
   c. The number of peer review cases varies from quarter-to-quarter independent of the other case types.

   Follow up has been initiated when appropriate. PQI and PPC cases will continue to be tracked, monitored and reported.

3. **MHN Performance Indicator Report for Behavioral Health** was reviewed in the October meeting with Q2 data presented**. I**n Q2 2021, MHN reported on 15 of 15 metrics that met or exceeded their targets.
   a. The ABA authorization timeliness metric result was slightly below 100%, but exceeded the threshold for action at 95%.
   b. Utilization appears to be up this year with an increase in members seeking services for mild to moderate issues.
   c. The raw number of PQIs has returned to baseline this quarter.
   d. The majority of Provider Disputes were noted to have been submitted by one provider. This provider has been re-educated and monitoring for improvement will continue.
4. **Initial Health Assessment Quarterly Audit Report** provides a summary of the various activities employed to facilitate completion of the Initial Health Assessment (IHA) for new Medi-Cal members within 120 days of enrollment. This 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.

   The Q2 2021 IHA Quarterly Report demonstrates CalViva Health's performance on IHA/IHEBA compliance monitoring from July 2020 – June 2021.
   a. The Report also describes CalViva's efforts to improve its IHA/IHEBA completion rates during Q1-Q3, 2021 in partnership with a provider organization. In Q1-Q2 2021, an IHA workgroup designed and implemented a successful process for completing member outreach and visit completion and documentation within the pilot provider's offices.
   b. In Q3 CalViva spread the resulting best practices throughout its provider network.
   c. Results of this initiative will be monitored and reported on in future IHA Quarterly Audit Reports.
5. **Access Related Reporting** for Quarter 4 included **Specialty Referral Reports for Health Net Q2 & Q3.** This report provides a summary of Specialty Referral services that required prior authorization in the three-county area (Fresno, Kings, and Madera) for the second and third quarters of 2021. This report captures three utilization case types:
   a. Key services that while within the service area and within the network require clinical review
   b. Services recognized as out of the tri-county area, but within the provider network
   c. 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.
6. **Additional Quality Improvement Reports** including SPD Health Risk Assessment and Provider Office Wait Time were presented.

III. UMCM Reports -

The following is a summary of some of the reports and topics reviewed:

1. **The Key Indicator Report (KIR)** provided data through September 30th, 2021. A quarterly comparison was reviewed with the following results:
   a. Acute Care Admission rates for SPDs remain low, however they appear to be increasing for the Family/Adult and Expansion populations.

b. Length of Stay remains higher than prior years for Family/Adult and Expansion populations.

c. Turn-around Times for Prior Authorizations were noted to have some opportunities for improvement this month. An increase in the number of requests submitted as "urgent" was noted along with some COVID-related staffing issues.

d. The volume of Deferrals is low and therefore the rate is highly sensitive to variations.

2. **Utilization Management Concurrent Review Report-** presents inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning and medical appropriateness during Quarter 3 2021.
    a. TANF and MCE populations experienced an increase in Admits in Q3. TANF bed days/1000 also increased in Q3.
    b. The SPD population experienced a decrease in readmissions during Q3 compared to prior months.
    c. Overall increases in bed days are attributable to increases in acuity for COVID-19 patients with a high percentage of these members requiring specialty care such as ICU upon admission.
3. **Additional Utilization Management/Case Management Reports** presented were the UM PA Member Letter Monitoring Report, and the Case Management & CCM Report.

IV. Pharmacy Reports – This quarter included the following Pharmacy reports: Pharmacy Call Report, Operation Metrics, Top 30 Medication Prior Authorizations, and the Inter-rater Reliability Report.

a. Authorization (PA) Requests, and quarterly Formulary changes were all reviewed.
b. All third quarter 2021 pharmacy prior authorization metrics were within 5% of standard.
c. The Interrater Reliability Report was presented. 90% threshold met. 95% goal not met, overall score was 94.17%. Follow up to occur when opportunities for improvement are identified both on an individual and team basis.

V. HEDIS® Activity

In Q4 HEDIS® related activities were focused on analyzing the results for RY2021 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile and initiating activities to address opportunities for improvement.

Two new PDSA projects were initiated to include:

1. Diabetes: A1c> 9% with Clinica Sierra Vista, Fresno County.
2. Cervical Cancer Screening with Clinica Sierra Vista, Fresno County.

Continuing Performance Improvement Projects (PIP) include:

1. Childhood Immunizations with Family HealthCare Network, Fresno County.
2. Breast Cancer Screening with Greater Fresno Health Organization, Fresno County.

The continuing Quality Improvement Projects (QIP) relating to COVID-19 includes:

1. Antidepressant Outreach
2. HTN & Diabetes outreach
3. Well-Child & Chlamydia screening

VI. Findings/Outcomes

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

Item #18

Attachment 18.E

Credentialing Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: February 17th, 2022

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 4 2021

Purpose of Activity:
This report is to provide the RHA Commission with a summary of the 4th Quarter 2021 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on October 21st, 2021. At the October 21st meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.
II. Reports covering the second quarter for 2021 were reviewed for delegated entities and the third quarter 2021 for Health Net. A summary of the second quarter data is included in the table below.

III. Table 1. Second Quarter 2021 Credentialing/Recredentialing

	Sante	ChildNet	MHN	Health Net	La Salle	ASH	Envolve Vision	IMG	CVMP	Adventist	**Totals**
Initial credentialing	14	5	28	3	35	0	1	6	54	35	**181**
Recredentialing	99	47	16	9	64	2	4	7	22	108	**378**
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	**113**	**52**	**44**	**12**	**99**	**2**	**5**	**13**	**76**	**143**	**559**

IV. There was no case activity to report for the Quarter 3 2021 Credentialing Report from Health Net.
V. The 2022 Credentialing Sub-Committee meeting schedule was reviewed and approved. No concerns with the proposed schedule were raised.

Item #18

Attachment 18.F

Peer Review Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	February 17th, 2022
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 4 2021

Purpose of Activity:

This report is to provide the 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 October 21st, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2021 were reviewed for approval. There were no significant cases to report.

II. The Quarter 3 2021 Peer Count Report was presented at the meeting with a total of five (5) cases reviewed. The outcomes for these cases are as follows:
   - All five (5) cases were closed and cleared. There were no (0) cases pending closure for Corrective Action Plan compliance. There were no cases (0) with outstanding CAPs. There were no (0) cases pended for further information.

III. Follow up will be completed to close out cases and ongoing monitoring and reporting will continue.

IV. The 2022 Peer Review Sub-Committee meeting schedule was reviewed and approved. No concerns with the proposed schedule were raised.

Item #18

Attachment 18.G

Executive Dashboard

	2020	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Month	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
CVH Members													
Fresno	303,493	304,759	305,990	307,463	308,852	310,191	311,420	312,453	313,499	314,657	315,334	316,422	317,500
Kings	31,570	31,802	31,984	32,109	32,332	32,512	32,645	32,699	32,883	33,043	33,114	33,260	33,378
Madera	39,919	40,209	40,381	40,607	40,868	41,173	41,402	41,662	41,802	41,951	42,058	42,175	42,247
Total	374,982	376,770	378,355	380,179	382,052	383,876	385,467	386,814	388,184	389,651	390,506	391,857	393,125
SPD	33,844	33,854	33,850	33,872	33,913	33,987	33,964	33,946	33,941	34,219	34,573	34,722	34,783
CVH Mrkt Share	70.10%	70.02%	69.92%	69.84%	69.74%	69.64%	69.56%	69.51%	69.44%	69.41%	69.33%	69.27%	69.20%
ABC Members													
Fresno	117,408	118,389	119,495	120,612	121,802	123,048	123,939	124,688	125,549	126,085	126,859	127,696	128,522
Kings	20,546	20,697	20,865	20,994	21,100	21,271	21,446	21,498	21,602	21,733	21,824	21,978	22,078
Madera	21,992	22,253	22,415	22,609	22,831	23,055	23,316	23,490	23,712	23,892	24,064	24,196	24,366
Total	159,946	161,339	162,775	164,215	165,733	167,374	168,701	169,676	170,863	171,710	172,747	173,870	174,966
Default													
Fresno	518	616	597	534	583	734	530	501	596	517	607	759	642
Kings	105	150	145	93	115	122	105	95	113	117	126	171	100
Madera	173	97	83	69	96	97	93	93	92	75	85	99	87
County Share of Choice as %													
Fresno	57.80%	59.10%	56.10%	59.20%	56.20%	56.80%	60.50%	58.90%	58.80%	63.90%	54.40%	58.30%	57.80%
Kings	45.40%	48.40%	53.10%	54.40%	54.30%	50.90%	49.10%	53.10%	60.40%	56.00%	47.70%	51.60%	47.90%
Madera	52.70%	57.90%	58.00%	61.00%	62.70%	64.20%	54.90%	58.90%	54.50%	50.40%	57.90%	55.80%	56.80%
Voluntary Disenrollment's													
Fresno	363	421	334	387	444	479	446	643	444	441	438	451	477
Kings	27	36	29	37	51	42	42	46	42	56	50	49	21
Madera	54	59	51	61	75	85	82	56	71	65	72	65	42

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	**4 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues, concerns, or items to note as it pertains to the Plan's IT Communications and Systems.		

Member Call Center CalViva Health Website		**Year**	**2020**	**2020**	**2021**	**2021**	**2021**	**2021**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**23,684**	**23,685**	**26,346**	**26,971**	**28,736**	**26,972**
		# of Calls Answered	**23,488**	**23,520**	**26,119**	**26,664**	**28,391**	**26,570**
		Abandonment Level (Goal < 5%)	**0.80%**	**0.70%**	**0.90%**	**1.10%**	**1.20%**	**1.50%**
		Service Level (Goal 80%)	**93%**	**95%**	**93%**	**85%**	**87%**	**92%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,798**	**936**	**1,196**	**1,232**	**1,182**	**1,076**
		# of Calls Answered	**1,752**	**927**	**1,189**	**1,220**	**1,166**	**1,068**
		Abandonment Level (Goal < 5%)	**2.60%**	**1.00%**	**0.60%**	**1.00%**	**1.40%**	**0.70%**
		Service Level (Goal 80%)	**78%**	**89%**	**94%**	**89%**	**85%**	**90%**
	Transportation Call Center	**# of Calls Received**	**10,011**	**9,867**	**7,364**	**7,768**	**6,737**	**8,470**
		# of Calls Answered	**9,801**	**9,808**	**7,209**	**7,628**	**6,663**	**8,411**
		Abandonment Level (Goal < 5%)	**2.10%**	**0.60%**	**1.60%**	**1.30%**	**0.80%**	**0.40%**
		Service Level (Goal 80%)	**44%**	**76%**	**61%**	**61%**	**75%**	**85%**
	CalViva Health Website	**# of Users**	**22,000**	**25,000**	**33,000**	**26,000**	**26,000**	**22,000**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (63%)**	**Mobile (61%)**	**Mobile (57%)**	**Mobile (62%)**	**Mobile (65%)**	**Mobile (62%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 1 minutes**	**~ 1 minutes**	**~ 2 minutes**	**~ 2 minutes**
Message from the CEO	The Transportation Call Center finished the year with meeting the Service Level Compliance Goal. At present time, there are no significant issues, concerns, or items to note as it pertains to the Plan's Member Call Center and CalViva Health Website.							

Provider Network Activities & Provider Relations	**Year**	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**144**	**144**	**144**	**144**	**141**	**143**	**143**
	PCP	**371**	**360**	**352**	**348**	**356**	**357**	**360**
	PCP Extender	**258**	**256**	**258**	**253**	**253**	**247**	**261**
	Specialist	**1431**	**1422**	**1405**	**1403**	**1404**	**1366**	**1413**
	Ancillary	**210**	**211**	**212**	**215**	**244**	**247**	**250**
	Year	**2020**	**2020**	**2020**	**2021**	**2021**	**2021**	**2021**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Pharmacy	**153**	**152**	**154**	**155**	**156**	**157**	**156**
	Behavioral Health	**357**	**354**	**359**	**376**	**412**	**430**	**447**
	Vision	**45**	**47**	**46**	**47**	**44**	**45**	**43**
	Urgent Care	**11**	**12**	**11**	**12**	**12**	**13**	**13**
	Acupuncture	**5**	**7**	**7**	**7**	**8**	**6**	**5**
	Year	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**	**2021**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**93%**	**93%**	**94%**	**94%**	**95%**	**96%**	**95%**
	% Of Specialists Accepting New Patients - Goal (85%)	**94%**	**97%**	**96%**	**96%**	**96%**	**96%**	**96%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**82%**	**95%**	**96%**	**98%**	**97%**	**96%**	**96%**
	Year	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Providers Touched by Provider Relations	**180**	**125**	**148**	**144**	**120**	**139**	**80**
	Provider Trainings by Provider Relations	**477**	**241**	**245**	**651**	**852**	**292**	**167**
	Year	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
	Total Providers Touched	**2,003**	**2,604**	**2,786**	**2,552**	**1,932**	**3,354**	**1,952**
	Total Trainings Conducted	**550**	**530**	**762**	**808**	**1,353**	**257**	**3,376**
Message From the CEO	Due to the Medi-Cal Rx Transition taking effect 1/1/2022, Pharmacy providers will no longer be tracked. The Plan on 12/10/2021 was placed on a Corrective Action Plan by DHCS for failure to comply with the California Advancing and Innovating Medi-Cal (CalAIM) Benefit Standardization of Major Organ Transplants (MOT) network certification requirements.							

Claims Processing	**Year**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**	**2021**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	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	99% / 99% N/A	99% / 99% N/A	97% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 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	99% / 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	100% / 100% NO	95% / 97% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	95% / 99% NO	93% / 99% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 100% NO	85% / 100% NO	95% / 100% NO	95% / 100% NO	91% / 98% NO	91% / 100% NO	84% / 93% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	93% / 100% NO	92% / 100% NO	98% / 99% NO	89% / 99% NO	96% / 99% Yes
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 99% NO	82%/100% YES	100% / 100% YES	99% / 100% YES	99% / 100% YES	98% / 100% YES	98% / 100% YES
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	87% / 100% YES	98% / 98% YES	99% / 100% YES	93% / 98% NO	100% / 100% NO	99% / 99% YES
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	73% / 100% YES	99% / 100% YES	90% / 92% YES	100% / 100% NO	100% / 100% YES	99% / 100% YES
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	92% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	96% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	98% / 100% NO	96% / 100% NO	93% / 100% NO	98% / 100% NO
Message from the CEO	Due to the Medi-Cal Rx Transition taking effect 1/1/2022, Pharmacy Claims Processing Timeliness will no longer be tracked. PPG 3 did not meet the 30 Day Claims Processing Timeliness Goal for Q3 2021. Management continues to work with PPG 4, 5, and 6, on resolving their trend of reporting Deficiency Disclosures.							

Provider Disputes	**Year**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**	**2021**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	97%	99%	99%	99%	99%	99%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	99%	100%	100%	100%	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%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	92%	100%	91%	88%	95%	99%	96%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	100%	100%	100%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	87%	91%	97%	66%	35%	66%	96%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	99%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	97%	99%	97%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	98%	99%	99%	98%	79%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	100%	100%	100%	100%	100%
Message from the CEO	PPG 3 did not meet Provider Dispute Processing Timeliness goal. All other areas met goal.							