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 10, 2023

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 16, 2023
1:30 pm to 3:30 pm

Where to attend:

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

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

3) 114 W. Main Street
Visalia, CA 93291

Meeting materials have been emailed to you.

Currently, there are **12** 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 can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
February 16, 2023
1:30pm - 3:30pm

Meeting Location(s):

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

2) Woodward Park Library
Large Study Room
944 E. Perrin Avenue
Fresno, CA 93720

3) 114 W. Main Street
Visalia, CA 93291

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B	**Reappointed Board of Supervisors Commissioners** • BL 23-001 2023 Reappointed BOS Commissioners • Appointment confirmations *Action: Ratify reappointment County Board of Supervisors Commissioners*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C Attachment 4.D Attachment 4.E Attachment 4.F Attachment 4.G	**Consent Agenda:** • Commission Minutes dated 11/17/22 • Finance Committee Minutes dated 9/15/22 • QI/UM Committee Minutes dated 10/20/2022 • 2023 Compliance Program Description • 2023 Code of Conduct • 2023 Anti-Fraud Plan • 2023 Privacy and Security Plan *Action: Approve Consent Agenda*	D. Hodge, MD, Chair

5	Attachment 5.A	**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)** **1) Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility.** Estimated Date of Public Disclosure: February 2025	
6 Information	Attachment 6.A Attachment 6.B *No attachment*	**Annual Administration** • BL 23-002 Annual Administration • Form 700 • Ethics Training (*link will be emailed*)	D. Hodge, MD, Chair
7 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 8 & 9* ***One vote will be taken for combined items 8 & 9***	
8 Action	Attachment 8.A Attachment 8.B	**2022 Annual Quality Improvement Work Plan Evaluation** • Executive Summary • Year End Evaluation	P. Marabella, MD, CMO
9 Action	Attachment 9.A Attachment 9.B Attachment 9.C	**2022 Annual Utilization Management Case Management Workplan Evaluation** • Executive Summary • Year End Evaluation **2023 Utilization Management Program Description** *Action: Approve 2022 Quality Improvement Year End Evaluation, and the 2022 Utilization Management Case Management Year End Evaluation, and 2023 Utilization Management Program Description.*	P. Marabella, MD, CMO
10 Action	Attachment 10.A	**2022 Annual Compliance Evaluation** *Action: Approve 2022 Compliance Evaluation*	M.L. Leone, CCO
11 Action	Attachment 11.A	**Emergency Preparedness & Crisis Response Plan** *Action: Approve the Disaster Preparedness Plan*	M.L. Leone, CCO

12 Action		**Standing Reports**	
		Finance Report	
	Attachment 12.A	• Financials as of December 31, 2022	D. Maychen, CFO
		Compliance	
	Attachment 12.B	• Compliance Report	M.L. Leone, CCO
		Medical Management	
	Attachment 12C	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 12.D	• Key Indicator Report	
		Executive Report	
	Attachment 12.E	• Executive Dashboard	J. Nkansah, CEO
	No attachment	• Annual Report – *hard copy provided independent of packet*	
	Attachment 12.F	• Medi-Cal Procurement Update	
		Action: Accept Standing Reports	
13		**Final Comments from Commission Members and Staff**	
14		**Announcements**	
15		**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.*	
16		**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 16, 2023 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

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

Item #3

Attachment 3.A – 3.B

- BL 23-001 2023 Reappointed BOS Commissioners
- 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

Michael Goldring
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 16, 2023

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Appointed / Re-Appointed County BOS Commissioners

BL #: 23-001
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 Rusty Robinson
Madera County has re-appointed Supervisor David Rogers
Madera County Alternate is Jordan Wamhoff

Term thru:	Commission Seat	Currently Occupied By:
January 2024 January 2024 January 2024 January 2024 January 2026 January 2026	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 Jordan Wamhoff
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 2025	Fresno At-Large Commission Appointed	John Frye Jr.
November 2025	Valley Children's Hospital	Michael Goldring
May 2025	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 2023		
	COMMITTEE	**2023**
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	**Kings River East Groundwater Sustainability Agency** *Alternate	Mendes *PW&P Designee
24	**Law Library Board of Trustees** (Chairman, another Board Member or a member of the Bar Association)	Brandau
25	**Local Agency Formation Commission** *Alternate	Mendes Magsig *Vacant
26	**McMullin Area of Kings Groundwater Subbasin** *Alternate	Pacheco *Mendes
27	**North Fork Kings Groundwater Sustainability Agency**	Mendes
28	**North Kings Groundwater Sustainability Agency** *Alternate	Pacheco *Mendes
29	**Pleasant Valley State Prison Citizens Advisory Committee**	Pacheco Mendes
30	**Retirement Board**	Magsig
31	**San Joaquin River Conservancy** *Alternates	Brandau *Pacheco *Magsig
32	**San Joaquin Valley Insurance Authority (SJVIA)** 4 members *Alternate	Mendes, Brandau, Magsig, Pacheco *Quintero
33	**San Joaquin Valley Supervisors Association**	All Board Members
34	**San Joaquin Valley Unified Air Pollution Control District**	Mendes
35	**San Joaquin Valley Water Infrastructure Authority** *Alternate	Mendes *Pacheco
36	**Selma-Kingsburg-Fowler County Sanitation District** (Chairman and District 4 Supervisor must serve) *Alternates	Mendes Magsig *Remaining Board Members

COUNTY OF KINGS
BOARD OF SUPERVISORS

KINGS COUNTY GOVERNMENT CENTER
1400 W. LACEY BOULEVARD.HANFORD, CA 93230
(559) 852-2362, 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

RUSTY ROBINSON – DISTRICT 4
ARMONA & HANFORD

RICHARD FAGUNDES – DISTRICT 5
HANFORD & BURRIS PARK

January 5, 2023

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 3, 2023, 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
Rusty Robinson, Supervisor Dist. 4
1400 W. Lacey Blvd
Hanford, CA 93230
(559) 852-2367
rusty.robinson@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

2023 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		1/1/2024	1/1/2024
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	Jordan Wamhoff	2 Years	1/1/2025	1/1/2025
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	1/1/2025	
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	Jordan Wamhoff			
Countywide Oversight 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)	Bobby Macaulay*	Jordan Wamhoff*			
Ag & Natural Resources	David Rogers		2 Years	1/1/2025	
Labor & Employment	Jordan Wamhoff		2 Years	1/1/2025	
Government Finance & Operations	Robert Poythress		2 Years	1/1/2025	
Health & Welfare	Leticia Gonzalez		2 Years	1/1/2025	
Housing/Land Use/ Transportation (Native American Issues)	Bobby Macaulay	Jordan Wamhoff	2 Years	1/1/2025	
Administration of Justice	Robert Poythress		2 Years	1/1/2025	
CSAC Board of Directors (Sets Policy for CSAC)	Leticia Gonzalez	Robert Poythress			
Meets: Twice per year as determined by Committee Chairperson Conferences:	**Spring Conference & Annual Meeting**				
Crane Valley Project	Bobby Macaulay				
Economic Development Commission	Jordan Wamhoff	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)	Bobby Macaulay	Jordan Wamhoff			
Advocacy for elderly; Advance the aims of the Older American Act. Meets: 3rd Thursday @10am					
Fresno-Kings-Madera Regional Health Authority Commission	David Rogers	Jordan Wamhoff	3 Years	1/1/2026	1/1/2026

Item #4

Attachment 4.A

Commission Minutes
Dated 11/17/22

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
November 17, 2022

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

	Commission Members		
✓	**Sara Bosse**, Director, Madera Co. Dept. of Public Health	✓	**David Luchini**, 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	✓	**Rose Mary Rahn**, Director, Kings County Dept. of Public Health
	David Hodge, M.D., Chair, Fresno County At-large Appointee		**David Rogers**, Madera County Board of Supervisors
	Kerry Hydash, Commission At-large Appointee, Kings County	✓	**Michael Goldring**, Valley Children's Hospital Appointee
		✓	**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 1:31 pm. A quorum was present	
#2 Roll Call Cheryl Hurley, Clerk to the Commission	A roll call was taken for the current Commission Members.	*A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#10 Valley Children's Hospital – Commission Appointee **Action** J. Nkansah, CEO	Item #10 was moved up to ratify Mr. Goldring's appointment to the Commission in order to activate his voting privileges for this meeting.	***Motion**: The appointment of Valley Children's Hospital appointee, Mr. Michael Goldring, was ratified by the Commission* *12 – 0 – 0 – 5* *(Soares / Naz)* *A roll call was taken*
#3 Consent Agenda a) Commission Minutes dated 9/15/2022 b) Finance Committee Minutes dated 7/21/2022 c) QI/UM Committee Minutes dated 7/21/2022 d) QI/UM Committee Minutes dated 9/15/2022 e) 2023 Commission Calendar f) 2023 Finance Committee Calendar g) 2023 QIUM Calendar h) 2023 Credentialing Sub-Committee Calendar	All consent items were presented and accepted as read.	***Motion**: Consent Agenda was approved.* *12 – 0 – 0 – 5* *(Nikoghosian / Fields-Keene)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
i) 2023 Peer Review Sub-Committee Calendar j) 2023 Public Policy Committee Calendar Action J. Neves, MD, Co-Chair		
#4 Closed Session A. **Conference with Legal Counsel-Existing Litigation** Name of case: Case # 21CV381776 Per Government Code Section 54956.9(d)(1) B. **Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Equity Officer Per Government Code Section 54957(b)(1)	Jason Epperson, General Counsel, reported out of closed session. The Commission considered those items agendized for closed session discussion, items A. and B. The Commission considered those matters in closed session and gave direction to staff. No other reportable action. Closed Session concluded at 1:41 pm.	
#5 Equity Officer Action J. Nkansah, CEO	The job description for the Equity Officer position was presented to the Commission for review and approval. Recommendations for edit on page two under Education to swap the first two bullets listing Master's or bachelor's degree first, with Medical Degree preferred to follow.	***Motion**: The Equity Officer job description was approved with edits.* *12 – 0 – 0 – 5* *(Bosse / Soares)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
		A roll call was taken
#6 Financial Audit Report for FY 2022 Action R. Suico, Moss Adams representative	Rianne Suico, representative with Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an 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.	***Motion**:* *12 – 0 – 0 – 5* *(Naz / Cardona)* *A roll call was taken*
#7 2022 Health Equity • **Executive Summary** • **Work Plan Mid-Year Evaluation** Action P. Marabella, MD, CMO	Dr. Marabella presented the 2022 Health Equity Executive Summary and Work Plan Mid-Year Evaluation. The 4 categories for the 2022 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, 2022 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 Ed and QI. 2. Provided multiple training sessions for new hires, A & G and Call Center.	***See #8 below for Motion***

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	3. Reviewed 27 grievances with 2 interventions identified. 4. Supported Breast Cancer Screening Disparity PIP including Mobile Mammography events. 5. Co-led internal BCS PIP Workgroup and Community Advisory Group (CAG). 6. Supported other Quality efforts including Immunization event (CIS-10) and Diabetes Project with Motivational Interviewing. All of the Work Plan activities continue on target for completion by end of calendar year 2022. The Plan will continue to assess circumstances to modify plans as needed in order to continue to implement, monitor and track Health Equity related services and activities.	
#8 2022 Health Education • **Executive Summary** • **Work Plan Mid-Year Evaluation** Action P. Marabella, MD, CMO	Dr. Marabella presented the 2022 Health Education Executive Summary and Work Plan Mid-Year Evaluation. Dr. Marabella presented the 2021 Health Education Work Plan Mid-Year Evaluation. Two areas of focus for 2022 consist of: 1. Programs and Services 2. Department Operations, Reporting and Oversight Of the 15 Program Initiatives, 12 are on track to meet year-end goals. These consist of: 3. Chronic Disease Education: Asthma 4. Chronic Disease: Diabetes 5. Chronic Disease: Hypertension 6. Community Engagement	***Motion**:* *12 – 0 – 0 – 5* *(Cardona / Luchini)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	7. Fluvention & COVID-19 8. Member Newsletter 9. Mental/Behavioral Health 10. Pediatric Education 11. Perinatal Education 12. Population Needs Assessment (complete) 13. Women's Health 14. Health Education Materials update, Development, Utilization & Inventory The three (3) initiatives that are off track consist of: 1. Obesity Prevention 2. Tobacco Cessation program 3. Compliance: Oversight & Report Barriers to full implementation of planned activities have been identified and are being addressed. 2022 initiatives will continue to be implemented in order to meet or exceed year-end goals.	
#9 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of September 30, 2022:</u> Total current assets recorded were approximately $285M; total current liabilities were approximately $164.5M. Current ratio is approximately 1.73. Total equity as of the end of September 2022 was approximately $130.5M which is approximately 792% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $762K which is approximately $677K more than budgeted primarily due to rates on the Plan's money market funds	***Motion**: Standing Reports Approved* *12 – 0 – 0 – 5* *(Naz /Bosse)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	being higher than projected. Premium capitation income actual recorded was approximately $326.2M which is approximately $15.2M more than budgeted primarily due to enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $261.4M which is approximately $13.4M more than budgeted due to enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $13.6M, which is approximately $368K more than budgeted due to higher than projected enrollment. Net income for the first three months of FY 2023 was approximately $2.5M which is approximately $2.4M more than budgeted due to enrollment being higher than budgeted. In addition, net income was higher than projected due to the Plan recording an approximate $1.3M MCO tax gain, and interest income being higher than projected.	
• **Compliance** M. Sanchez, Compliance Manager	**Compliance** There were 160 Administrative & Operational regulatory filings for total YTD 2022; 26 Member Materials filed for approval; 177 Provider Materials reviewed and distributed; and 40 DMHC filings. There were 29 Privacy & Security Breach Cases that were No-Risk/Low-Risk cases filed total YTD 2022. There have been four (4) Fraud, Waste & Abuse MC609 cases filed with DHCS for YTD 2022.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The Plan's management team continues to monitor monthly and quarterly reports covering overall performance. The Plan continues to meet with Health Net weekly and monthly to review and discuss activities related to projects and upcoming transitions. The Annual Oversight Audits of HN in-progress are Credentialing, Access and Availability; Emergency Services, and Utilization Management. Audits completed since the last report are Annual Claims, and PDR, which there was a CAP issued. The Plan is still awaiting responses for both the 2021 DMHC 18-Month Follow-Up Audit CAP response, and the DHCS 2020 Medical Audit CAP. The Exit Conference for the Plan's DHCS 2022 Medical Audit was held on 10/4/22. There were three audit findings; two concerned lack of documentation related to the provision of blood lead screening of young children, and one related to the lack of documentation of a Physician Certification Statement form for member's request for non-emergency medical transportation (NEMT). The Plan responded to these findings on October 19m 2022; currently pending a response. The DMHC 2022 Medical Audit was conducted 9/19/22 and 9/20/22. The Plan is currently responding to several audit requests from the DMHC. The Plan continues to submit necessary documents for the Cal-AIM programs. With regard to ECM/Community Supports, the Plan submitted updated Model of Care documents on 10/25/22; currently pending a response.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	With regard to Long Term Care, the plan submitted all network readiness requirements; confirmation from DHCS was received on 10/14/22 stating the Plan was in compliance with all requirements. The Plan filed its Population Health Management program deliverables on 10/28/22; currently pending approval. The Plan received DHCS and DMHC approval for its 2023 Member Handbook which will be posted to the Plan's website on 1/1/2023. DHCS issued its 2024 Procurement Contract Operational Readiness Work Plan on 6/30/22; of which 238 deliverables must be submitted during phases, beginning August 12, 2022 for phase 1; December 15, 22 for phase 2; and April 20, 2023 for phase 3. The Plan has begun filing; which some have come back with errors which are mainly policy related. The Plan has been updating polices and submitted responses to those errors. The Plan has completed the 9/12/22 filing and is in the process to complete the 12/19/22 required filing. The next Public Policy Committee meeting will be held on December 7, 2022 at 11:30am in the Plan's Administrative Office. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through Q3 2022. • The total number of grievances had a slight increase in Q3 2022. • Quality of Service Grievances have increased from prior 2022 quarters.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Quality of Care Grievances have remained consistent for 2022 when compared to previous year. • Exempt Grievances have had a slight decrease when compared to prior year. • Appeals through Q3 2022 have significantly decreased when compared to prior year, this is a result of the Pharmacy carve-out, Medi-Cal Rx. <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through Q3 2022. A summary was shared that provided the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through Q3 2022. Membership continues to increase; Utilization for TANFs and SPDs has leveled off. Case Management results through Q3 2022 have shown increased referrals and engagement and demonstrate positive outcomes in the areas of Integrated CM, Transitional CM, and Palliative CM. <u>QI & UMCM Quarterly Report – Q3 2022</u> Dr. Marabella provided the QI & UMCM Q3 2022 update. Two QI/UMCM meetings were held in Quarter 3; one in July and one in September 2022. The following guiding documents were approved at this meeting: 1. 2022 QI Work Plan Mid-Year Evaluation 2. 2022 UMCM Work Plan Mid-Year Evaluation 3. Clinical Practice Guidelines 4. Prior Authorization Requirements	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In addition, the following general documents were approved at the meeting: 1. Pharmacy Provider Updates 2. Medical Policies The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard and Quarterly A & G reports, the MHN Performance Indicator Report for Behavioral Health Services, Initial Health Assessment (IHA), and Potential Quality Issues (PQI) report. Additional Quality Improvement reports as scheduled during Q3. The Utilization Management & Case Management reports reviewed were the Key Indicator Report, the PA Member Letter Monitoring Report, and UM Top 10 Diagnosis Report. Additional UMCM Reports include the Concurrent Review IRR Report, TurningPoint, Specialty Referrals Report, Case Management and CCM Report, MedZed Report, NIA/Magellan, and other reports scheduled during Q3. Pharmacy quarterly report include Executive Summary, Operation Metrics, Top Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR). HEDIS® Activity: In Q32, HEDIS® related activities focused on analyzing the results for MY 2021 under the Manage Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. Upcoming measures with no MPL established as of yet, include: • Lead Screening in Children • Follow-Up after ED Visit for Mental Health Illness – 30 Days	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Follow-Up after ED Visit for Substance Abuse – 30 Days Managed Care Accountability Set 2022-23 Requirements at this time: • Current Performance Improvement Projects (PIPs) will continue through 12/31/2022 • Final documentation on PIPs due 04/21/2023 • CalViva will initiate a project with a Well-Child Visit and CIS 10 Immunization focus using SWOT format. • Awaiting Annual DHCS Notification. No significant compliance issues have been identified. Oversight and monitoring processes will continue. <u>Credentialing Sub-Committee Quarterly Report</u> The Credentialing Sub-Committee met on October 20, 2022. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q2 2022 were reviewed for delegated entities, and Q3 2022 for MHN and Health Net. There was one (1) case for the Quarter 4 2022 CalViva Adverse Action Credentials Report from Health Net, covering July to September 2022. The 2023 Credentialing Sub-Committee meeting schedule was reviewed and approved. No concerns with the proposed schedule were raised. <u>Peer Review Sub-Committee Quarterly Report</u>	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	The Peer Review Sub-Committee met on October 20, 2022. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2022 were reviewed for approval. There were no significant cases to report. The Q3 2022 Peer Count Report was presented with a total of seven (7) cases reviewed. There were three (3) cases closed and cleared. There were no cases pending closure for Corrective Action Plan compliance. There was one (1) case with an outstanding CAP. There were three (3) cases pended for further information. Ongoing monitoring and reporting will continue. The 2023 Peer Review Sub-Committee meeting schedule was reviewed and approved. No concerns with the proposed schedule were raised. **Executive Report** Enrollment through August 31 2022 is 411,852 members. Enrollment continues to increase as a result of the Public Health Emergency (PHE). Choice percentages are appearing to show some promise of rebounding. Procurement remains to be monitored and will report updates in 2023. A brief presentation of the CalViva Health website was shown which includes a new YouTube health education link, as well as a Community Giving section.	
#10 Final Comments from Commission Members and Staff	None.	
#11 Announcements	None.	
#12 Public Comment	None.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#13 Adjourn	The meeting was adjourned at 3:03 pm. The next Commission meeting is scheduled for February 16, 2023 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #4

Attachment 4.B

Finance Committee Minutes
Dated 9/15/22

CalViva Health
Finance
Committee Meeting Minutes

September 15, 2022

Meeting Location
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.	
#2 Finance Committee Minutes dated July 21, 2022 Attachment 2.A Action D. Maychen, Chair	The minutes from the July 21, 2022 Finance meeting were approved as read.	Motion: *Minutes were approved* *3 – 0 – 1 – 3* *(Neves / Nkansah)*
# 3 Financials – Fiscal Year End	Fiscal year end 2021 financials are currently being audited by Moss	Motion*: Financials Fiscal Year End*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2022 Action D. Maychen, Chair	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 2022. Current total assets are approximately $278.5M; current liabilities are approximately $160.5M, this gives a current ratio of 1.73. TNE as of June 30, 2022 is approximately $127.9M which is approximately 758% of the minimum required TNE by DMHC. Interest income actual recorded was approximately $551K which is approximately $455K more than projected mainly due to the implementation of GASB 87, in addition the rates on the Plan's money market funds has increased. Premium capitation income actual recorded was approximately $1.34B which is approximately $88.5M higher than what was budgeted primary due to rates and enrollment being higher than budgeted. The Plan had budgeted for the PHE to end approximately December 2021 which did not occur, and therefore actual enrollment was higher than budgeted. Total costs of medical care expense actual recorded is approximately $1.1B which is approximately $83.3M above what was budgeted primarily due to higher enrollment and rates. Admin service agreement fees expense actual recorded was approximately $52.3M which is approximately $2.3M above what was budgeted primarily due to enrollment being higher than projected. Grants expense actual recorded is approximately $2.9M which is approximately $720k less than budgeted due to the Plan's Grants/Community Support Program related funds not being fully utilized due to Provider Recruitment grants not being fully utilized and also contingency funding not being utilized during FY 2022. All other expense items line items are in line, or below, with what was budgeted.	*2022 were approved* *5 – 0 – 0 – 2* *(Frye / Soares)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Total net income for FY 2022 was approximately $8.7M, which is approximately $5.1M more than budgeted, primarily due to a budgeted $2.2M MCO tax loss which did not occur as actual enrollment was higher than budgeted noting that the MCO tax revenue amount is directly correlated with enrollment. And secondly the Plan had higher enrollment and rates than projected. *John Frye arrived at 11:31 am*	
#4 Financials as of July 31, 2022 Action D. Maychen, Chair	Total current assets recorded were approximately $249.3M; total current liabilities were approximately $131.5M. Current ratio is approximately 1.89. Total equity as of the end of July 2022 was approximately $127.8M which is approximately 757% above the minimum DMHC required TNE amount. The net loss for July 2022 is due to CalViva frontloading the grants so that funds could be distributed to the Plan's community-based organizations sooner than later, which is consistent with prior years. Interest income actual recorded was approximately $160K which is approximately $131K more than budgeted primarily due to rates on the Plan's money market funds being higher than anticipated. Premium capitation income actual recorded was approximately $107.3M which is approximately $3M more than budgeted primarily due to enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $85.8M which is approximately $2.5M more than budgeted due to enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $4.5M, which is approximately $77K more than budgeted due to higher than projected enrollment. All other expense line items are in line with what was	Motion: *Financials as of July 31, 2022 were approved* *6 – 0 – 0 – 1* *(Frye / Soares)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	budgeted. For the first month of FY 2023 there was a net loss of approximately $182K which is approximately $623K less than the projected net loss of $804K; The main reasons for lower net loss than projected are due to an MCO tax gain of approximately $393K for July 2022, in combination with higher enrollment than projected. *Harold Nikoghosian arrived at 11:38 am*	
#5 Proposed 2023 Finance Meeting Calendar Action D. Maychen, Chair	The proposed 2023 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* *(Soares / Neves)* A roll call was taken.
#6 Announcements	The DMHC Routine Financial Examination Audit responses have been accepted by DMHC and has been closed.	
#7 Adjourn	Meeting was adjourned at 11:47 am	

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

Dated: 11-17-2022

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 11/17/2022

Item #4

Attachment 4.C

QIUM Committee Minutes
dated 10/20/22

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

October 20th, 2022

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

Th	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	✓	**Iris Poveda**, Senior Medical Management Administrative Specialist
✓	**Paramvir Sidhu, M.D.,** Family Health Care Network	✓	**Mary Lourdes Leone,** Chief Compliance Officer
	David Cardona, M.D., Fresno County At-large Appointee, Family Care Providers	✓	**Maria Sanchez**, Compliance Manager
✓	**Raul Ayala, MD,** Adventist Health, Kings County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**Joel Ramirez, M.D.,** Camarena Health Madera County		
✓	**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

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D Chair	The meeting was called to order at 10:33am. A quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: September 15th, 2022 - Standing Referrals Report (Q2) - Facility Site & Medical Record & PARS Review Report (Q1 & Q2) - Performance Improvement Project Updates (PDSA & PIPS) CDC-H9	The September 15th, 2022 QI/UM 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. A link for Medi-Cal Rx Contract Drug List was available for reference.	Motion: *Approve* Consent Agenda (Ramirez/Verma) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- SPD HRA Outreach (Q2) (Attachments A-E) **Action** Patrick Marabella, M.D Chair		
#3 **QI Business** - Appeals & Grievances Dashboard and TAT Report (August) (Attachment F) **Action** Patrick Marabella, M.D Chair	**Appeals & Grievances Dashboard** (August) The **Appeals & Grievances Dashboard** through August 2022 was presented noting the following trends: ➢ The total number of grievances through August 2022 has increased slightly compared to last year. ➢ 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 increased compared to last year. ➢ Exempt Grievances have decreased compared to last quarter and last year. ➢ The total number of Appeals Received through Q2 2022 has decreased compared to last year due to Medi-Cal Rx transition.	Motion: *Approve* - Appeals & Grievances Dashboard and TAT Report (August) (Verma/Sidhu) 5-0-0-2
#3 **QI Business** - MHN Performance Indicator Report for Behavioral Health Services (Q2) (Attachment G) **Action** Patrick Marabella, M.D Chair	The **MHN Performance Indicator Report for Behavioral Health Services** (Q2) provides a summary of an array of indicators in order to evaluate the behavioral health services provided to CalViva members. Fourteen (14) out of the fifteen (15) metrics met or exceeded their targets this quarter. ➢ CalViva Membership increased 1.3% from Q1 2022 ➢ There were 29 non-ABA reviews in Q2 2022 and all were complaint with the timeliness standards. There were 527 ABA reviews in Q2. Even though ABA authorization timeliness did not meet the 100% target at 99%, but did exceed the threshold for action of 95%. ➢ 1 PQI case noted in Q2. ➢ 162 provider disputes in Q2. All of them were resolved within timeliness standards, resulting in a 100% compliance rate.	Motion: *Approve* - MHN Performance Indicator Report for Behavioral Health Services (Q2) (Ramirez/Sidhu) 5-0-0-2
#3 **QI Business** - Provider Preventable Conditions (PPC) (Q2)	**Provider Preventable Conditions (PPC) (Q2)** This report provides a summary of member impacted Provider Preventable Conditions (PPC). PPCs are identified via four (4) mechanisms:	Motion: *Approve* - Provider Preventable Conditions (PPC) (Q2)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment H) **Action** Patrick Marabella, M.D Chair	1. Provider / Facility confidential submission of DHCS Form 7107 2. Monthly Claims Data review 3. Monthly Encounter Data review 4. Confidential Potential Quality Issue (PQI) submission of identified/suspected quality cases The six (6) potential PPC Cases reviewed in Quarter 2 do not represent reportable events that occurred in Quarter 2, but rather cases ready for review in Q2 after records have been obtained and initial review completed. Four (4) cases were found to meet PPC criteria and were reported to DHCS via the secure online portal.	(Ayala/Ramirez) 5-0-0-2
#4 Health Equity / Health Education - Health Equity Work Plan Mid-Year Evaluation and Executive Summary 2022 - Health Equity Language Assistance Program Report (Semi-annual) (Attachments I-J) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **2022 Mid-Year Health Equity Work Plan Evaluation.** 2022 Work Plan is divided into 4 Categories: ➢ Language Assistance Program ➢ Compliance Monitoring ➢ Communication, Training, and Education ➢ Health Literacy, Cultural Competency & Health Equity By June 30th all activities were on target for end of year completion with some already completed. Some of the Activities Completed include: ➢ Population Needs Assessment was completed in collaboration with Health Ed and QI. ➢ Provided multiple training sessions for new hires, A&G and Call Center. ➢ Reviewed 27 grievances with 2 interventions identified. ➢ Supported Breast Cancer Screening Disparity PIP including Mobile Mammography events. ➢ Co-led internal BCS PIP Workgroup and Community Advisory Group (CAG). ➢ Supported other Quality efforts including Immunization event (CIS-10) and Diabetes Project with Motivational Interviewing. The Annual Comparative Analysis of language service utilization was presented: Race/Ethnicity, Race/Ethnicity by Gender and Languages and interpreter utilization data. ➢ Spanish and Hmong are CalViva Threshold Languages. Spanish is highest. ➢ Most interpretation is done via telephonic interpreters but face-to-face increased to 26% from 22% at this same time last year. ➢ MHN (behavioral health) language services are also monitored. o 9% (207) of Calls were non-English	Motion: *Approve* - Health Equity Work Plan Mid-Year Evaluation and Executive Summary 2022 - Health Equity Language Assistance Program Report (Semi-annual) (Ramirez/Verma) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ 94% Spanish ○ 2% Hmong All Work Plan activities continue on target for completion by end of calendar year 2022. Continue to assess circumstances to modify plans as needed in order to continue to implement, monitor and track Health Equity related services and activities.	
#4 Health Equity / Health Education - Health Education Work Plan Mid-Year Evaluation and Executive Summary 2022 (Attachment K) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **2022 Mid-Year Health Education Work Plan Evaluation. The** Work Plan has two Areas of Focus for 2022: ➢ Programs and Services ➢ Department Operations, Reporting and Oversight Health Education activities are selected based upon the Population Needs Assessment. Mid-Year outcomes: ➢ Fifteen (15) Program Initiatives for 2022 ➢ Twelve (12) initiatives are on track to meet year-end goals. ➢ Three (3) Initiatives are off track to meet year-end goals (Obesity Prevention, Tobacco Cessation and Compliance Oversight and Reporting). Barriers to full implementation of planned activities have been identified and are being addressed. Continue with implementation of 2022 initiatives to meet or exceed year end goals.	Motion: *Approve* - Health Education Work Plan Mid-Year Evaluation and Executive Summary 2022 (Sidhu/Ramirez) 5-0-0-2
#5 Access Business - Specialty Referrals Report (Q2) (Attachment L) **Action** Patrick Marabella, M.D Chair	**Specialty Referral Report (Q2).** 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 quarters of 2022. This report captures four utilization case types: 1. Key services that while within the service area and within the network require clinical review. 2. Services recognized as out of the service area, but within the provider network. 3. Out of network requests, but in the service area. 4. Requests that are out of network and out of service area. This report provides evidence of a system-wide process for tracking and following up on member referrals requiring prior authorization, and includes a breakdown of SPD and non-SPD member specialty referral requests. Denial rates remain consistent. Volumes are noted to be low in Table 4: Specialist Referral and will be monitored for trends.	Motion: *Approve* - Specialty Referrals Report (Q2) (Ayala/Ramirez) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#6 **UM/CM Business** - Key Indicator Report and TAT Report (August) - TurningPoint Musculoskeletal Utilization Review (Q2) (Attachments M-N) **Action** Patrick Marabella, M.D Chair	**Key Indicator Report** (KIR) through August was presented. The following trends were noted: ➢ Membership continues to increase. ➢ Acute admits remain consistent. ➢ Overall length of stay has declined since the beginning of this year. ➢ Turn-around times met the standard for all case types in August. ➢ Case Management referrals increased for almost all programs (Perinatal, Integrated, Palliative and Behavioral) in August. **TurningPoint Musculoskeletal Utilization Review** processes prior authorizations (PA's) for CalViva Direct network providers for certain orthopedic procedures such as hip/knee replacement, spinal fusion, certain pain management procedures, etc. The Q2 summary report provides an evaluation of compliance with prior authorization (PA) performance standards. TurningPoint reviewed 159 authorizations in Q2 which continues to be low. Many elective surgeries continue to be postponed due to the pandemic. Fewer appeals were submitted in Q2 and all were overturned which may indicate improved network familiarity with guidelines. The plan has updated the calculation for % Denials to reflect Finalized authorizations. This will increase the percent denied for this report going forward. TP continues to provide additional training as required and/or requested by the providers.	Motion: *Approve* - Key Indicator Report and TAT Report (August) - TurningPoint Musculoskeletal Utilization Review (Q2) (Sidhu/Ramirez) 5-0-0-2
#7 **Policy & Procedure** - Public Health Policy Grid (Attachment O) **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. • PH-020 Mental Health Services and PH-021 Mental Health Dispute Resolution were updated to be consistent with APL 21-013 and APL 22-005. • Two (2) new policies were included in the meeting packet and reviewed with the committee: o PH-023 Non-Specialty Mental Health Services o PH-024 Eating Disorder Treatment Services	Motion: *Approve* - Public Health Policy Grid (Ramirez/Ayala) 5-0-0-2
#9. **Compliance Update** - Compliance Regulatory Report (Attachment P)	Mary Lourdes presented the **Compliance Regulatory Report.** **CalViva Health Oversight Activities.** 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	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Health. **Oversight Audits.** The following annual audits are in-progress: Access and Availability, Emergency Services, and Utilization Management. Annual Claims & PDR (CAP) have been completed since the last commission report. **Fraud, Waste & Abuse Activity.** Since the last report to the Committee, there have been no new MC609 cases filed with DHCS. **2021 Department of Managed Health Care ("DMHC") 18-Month**. The Plan is still awaiting the DMHC's final determination on our 2021 CAP response. **Department of Health Care Services ("DHCS") 2020 Medical Audit – CAP.** The Plan is still awaiting DHCS' final response in order to close the 2020 CAP. **Department of Health Care Services ("DHCS") 2022 Medical Audit**. The Plan received the DHCS' draft 2022 Audit Final Report on 9/29/22, held its Exit Conference with the Plan on 10/4/22. The Report identified three audit findings: two concerned lacks of documentation related to the provision of blood lead screening of young children, and one related to lack of documentation of a Physician Certification Statement (PCS) form for member's request for non-emergency medical transportation (NEMT). The Plan has an opportunity to provide a response to these findings by 10/19/22. **Department of Managed Health Care ("DMHC") 2022 Medical Audit.** The DMHC "on-site" audit was conducted via teleconference on 9/19/22 and 9/20/22. Since then, the Plan has been responding to several "post-Onsite" audit requests from the DMHC. **Member Handbook/Evidence of Coverage.** The Plan received DHCS and DMHC approval of its Member Handbook on 9/12/22 and 9/15/22, respectively. The Plan is required to provide the Member Handbook to members by 1/1/2023. **DHCS 2024 Operational Readiness Work Plan & Contract.** On 6/30/22, the DHCS issued its 2024 Procurement Contract "Operational Readiness Work Plan". The work plan contains 238 deliverables that must be submitted during the following phases: • Phase 1: August 12, 2022 – December 8, 2022 • Phase 2: December 15, 2022 - March 31, 2023 • Phase 3: April 20, 2023 - July 31, 2023 The Plan has completed the 9/12/22 filing of documents and is in the process to complete the 12/19/22 required filing. **Public Policy Committee.** The next meeting will be held on December 7, 2022 at 11:30am in the	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Plan's Administrative Office.	
#10 **Old Business**	None.	
#11 **Announcements**	Next meeting November 17th, 2022	
#12 **Public Comment**	None.	
#13 **Adjourn**	Meeting was adjourned at 11:32am	

NEXT MEETING: November 17th, 2022

Submitted this Day: November 17, 2022

Submitted by: Amy Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #4

Attachment 4.D

2023 Compliance Program Description

COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

Mary Lourdes Leone, CHC
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
MLLeone@CalVivahealth.org
(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

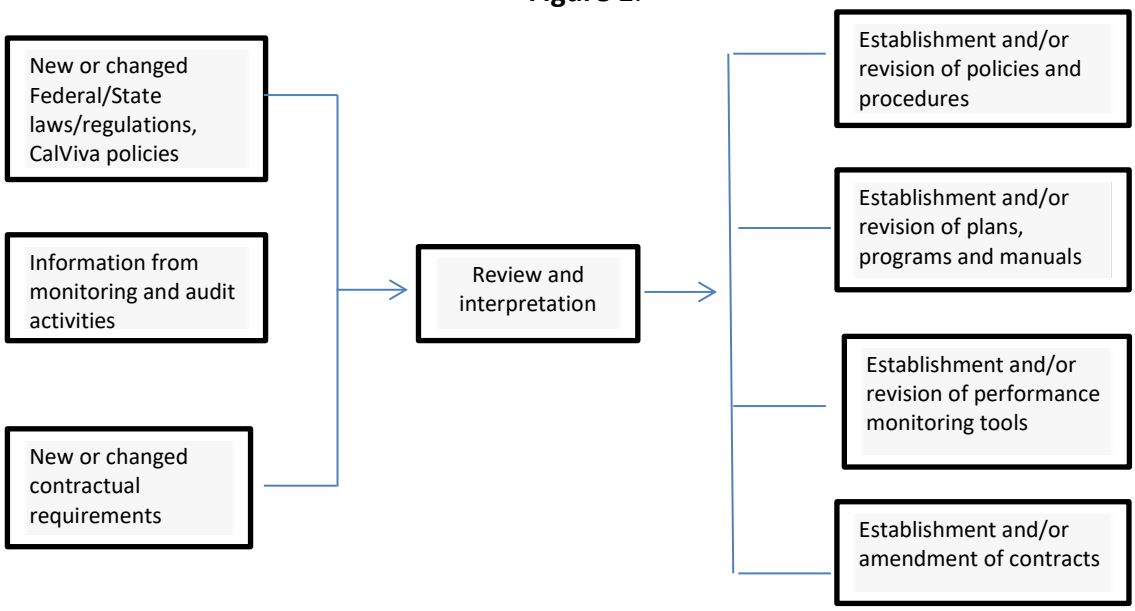
Prevention is the cornerstone to CalViva's Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from 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 16, 2023 _____
Name:	Mary Lourdes Leone	Date
Title:	Chief Compliance Officer	
	_____	February 16, 2023 _____
Name:	Jeffrey Nkansah	Date
Title:	Chief Executive Officer	
	_____	February 16, 2023 _____
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.
1/29/23	Annual review; No changes

Item #4

Attachment 4.E

2023 Code of Conduct

Code of Conduct

For inquiries regarding this Code of Conduct, 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.

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 16, 2023

_____ Date: _____

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

F**ebruary 16, 2023**

_____ Date: _____

Name: Jeffery Nkansah
Title: Chief Executive Officer

_____ Date: _____

Name: David S. Hodge
Title: RHA Commission Chairperson

Item #4

Attachment 4.F

2023 Anti-Fraud Plan

ANTI-FRAUD PLAN

For inquiries regarding this Anti-Fraud 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

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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 16, 2023

Date: _____

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

February 16, 2023

Date: _____

Name: Jeffery Nkansah
Title: Chief Executive Officer

February 16, 2023

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).
1/29/23		Annual Review; No Changes

Item #4

Attachment 4.G

2023 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 to violate 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"). All employees/associates are prohibited from disclosing medical information related to sensitive services to anyone other than the enrollee without the individual's express written authorization, including the policyholder or parent of a minor patient.

The Plan is prohibited from requiring a protected individual, as defined, to obtain the policyholder, primary subscriber, or other enrollee's authorization to receive the sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care. Upon written request from a member, the Plan must direct communications regarding a member's protected health information (PHI) directly to the member's designated alternative mailing address, email address, or telephone number.

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. Protected Individual – Any adult member covered under the Plan, or a minor member who can consent to a health care service without the consent of a parent or legal guardian.

J. **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.

K. **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.

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

M. **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".

N. Sensitive Services - all health care services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

O. **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.

P. **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, Assembly Bill 1184, 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 16, 2023**
Name:	Mary Lourdes Leone		
Title:	Chief Compliance Officer		
		Date:	**February 16, 2023**
Name:	Jeffrey Nkansah		
Title:	Chief Executive Officer		
		Date:	**February 16, 2023**
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
2/16/2023		Annual Review; Updated language to capture Assembly Bill 1184 surrounding requests for confidential communication, added definition of protected individual and sensitive services.

Item #6

Attachment 6.A – 6.B

- BL 23-002 Annual Administration
- 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

Michael Goldring
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 16, 2023

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Annual Administration

BL #: 23-002
Agenda Item 6
Attachment 6.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 3, 2023.

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, **2022,** through December 31, **2022**.

-or-

The period covered is _____/_____/_____, through December 31, **2022**.

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

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

☐ The period covered is January 1, **2022**, 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 (required)

► ***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.)

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:

___/___/**22** ACQUIRED ___/___/**22** 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:

___/___/**22** ACQUIRED ___/___/**22** 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:

___/___/**22** ACQUIRED ___/___/**22** 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:

___/___/**22** ACQUIRED ___/___/**22** 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:

___/___/**22** ACQUIRED ___/___/**22** 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:

___/___/**22** ACQUIRED ___/___/**22** DISPOSED

Comments: ______________________________

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:
__/__/22 ACQUIRED __/__/22 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:
__/__/22 ACQUIRED __/__/22 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:
__/__/22 ACQUIRED __/__/22 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:
__/__/22 ACQUIRED __/__/22 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: _____

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:
__/__/22 ACQUIRED __/__/22 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:
__/__/22 ACQUIRED __/__/22 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: _____

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: _____

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: ____

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: _____

Item #8

Attachment 8.A – 8.B

2022 Annual Quality Improvement Work Plan Evaluation

8.A Executive Summary
8.B Year End Evaluation

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 16th, 2023
SUBJECT:	Quality Improvement Year-End Work Plan Evaluation Executive Summary 2022

Summary:
CalViva Health's 2022 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 2022, 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 2022 QI Year-End 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 2021 surveys between September and December 2021. Results indicated a need for improvement in several areas.

- For PAAS -Urgent Care Primary Care Physicians (PCPs), overall results for MY 2021 were reflected with notable decrease of 18.0 percentage points compared to MY 2020. Urgent Care Specialists overall scores showed a 4.2 percentage point improvement but continue to be low for MY 2021. Non-Urgent Care PCPs overall scores decreased in MY 2021 with 14.5 percentage points. Specialist overall scores also decreased with 13.6 percentage points compared to MY 2020.
- For PAHAS- the performance goal of 90% for After-Hours Emergency Instructions were met in all of the three CalViva Health counties. A statistically significant increase was noted overall for all counties compared to MY 2020 for Emergency

Instructions. For After-Hours Physician Availability the performance goal of 90% was not met in Fresno and Kings County which fell slightly short of the goal. The goal was met for Madera County. While some restrictions have been relaxed, providers continued to have difficulty meeting appointment standards due to administration of the survey for MY 2021 which took place during the surge of Omicron variant and may have impacted provider appointment availabilities.

Corrective Action Plan (CAP)

- For MY 2021 a revised Corrective Action Plan (CAP) process was implemented using targeted PPG approach to address non-compliance and improved escalation process for non-responding PPGs. Deficiencies were identified through analysis of the survey results and CAP packets were issued to PPGs who failed in one or more of the timely access or after-hours measures. Priority PPGs are required to complete an Improvement Plan (IP) within 30-days of receipt and attend a Timely Access webinar.
    - A total of seventeen (17) Tier 1 CAP packets were issued, with eleven (11) PPGs and six (6) direct network providers.
    - A total of forty-one (41) Tier 2 educational packets were issued, with twelve (12) PPGs and twenty-nine (29) direct network providers.
    - Both Tier 1 & Tier 2 PPGs were required to complete an attestation to be returned within 30 days.
- All received IPs were validated and requests sent for supporting documentation as applicable. The majority of the CAPs were closed out by 12/31/22. One CAP remains open for supporting documentation and is closely monitored.
- In 2022, the Access & Availability team conducted a total of ten (10) Timely Access webinars sessions with 570 total participants including attendees from the CalViva Health service area. The web-based training was conducted in June and July 2022, with topic specific to Timely Access survey preparation, for provider office-staff and PPGs, to improve performance in access and availability. Additional webinars conducted in November and December 2022, focusing on CAP response and development. Webinar certificates were received and tracked. A self-study option with certificate was available to those unable to attend the webinars.

1.2 Improve Member Satisfaction: The annual CalViva Health Access Survey was launched to members in early April 2022. Final results revealed that one of the four measures, *Ease to get specialist appointment* increased from prior year. The other three measures declined year over year. Quarterly root cause analysis on appeals and grievances data was conducted to identify trends in member pain points, as well as areas for improvement. Access to care continues to be the main driver of grievances filed, especially around prior authorization delays. Findings were shared with internal stakeholders and teams during Quarterly CAHPS Workgroup calls held throughout the year. CAHPS and member experience awareness and education continue to be a focus since there are multiple stakeholder teams that are member-facing and have the potential to impact CAHPS scores. Preparations and coordination have been successful in meeting all requirements for CalViva Health to launch the regulatory CAHPS survey in Q1 2023.

2. Quality and Safety of Care

2.1 All HEDIS® Default Measures Rates for MY 2021 Minimum Performance Level (MPL) (50th percentile)

Cervical Cancer Screening (CCS)	Fresno (**63.04**), Kings (**64.17**) and Madera (**64.42**) counties exceeded MPL of 59.12%.
Childhood Immunization Combo 10 (CIS-10)	Madera (**49.64**) exceeded MPL of 38.20%. Kings (**31.87**) and Fresno (**35.04**) counties fell below the MPL. A Performance Improvement Project (PIP) was continued in an effort to improve rates in Fresno County. The PIP ended 12/31/22.
Controlling High Blood Pressure (CBP)	Fresno (**56.3**), Kings (**65.10**) & Madera (**67.29**) counties exceeded MPL of 55.35%.
Timeliness of Prenatal Care (PPC-Pre)	Fresno (**86.11**), Kings (**91.70**) and Madera (**88.15**) counties exceeded the MPL of 85.89%.

2.2 Non-Default HEDIS Minimum Performance Level (MPL) Rates For Measures Below the MPL in MY 2021

Breast Cancer Screening (BCS)	Kings (**56.64**) and Madera (**56.63**) Counties exceeded the MPL of 53.93%. Fresno County (**49.11**) did not meet the MPL. A Disparity PIP was in progress in Fresno County and continued until 12/31/22.
Child and Adolescent Well-Care Visits (WCV)	Fresno (**46.30**) and Madera (**55.2**) counties exceeded the MPL of 45.31%. Kings (**38.8**) County fell below the MPL.
Comprehensive Diabetes Care: HbA1c Poor Control > 9.0% (CDC-H9)	Fresno County (**42.64**), Kings (**34.04**) and Madera (**40.45**) exceed the MPL of 43.19% (inverted measure).
Immunizations for Adolescents: Combo 2 (IMA-2)	Madera (**50.49**) and Fresno (**37.23**) counties exceeded the MPL of 36.74% and Kings (**32.66**) Counties fell below the MPL.
Timeliness of Postpartum Care (PPC-Post)	Fresno (**81.60**), Kings (**87.34**) and Madera (**80**) counties exceeded the MPL of 76.40%.
Well-Child Visits in the First 15 Months of Life-Six or more Well-Child Visits (W30-6+)	Kings (**55.56**), and Madera (**65.06**) counties exceeded the MPL of 54.92%. Fresno (**48.80**) county fell below the MPL.
Well-Child visits for age 15 Months to 30 Months- Two or more Well-Child Visits (W30-2+)	Madera (**73.23**) County exceeded the MPL of 70.67%. Fresno (**61.86**) and Kings (**54.43**) counties fell below the MPL.

3. Performance Improvement Projects (PIPs)

For 2022, two PIPs, targeted in Fresno County, were both in the intervention implementation phases.

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

3.1 Childhood Immunization (CIS-10):

In Q1 to Q4 2022, 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 (IZ) completion rates. In Q1 to Q2 2022, an educational text messaging campaign was implemented with the clinic. In Q3, CalViva Health worked with Health Education to develop and finalize scripting of the text messaging. The addressed failure mode was lack of knowledge and misperceptions regarding the childhood immunization; key driver addressed, member understands the importance of childhood vaccinations and the vaccine schedule.

In Q2, a second intervention was implemented, “Heroes for Health IZ Re-occurring Events.” The failure mode addressed was transportation and childcare, and the key driver addressed was convenient access to the clinic. The pediatric clinic was opened for a Saturday event which included interpreters, refreshments, and snacks. Members were offered gift cards and diaper bags upon completion of the immunizations. A total of 73 immunizations were given from the Provider Profile (non-compliant member list) and 149 members scheduled appointments which resulted in a 49.0% compliance rate. Overall Clinic compliance rate was 34.3% with a goal rate of 34.53% and a baseline rate of 28.03%. In Q4, the name was changed to “Journey for Health IZ Re-Occurring Events.”

CalViva Health will continue to offer health education materials to members and help parents understand the importance of childhood immunizations.

Per HSAG, the CIS-10 PIP ended December 31, 2022.

3.2 Breast Cancer Screening (BCS) Disparity

In Q1 to Q4 2022, CalViva Health Medical Management staff continued a Breast Cancer Screening (BCS) performance improvement project in collaboration with one high volume, low compliance clinic, and a community-based organization that supports the Hmong population in Fresno County.

- In Q1 to Q2, a mobile mammography two-day event was held which resulted in a 73.5% compliance rate (72/98)
- In Q3 and Q4, three additional mobile mammography events were held which resulted in a 54.9% compliance rate. (40/72).

A total of 112 breast cancer screenings exams were completed from the Provider Profile during the mobile mammography events from a baseline rate of 38.4% to a

(sustained) goal rate of 47.8%. CalViva Health met and exceeded the goal for the project. In Q2, video testimonials were developed from three breast cancer survivors, and the videos are being shown in medical office waiting rooms, YouTube site, Hmong TV, The Fresno Center, and community events to raise awareness of breast cancer.

Per HSAG, the Disparity PIP BCS ended December 31, 2022.

CalViva Health Quality Improvement Year-End Work Plan Evaluation 2022

02/16/2023

CalViva Health 2022 Quality Improvement Year-End Work Plan Evaluation

TABLE OF CONTENTS

CalViva Health 2022 Quality Improvement Year-End Work Plan Evaluation

Submitted by:

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

CalViva Health 2022 Quality Improvement Year-End Work Plan Evaluation

I. Purpose

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

II. CalViva Health Goals

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

III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2022. The development of this document requires resources of multiple departments.

CalViva Health 2022 Quality Improvement Year-End Work Plan Evaluation

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
CCM:	Chronic Conditions Management
CDC:	Comprehensive Diabetes Care
CM:	Care 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
HEDIS®:	Healthcare Effectiveness Data and Information Set
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:**	A. Schneider, Director, CalViva Health Medical Management	**Secondary:**	P. Fuentes, Provider Relations Specialist;A. Wittig, Director, 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 CalViva Health 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 CalViva Health 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 2022 Survey Prep Q3: MY 2021 Survey Results	CVH/HN
Conduct provider training webinars related to timely access standards and surveys.	P	Q1-Q4	CVH/HN
Conduct Telephone Access surveys annually to monitor provider office answer time and member callback times.	P	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	Q3-Q4	CVH/HN
Complete a CAP as necessary when CalViva Health 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	Q2-Q4	CVH/HN

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

• MY 2022 PAAS and PAHAs surveys are scheduled to begin in September and will be conducted by Sutherland Global.
 	
• Provider Updates, alerts, and toolkits related to timely access are scheduled to be released in Q3 2022:
  ○ MY 2021 PAAS and PAHAS survey results
  ○ MY 2022 Provider Satisfaction survey preparation
  ○ MY 2022 PAAS & PAHAS survey preparation.
  ○ Improve your Access and Availability flyer for information on how to register for provider webinars.
	• The MY 2022 PAAS & PAHAS surveys will be completed by end of December. Audit and reporting are underway with final report generation at the end of January 2023.
	
	• Provider update related to MY 2022 PAAS & After-Hours surveys was published on July 29th.
	
	• Telephone access survey conducted in Q4 2022 ended in December with final report generation at the end of January 2023.

○ Improve Health Outcomes, a Guide for Providers. • MY 2021 PAAS and After-hours survey results were shared with CalViva Health at the June 2022 Access WG ad-hoc meeting. There was a need to improve PAAS response rates by improving provider ineligibility and non-response. • The MY 2021 Corrective Action Plan (CAP) processes will remain the same as MY 2020, but will propose the focus on Urgent and Non-Urgent metrics to target providers that need improvement in these areas. It is on track with revamping the process to create criteria to identify noncompliant PPGs and providers and align PPG-level CAPs with DMHC proposed 70% compliance rate for MY 2022 PAAS. • Provider webinars: Two sessions were held in Q2 (June) and there will be one session in Q3 (July) and three sessions in Q4 (December). • Due to the pandemic, the survey was not conducted quarterly in 2021, but will be an annual survey conducted in December 2022 by Sutherland Global. This will continue as an annual survey going forward.	• MY 2021 PAAS and After-Hours survey outcomes including Corrective Action Plan (CAP) results were presented during the October 5th Access Workgroup meeting. ○ A total of 17 Tier 1 CAP packets were sent with Improvement Plans due on October 15th. There were 11 Tier 1 group CAPs and 6 Direct Network provider CAPs sent out via e-mail on September 14th with Improvement Plans due October 15th. There were two groups that were moved from Tier 1 to Tier 2 PPGs. and there was 1 group found to be non-compliant for MY 2020 & MY 2021 and was moved to Tier 1. ○ A total of 42 Tier 2 Ed packets (12 PPGs & 29 Direct Network) were emailed on September 14th. ○ Both Tier 1 & Tier 2 PPGs were required to complete an attestation form and return it within 30 days of receiving the CAP. ○ Improvement Plans has not been received for 1 PPG and 2 direct network providers. Follow-up on missing Improvement Plans continued. Receipt of supporting documentation is required to close out CAPs. • Provider webinars: Enhanced access and availability provider training webinar flyer for clear information and easy registration. In 2022, the Access and Availability team conducted a total of 10 provider webinar sessions with 570 total participants with attendees from the CalViva Health service area. Webinar certification continued to be received and tracked. Self-study packet option was available to those unable to attend the webinars in 2022. • Appointment access P&P update was presented for annual review during the October 5th Access Work Group meeting. • DHCS Medi-Cal Managed Care Timely Access Report: DHCS confirmed they will resume surveys in January 2023. • Resource updates: Improve Health Outcomes – Provider Toolkit rebrand/refresh were distributed in Q3 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)					
Measure(s)	**Performance Goal**	**Rate (%) MY 2020**	**Rate (%) MY 2021 (Populated mid-year)**	**Baseline Value Source**	**Baseline Value (%) MY 2019**
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= 45.5↓ (-10.4) Non-Urgent= 68.1↓ (-13.8) Prenatal= 86.1↑ (0.8)	CVH Performance MY 2019	Urgent= 60.3 Non-Urgent= 78.7 Prenatal= 90.1
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= 50.9↓ (-18.0) Fresno= 49.5↓ Kings= 57.1↓ Madera= 52. 4↓	CVH Performance MY 2019	Overall= 70.9 Fresno= 71.9 Kings= 67.3 Madera= 70.3
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= 40.2↓ (-4.2) Fresno= 39.6↓ Kings= 50.0↑ Madera= 39.0	CVH Performance MY 2019	Overall= 52.2 Fresno= 53.8 Kings= 42.3 Madera= 50.9
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= 71.4↓ (-14.5) Fresno= 65.9↓ Kings= 87.5↓ Madera= 90.9↓	CVH Performance MY 2019	Overall= 84.7 Fresno= 85.5 Kings= 84.9 Madera= 79.5
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= 64.8↓ (-13.6) Fresno= 64.3↓ Kings= 76.9↓ Madera= 62.9↓	CVH Performance MY 2019	Overall= 75.4 Fresno= 77.1 Kings= 64.3 Madera= 74.2
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= 92.3↑ (5.2) Fresno= 100.0↑ Kings= 66.7* Madera= NR	CVH Performance MY 2019	Overall= 88.4 Fresno= 90.0 Kings= 91.3 Madera=70.0
First Prenatal Visit (SCP) – Within 2 weeks of request	90%	Overall= 80.9 (-10.3) Fresno= 81.8 Kings= 57.1* Madera= 100*	Overall= 80.0↓ (-0.9) Fresno= 78.1↓ Kings= 100.0* Madera= 100.0*	CVH Performance MY 2019	Overall= 91.2 Fresno= 90.3 Kings= 100* Madera= NR
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= 67.7↓ (-13.2) Fresno= 70.4↓ Kings= 66.7* Madera= 0.0*	CVH Performance MY 2019	Overall= 76.9 Fresno= 77.5 Kings= 79.6 Madera= 70.3

Measure(s)	Performance Goal	Rate (%) MY 2020	Rate (%) MY 2021 (Populated mid-year)	Baseline Value Source	Baseline Value (%) MY 2019
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= 86.7↓ (-2.3) Fresno= 88.5↑ Kings= 100.0* Madera= 0.0*	CVH Performance MY 2019	Overall= 87.8 Fresno= 88.1 Kings= 91.5^ Madera= 81.6
Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	90%	Overall= 100 (6.7) Fresno= 100 Kings= 100* Madera=100*	Overall= 94.1↓ (-5.9) Fresno= 92.3↓ Kings= 100.0* Madera=100.0*	CVH Performance MY 2019	Overall= 93.3 Fresno= 90.9 Kings= 100* Madera= 100*
Appropriate After-Hours (AH) emergency instructions	90%	Overall=96.0 (-1.9) Fresno= 95.0 Kings= 99.1 Madera= 100	Overall= 100.0 (4.0) Fresno= 99.0↑ Kings= 100.0↑ Madera= 100.0	CVH Performance MY 2019	Overall= 97.9 Fresno= 97.9 Kings= 99.0 Madera= 96.1
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= 82.0↓ (-2.2) Fresno= 80.0↓ Kings= 89.0↑ Madera= 93.0↓	CVH Performance MY 2019	Overall= 99.4 Fresno= 99.4 Kings= 99.0 Madera= 100

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

↑↓ Statistically significant difference between RY 2021 vs RY 202, p<0.05.

NR – No reportable data.

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

Analysis: Intervention Effectiveness with Barrier Analysis	• PAAS & After-Hours Surveys:
	  ○ Urgent Care – PCP's overall score for MY 2021 were reflected with a notable decrease of 18.0 percentage points (PP) as compared to MY 2020. Overall, specialists scores showed improvement but continue to be low in MY 2021 of 4.2 Percentage points (PP).
	  ○ Non-Urgent Care – PCP overall scores decreased in MY 2021 with 14.5 percentage points (PP). Specialist overall scores also decreased significantly with 13.6 percentage points (PP) as compared to MY 2020.
	  ○ After-Hours - The performance goal of 90% for After-Hours Emergency Instructions were met in all of the three CalViva Health counties. A statistically significant increase was noted overall for all counties compared to MY 2020 for Emergency Instructions. For After-Hours Physician Availability the performance goal of 90% was not met in Fresno and Kings County which fell slightly short of the goal. The goal was met for Madera County.

	○ Survey administration for MY 2021 took place during a global pandemic and due to these extraordinary circumstances caution should be exercised when comparing and interpreting trend results from the prior year. • Provider Training: ○ Access & Availability team conducted ten Timely Access provider webinars 2022 with a total of 570 participants including attendees from CalViva Health service area. A self-study option was offered upon request for those who have not attended the training online. Webinar certification continued to be received and tracked. **Barriers:** • PAAS & After-Hours Surveys: ○ Providers continued to have difficulty meeting appointment standards after some of covid restrictions have been relaxed. This was due to the survey conducted during the surge of Omicron variant which may likely impacted provider appointment availability. Contributing factor could be surge of members request for appointment due to not being seen the previous year during the start of the pandemic. ○ Members still prefer to be seen in person for appointment rather than utilize Telehealth option. • PAAS Non-Responders - Provider staff require additional education regarding PAAs process to minimize non-responders.
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:**	A. Schneider, Director, CalViva Health Medical Management	**Secondary:**	A. Alfonso, Program Manager; Health Net QI Department
Rationale and Aim(s) of Initiative				
Member experience is impacted 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 Health is monitored in two ways:

1. **CalViva Health 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 Health & 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 Results Rates: August 2021 – May 2021
    e. Results: Results are posted on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx

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

Measure rates captured below for both the CalViva Health 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 Health 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 Health 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)

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. Resource topics include: Appointment Scheduling Tip Sheet and Quick Reference Guide, Talking with my Doctor Guide, Interpreter Services Guide, Access Standards.	P	Q3 2022	CVH/HN
Update the following articles and distribute in Member newsletter: Access standards, interpreter services, nurse advice line.	M	Q3 2022	CVH/HN
Update (as needed) and conduct scaled-back member survey/Annual CalViva Health Access Survey to assess effectiveness of interventions implemented. Share and review results once they are made available.	M	Q1-Q2 2022	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 2022	CVH/HN
Quarterly root cause analysis on appeals and grievances data to highlight member pain	P	Quarterly basis	CVH/HN

points, trends and opportunities for improvement. Share results and recommendations with Medical Management leadership at least quarterly.			
Prepare and coordinate all needed requirements for CalViva Health to launch regulatory CAHPS Survey in Q1 2023.	M	Q4 2022	CVH/HN
Launch Provider Training Series Pilot: trainings will cover several topics related to member experience/CAHPS and will be offered in different formats (Lunch & Learn Sessions, On-Demand Videos).	P	Q1 2022	CVH/HN
CAHPS Tip Sheet: Provider Tip Sheet highlighting the importance of CAHPS, member experience, and best practices of major CAHPS measures.	P	Q2 2022	CVH/HN
On-Demand Provider Training Series: Short video trainings that providers can access anytime, on-demand. 4 topics will include: Motivational Interviewing, Patient Empathy, Cultural Competency, Psychotropic Medications (Behavioral Health focus)	P	Q4 2022	CVH/HN

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

• The annual CalViva Health survey was launched in early April 2022 and was fielded for 3 weeks until the target number of respondents was met. Results from the survey were available early June.
  ○ Two measures, Got Routine Care As Soon As Needed and Ease of Getting Care/Test/Treatment, rose from last year, both seeing a 2-percentage point increase.
  ○ Got Urgent Care As Soon As Needed and Ease to Get Specialist Appointment decreased from last year. The decrease of the Ease of Getting a Specialist Appointment measure was mainly impacted by delays in approval and authorizations and members not getting a convenient appointment time.
  ○ Final results shared with QI MCAL Manager and PNM Director and team members. Highlights of the results were flagged so
	• The CAHPS articles in the Provider Tool Kit were reviewed and updated earlier in the year, but the launch of the final tool kit to make it electronically available to providers and staff, was delayed. The updated estimated launch date is mid/late Q1 2023.
	
	• The CalViva Health Member Newsletter articles were updated and launched to members in November 2022. The newsletter was mailed to the following unique households: English: 134,064; Hmong: 3,158; Spanish: 52,349. An e-version of the newsletter was also posted online.
	
	• The CAHPS PPG webinar was conducted in Q3 2022, across two sessions (one morning session, one lunch hour session). The webinar included an overview of CAHPS, drilling down into the measures that

teams could reference when planning future improvement initiatives. • Root cause analysis was conducted on Q1 member pain points data. Top grievance categories included: prior auth delays and limited appointment availability for PCPs and specialists. Findings were shared with stakeholder teams during the Q2 CAHPS Workgroup call (May 2022). • Provider Training Series Pilot was canceled for 2022. Appropriate logo use and approvals were not fulfilled by the pilot's scheduled launch date. • CAHPS Provider Tip Sheet was completed and launched early June. • On-Demand Provider Training Series has been delayed and will launch in Q4 this year.	were heavily impacted by providers and clinic staff. The webinar also highlighted the importance of customer service and patient loyalty, and how it could have a positive impact on patient experience. • The CAHPS Team had been working alongside the Program Accreditation Team and Corporate CAHPS Team, ensuring that all requirements were met to launch the CAHPS regulatory survey to CalViva Health members. All items have been properly addressed. The survey is scheduled to launch mid-February 2023. • The On-Demand Provider Training Series was delayed. The content was created, but more time was needed to find resources needed to record the online series. Updated ETA launch is early Q2 2023.

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 2022)

CalViva Health Access Survey Measure(s)	Specific Goal	MY 2020	MY 2021	Baseline Source (Source: Previous Year CalViva Health Access Survey)	Baseline Value
Got urgent care as soon as needed	Improve YOY	78%	77%	MY 2019 Rate	76%
Got routine care as soon as needed	Improve YOY	67%	62%	MY 2019 Rate	65%
Ease to get specialist appointment	Improve YOY	59%	65%	MY 2019 Rate	59%
Ease of getting care/test/treatment	Improve YOY	76%	69%	MY 2019 Rate	77%

DHCS CAHPS Survey Measure(s)	Specific Goal	MY 2018	MY 2020	Baseline Source (Source: Quality Compass National Benchmark)	Baseline Value
Getting Needed Care	Meet or Exceed Quality Compass 50th Percentile	69.10%	79.9%	MY 2020 50th Percentile	83.4%
Getting Care Quickly	Meet or Exceed Quality Compass 50th Percentile	73.31%	76.1%	MY 2020 50th Percentile	83.5%
How Well Doctors Communicate	Meet or Exceed Quality Compass 50th Percentile	86.52%	85.8%	MY 2020 50th Percentile	93.4%
Customer Service	Meet or Exceed Quality Compass 50th Percentile	NA	NA	MY 2020 50th Percentile	89.6%
Rating of All Health Care	Meet or Exceed Quality Compass 50th Percentile	63.41%	72.2%	MY 2020 50th Percentile	57.6%
Rating of Personal Doctor	Meet or Exceed Quality Compass 50th Percentile	75.46%	77.8%	MY 2020 50th Percentile	69.7%
Rating of Health Plan	Meet or Exceed Quality Compass 50th Percentile	73.35%	75.9%	MY 2020 50th Percentile	62.8%
Rating of Specialist	Meet or Exceed Quality Compass 50th Percentile	74.44%	NA	MY 2020 50th Percentile	70.4%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness With Barrier Analysis	• Results from the MY 2021 Annual Access Survey showed YOY improvement in 1 of the 4 measures: Ease To Get Specialist Appointment, which saw a 6 percentage point increase. The 3 remaining measures (Got urgent care as soon as needed; Got routine care as soon as needed; East of getting care/test/treatment) declined from the previous year, highlighting the need to continue efforts to improve care access for members.

	• Close collaboration with the PNM Department will continue into 2023, with a focus on improving routine care appointment availability. • CAHPS education and exposure remained a top priority, seeing that multiple member-facing departments and teams can have the potential to impact CAHPS and member experience. Internal and external member feedback will be routinely monitored to help guide where improvement efforts should be focused on throughout the year. With the regulatory CAHPS survey launching next year, MY 2023 results will also help show where improvement opportunities lie.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

II. QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)				
2-1: Cervical Cancer Screening (CCS)				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**		☒ **Safety Clinical Care**
Reporting Leader(s)	**Primary:**	A. Schneider, Director, CalViva Health Medical Management	**Secondary:**	R. Dick, Sr. QI Specialist, Health Net QI Department; R. CalVa-Songco; Manager,Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: The overall aim is to increase treatment choices and improve survival rates of CalViva Health members in Fresno County who are diagnosed with cervical cancer through early detection.

Rationale: Screening is looking for cancer before a person has any symptoms. This can help find cancer at an early stage. When abnormal tissue or cancer is found early, it may be easier to treat. By the time symptoms appear, cancer may have begun to spread.

Key Points:

- Cervical cancer is a disease in which malignant (cancer) cells form in the cervix.
- Screening for cervical cancer using the Pap test has decreased the number of new cases of cervical cancer and the number of deaths due to cervical cancer since 1950.
- Human papillomavirus (HPV) infection is the major risk factor for cervical cancer.

Cervical dysplasia occurs more often in women who are in their 20s and 30s. Death from cervical cancer is rare in women younger than 30 years and in women of any age who have regular screenings with the Pap test. The Pap test is used to detect cancer and changes that may lead to cancer. The chance of death from cervical cancer increases with age. In recent years, deaths from cervical cancer have been slightly higher in Black women younger than 50 years than in White women younger than 50 years. Deaths from cervical cancer are almost twice as likely in Black women older than 60 years than in White women older than 60 years.

Although most women with cervical cancer have the human papillomavirus (HPV) infection, not all women with HPV infection will develop cervical cancer. Many different types of HPV can affect the cervix and only some of them cause abnormal cells that may become cancer.

Other risk factors for cervical cancer include:

- Giving birth to many children.
- Smoking cigarettes.
- Using oral contraceptives

- Having a weakened immune system.[1]

Cervical cancer can be prevented with detection and treatment of precancerous cell changes caused primarily by high-risk types of human papillomavirus (hrHPV), the causative agents in more than 90% of cervical cancers. Effective screening and treatment for precancerous lesions are associated with low rates of cervical cancer mortality in the United States.[2]

[1] NIH National Cancer Institute (2021). Cervical Cancer Screening (PDQ®) - Patient Version. https://www.cancer.gov/types/cervical/patient/cervical-screening-pdq#_7

[2] U.S. Task Force Preventive Services (2018). Cervical Cancer: Screening https://www.uspreventiveservicestaskforce.org/uspstf/document/evidence-summary/cervical-cancer-screening#bootstrap-panel--3

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

The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:
- Women 21-64 years of age who had cervical cytology performed within the last 3 years.
- Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.

Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) contesting within the last 5 years.
At the targeted high volume, low performance clinic.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with a high volume, low compliance clinic in Fresno County to improve CCS screening rates.	P/M	Q1-Q2	CVH/HN
Conduct regular meetings with Fresno County provider to plan improvements to increase the frequency of CCS screenings in women.	P	Q1-Q2	CVH/HN
Using a call script for outreach and education to members, 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
Members will be mailed a letter after three unsuccessful phone attempts have been made.	P/M	Q1-Q2	CVH/HN
Work with targeted provider to develop a second intervention to address women we have been unable to reach (voicemail left, initial refusal) and newly eligible to further increase testing rate at the clinic and in Fresno County.	M	Q1-Q2	CVH/HN
Members will receive a $25 VISA Gift Card Incentive upon completion of the CCS Screening.	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 2022, CalViva Health led a Cervical Cancer Screening (CCS), Performance Improvement Project and continued to work with one high volume, low compliance clinic in Fresno County. • In Q1 and Q2, 2022, the partner organization and CalViva Health established a multidisciplinary CCS 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. • A call script was developed to be used for member outreach. Health Ed staff, along with QI and clinic staff worked to ensure a quality and compliant script was developed. The script was translated into Spanish. • A provider profile was developed to include non-compliant members including patient demographic information; appointment scheduled; attending the appointment; test completion; date of the screening completed; if not completed, reasons for not completing the screening; and staff feedback.	• In Q3, CalViva Health continued to work with one high volume, low compliance clinic in Fresno County. The multi-disciplinary team continued the established bi-weekly meetings with the clinic. The CCS PDSA improvement team reviewed progress with the activities, addressed new barriers, and made modifications to the project as needed. • A call script was developed and used for member outreach. • A Provider Profile was developed in collaboration with the clinic/staff to include non-compliant members on patient demographic information, appointment scheduled; attending appointment, test completion; date of the screening completed; and reasons for not completing the screening, and any staff feedback. • Members who could not be contacted via phone with at least three call attempts on different days at different times or could not be reached due to disconnected phone numbers, a letter was mailed from the clinic asking the patients to call and schedule an

• After three unsuccessful call attempts to the patients, or if the patients were a “No Show” for an appointment, a letter was mailed from the clinic. • CalViva Health Medical Management team will continue to collaborate with the clinic and continue current strategies while considering potential interventions that might be successful for those patients who refused their Pap test or have not returned a voicemail message. This intervention was successful because it was integrated into the existing clinic workflows, and existing data capture process. We will also consider sustainability and reproducibility and extending this successful intervention to other providers. • The following are results of the outreach and education call script by staff: o 50.40% (125/248) Pap tests completed o 14.11% (35/248) Appointment scheduled o Total: 160/248 (64.52%) had a positive outcome for Cycle 2. o 18.15% (45/248) Left voice mail-call back in 1 week o 4.44% (11/248) Refused/Declined • In Cycle 1 of the PDSA CCS:38 women completed the CCS exam exceeding the goal of 30 women. In Cycle 2: an additional 87 Pap Tests were completed exceeding the goal of 37 women for a total of 125 Pap test completed. At the end of the second cycle, there was also 35 eligible women scheduled for an appointment in the coming weeks. In Cycle 1, 30 appointments were scheduled. • The new CCS compliance rate after Cycle 2 = 50.40% (125/248), exceeding the goal of 30.49% as stated in the SMART Aim. • 125 $25 VISA gift cards were given out to members upon completion of the cervical cancer screening.	appointment. A letter was also mailed if the patient was a “No-Show” to the appointment, asking them to reschedule. • CalViva Health adapted the project to focus on the “unable to reach” members. The Profile was refreshed in order to continue to schedule patients and document use of alternate numbers provided. • In Q3, the PDSA CCS project was completed with 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 2020**	**Rate MY 2021**	**Baseline Source**	**Baseline Value**
HEDIS CCS Screening in Women (CCS) – County Goal	Meet or Exceed DHCS 50th Percentile 61.31%	Fresno: 61.26%	63.04%	MY 2021 HEDIS Data	61.31%
HEDIS CCS Screening – Provider Goal	By 2/15/2022 increase rate to 55.35% By 06/15/2022 increase rate to 70.80%	Fresno: N/A	30.49%	MY 2021 Provider Results	44.1%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness with Barrier Analysis	**Successes:** • The clinic staff were diligent in reaching out to all members on the Provider Profile in Cycle 2 to support completion of CCS Screenings. • Integrating the outreach and education into the clinic's script for initial patient contact contributed to the success of this intervention. Staff had the information they needed to respond to patient questions and concerns readily available. Clinic was very engaged in the project and two to three staff members consistently attended meetings. **Barriers:** • Despite an improved reach rate, ongoing challenges with contacting patients, continued to be a barrier, due to voicemails full or not setup, not returning messages, and disconnected or invalid phone number. • COVID-19 issues impacted not only patients from attending appointments but impacted the clinic staff with frequent staff shortages due to illness, exposure or caring for family with COVID-19. • Members do not know the importance of the CCS screening or what it was for. CalViva Health will continue to provide health educational materials to the clinic in English, Spanish, and Hmong. **Lessons Learned**:

	• A clinic champion and the support of the clinic's Quality Improvement leadership are critical to the success of planning and implementation. • Obtaining staff feedback is crucial to successful intervention implementation. CalViva Health Medical Management staff scheduled and held 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**

Section A: Description of Intervention (due Q1)				
2-2: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC) PDSA				
☒ **New Initiative** ☐ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**		☒ **Safety Clinical Care**
Reporting Leader(s)	**Primary:**	A. Schneider, Director, CalViva Health Medical Management	**Secondary:**	A. Banaji, QI Specialist, Health Net QI Department; R. Calva-Songco, Manager, Health Net Health Education Department

Rationale and Aim(s) of Initiative

Overall Aim: The overall aim is to assist CalViva Health diabetic members to control and maintain their blood glucose levels within a healthy range, thereby minimizing the long-term risks and complications associated with this highly prevalent chronic disease. This can be accomplished through basic diabetes education, routine testing, lifestyle changes, healthy behaviors and optimal medication management.

Rationale: Our review of literature, internal and external data, and discussions (brainstorming sessions) with our new CalViva Health Diabetes- H9 Improvement Team indicates that many of the same issues remain, they have just been escalated by the Public Health Emergency. A high volume of CalViva Health members in Fresno County are noted to have blood glucose levels out of range (greater than 9%) or have not had any testing administered for HbA1c levels, with the COVID-19 pandemic likely to be a major contributing factor.

CalViva Health is committed to improving the quality of care for our diabetic population in Fresno County by increasing the frequency of HbA1c testing and screening for members who have difficulty with maintaining their glycated hemoglobin levels below 9%. For this PDSA cycle, we are targeting Fresno County because it was the poorest performer in MY 2020 with the highest rate increase (CDC-H9 is an inverse measure, so a rate increase indicates poorer performance) of 7.43% from the previous year (MY 2019), as seen in Table 1.

Table 1: CalViva Health CDC-H9 County Rates for MY 2019 and MY 2020

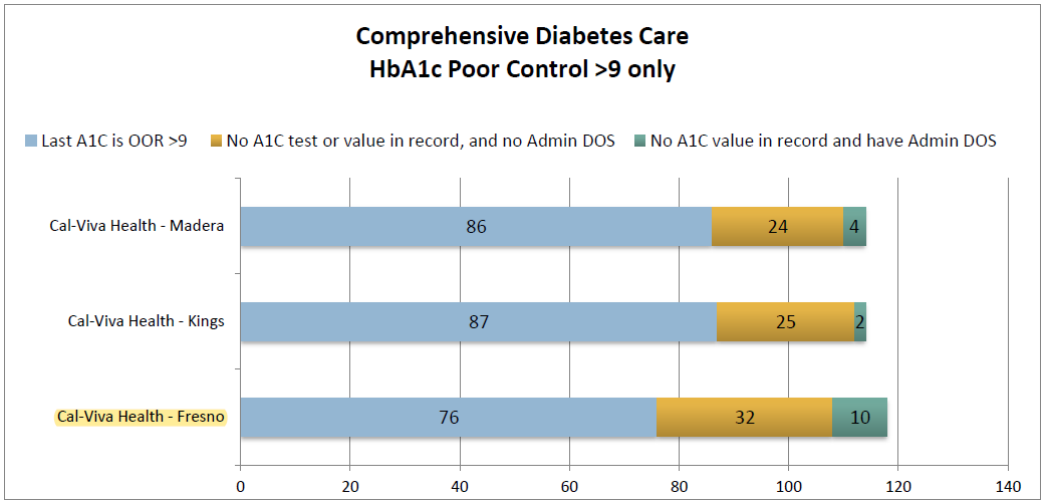
Comprehensive Diabetes Care (CDC) HbA1C Poor Control >9

Population	MY 2019 Rate	MY 2020 Rate	Rate Change From Prior Year	Goal 50th Percentile	Records to Hit Goal
Cal-Viva - Fresno	34.06 %	41.49 %	7.43	37.47 %	16
Cal-Viva - Kings	35.77 %	35.00 %	- 0.77	37.47 %	9
Cal-Viva - Madera	36.25 %	40.63 %	4.38	37.47 %	13

** Per NCQA: A lower rate indicates better performance (i.e. low rates...indicate better care).*

Fresno County also had the highest proportion of noncompliant members who were not screened or tested for HbA1c in MY 2021 as seen in Table 2 below. Twenty-seven percent of non-compliant members in Fresno County did not have a HbA1c test in MY 2020, compared to 22% of members in Kings County and 21% in Madera County. These issues were likely a result of the various COVID-19 challenges affecting provider offices (decreased staff capacity, office closures, etc.) and hesitancy from members who feared they would contract the virus despite all preventative measures in place at provider offices.

Table 2: CalViva Health Non-Compliant Analysis of CDC-H9 Medical Records for MY 2020



CalViva Health's primary reasons for CDC-H9 noncompliance in MY 2020:

- The most common reason was the member's last A1c for the measure year was out of range (> 9.0%)
- Secondly, members did not have an A1c test performed during the measurement year

CalViva Health targeted one of the largest providers in Fresno County for the Planned Care Visit intervention. The provider demonstrated the lowest compliance rate among FQHCs for this measure. Within the FQHC, CalViva Health selected a sub-site location (E) because they had the second lowest compliance rate of 61.5% in MY 2020, which subsequently continued to decrease going into MY 2021.

Table 3: Provider Partner CDC-H9 Compliance Rates for MY 2020 - MY 2021

	MY 2020 MPL = 37.47%*	MY 2021 YTD (9/2021) MPL = 37.47%*		
Partner Provider Locations – Fresno County	**Final Rate**	**YTD Rate**	**Denominator**	**Gaps to 50th**
Site Location A	**55.9%**	**63.3%**	**708**	**183**
Site Location B	**59.2%**	**64.6%**	**362**	**99**
Site Location C	**54.7%**	**56.7%**	**156**	**53**
Site Location D	**65.9%**	**72.2%**	**91**	**44**
Site Location E	**61.5%**	**72.6%**	**82**	**40**

Note: Table 3 does not reconcile exactly due to different report run dates. However, the table indicates a need for HbA1c testing and improved results.

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

Utilize the Planned Care Visit Workflow intervention to reduce the number of diabetic members with Poor control (HbA1c >9%) assigned to provider partner clinic, in Fresno County by first obtaining current HbA1c testing for at least 60% of this target population from a baseline testing rate of 34%.

Reduce the number of members with HbA1c Poor Control (>9.0%) in the targeted population.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Collaborate with a high volume, low compliance clinic in Fresno County to improve HbA1c testing rates among noncompliant diabetic members (HbA1c > 9%)	P/M	Q1-Q2	CVH/HN
Conduct regular meetings with the Fresno County provider and staff, to discuss improvement plans for increasing the frequency of HbA1c testing for members	P	Q1-Q2	CVH/HN
Using a call script for member outreach and education, and to facilitate completion of member HbA1c testing, via 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 HbA1c testing. The Profile will facilitate documentation of each member outreach attempt and test completion.	P/M	Q1-Q2	CVH/HN
Shifting our PDSA focus in Cycle 2 from obtaining HbA1c tests, to changing lifestyle behaviors and drawing meaningful insight from our target population. New intervention will prioritize more emphasis on lowering A1c levels for members with values greater than 9%. CalViva Health will be collaborating with a clinic provider who has a panel of diabetic members eligible to receive case management and registered dietician support.	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 2022, CalViva Health collaborated with a high volume, low compliance provider partner in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) testing. • CalViva Health Medical Management conducted regular bi-weekly interdisciplinary meetings with the Fresno County provider partner and clinic staff, to implement a rapid cycle Plan-Do-Study-Act (PDSA) quality improvement regulatory project focused on noncompliant diabetic members with HbA1c values greater than 9%. • Medical Management completed its first PDSA cycle in Q1, which was focused on conducting outreach calls to the noncompliant members identified in the Provider Profile and obtaining their current HbA1c values. Fresno County clinic staff utilized the Diabetes Call Script and an engagement incentive to encourage member participation for HbA1c testing. Members who were successfully reached either completed or were scheduled for an appointment to complete testing. • During the first PDSA cycle, 100% of members (28/28) who were contacted successfully heard the Diabetes Call Script in its entirety and 64.3% of members (18/28) completed an HbA1c test. When compared to the SMART objective, the first PDSA intervention successfully increased testing rates and exceeded the 60% testing rate goal. • In Q2, CalViva Health Medical Management and the Fresno County provider partner collaborated again to schedule in-person nutrition classes led by a registered dietician and disseminate health education materials for the noncompliant members identified in the Provider Profile. • During the second PDSA cycle, a total of 68% of members (15/22) who were successfully outreached to by the Fresno County provider partner heard the Diabetes Call Script in its entirety to learn about the three in-person nutrition classes and three individual sessions with a registered dietician.	• In Q2 2022, CalViva Health Medical Management staff continued its collaboration with the high volume, low compliance provider partner in Fresno County. The multidisciplinary PDSA team continued the established bi-weekly meetings (every two weeks) with the provider partner to oversee, guide and monitor the project. • For the Cycle 2 intervention (held March 2022 to July 2022), the multidisciplinary PDSA team continued to meet bi-weekly (every two weeks) to oversee, guide and monitor the project. The new target population was identified as 22 members who were eligible to attend three in-person nutrition classes and three individual follow-up sessions, both led by a registered dietician. Class content followed the CalViva Health “Your Guide to Diabetes” Handbook (20-page guide) and the “MyPlate” methodology. All participating members were requested to complete a brief evaluation provided by the registered dietician, to assess the overall effectiveness of this intervention. Classes were offered in both English and Spanish. • Edits were made in the Diabetes Call Script, which was utilized by the registered dietician (with support from QI) to conduct outreach calls to patients and explain the new program. The existing Provider Profile was modified in collaboration with the clinic staff, to include appropriate data fields for tracking Cycle 2 intervention outcomes. The registered dietician utilized the modified Provider Profile to document class attendance, feedback obtained and member incentive distribution on a weekly basis. • Members who declined to schedule their in-person classes and reported that a virtual or hybrid model would work better for them, were able to participate in a small test of Virtual Diabetes Classes. The multidisciplinary PDSA team, registered dietician and provider partner clinic staff quickly converted the contents of each nutrition class into three (3) separate videos, by using the already prepared slides with a voice-over. All materials were developed in both English and Spanish. • CalViva Health completed the CDC-H9 PDSA project with DHCS and our Fresno County provider partner in Q3 2022.

• A summary of the initial call outcomes resulted in 10/22 members who refused to schedule, 3/22 members who agreed to schedule in-person classes and 7/22 members who could not be reached (due to disconnected phone numbers, voicemail only, no answer). • In an effort to understand why the 10/22 members declined, CalViva Health Medical Management utilized a QI Health Educator was able to speak to 5/10 members to obtain anecdotal feedback. The QI Health Educator implemented a series of discussion questions, informal conversations and applied Motivational Interviewing techniques. • CalViva Health Medical Management and the Fresno County provider partner learned that many of these members do have an interest in improving their health and wellness, but a standard classroom setting during regular business hours may not work for them. • Most of these members reported that a virtual or hybrid model would work better for them. Therefore, the team decided to do a small test of Virtual Diabetes Classes. The three classes could be quickly converted to video by using the already prepared slides with a voice-over and the Clinic QI staff turned those around within a week. Each video was created in English and Spanish. The team decided to follow a similar format to the in-person process with three (3) videos followed by three (3) One-on-One calls with the dietitian. • Final outcomes from the small test of the Virtual Diabetes Classes resulted in a total of 27% of members (6/22) viewing all three (3) videos and completing three (3) One-on-One calls with the dietician. When compared to the SMART objective, the second PDSA intervention successfully helped educate at least 20% of this target population on lifestyle changes and a healthy diet.	

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 2020**	**Rate MY 2021**	**Baseline Source**	**Baseline Value**
HEDIS Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC H9) – County Goal	Meet or Exceed DHCS 50th Percentile 37.47%	Fresno: 43.88%	42.64%	MY 2021 HEDIS Data	43.19%
HEDIS Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) – Provider Goal	Obtain current HbA1c testing for at least 60% of this target population.	Fresno: N/A	37.00%	MY 2021 Provider Results	32.83%
HEDIS Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) – Provider Goal	Reduce the number of members with Poor control (HbA1c >9%) by educating at least 20% of this target population on lifestyle changes and a healthy diet from a baseline rate of 0%.	Fresno: N/A	27.50%	MY 2022 Provider Results	34.00%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness with Barrier Analysis	**Successes:** • Offering of information and education in a variety of formats was successful. • Despite the short implementation timeline for this regulatory project, CalViva Health Medical Management in partnership with the provider partner staff and the interdisciplinary CDC-H9 PDSA team quickly adapted and utilized existing class content to develop education videos for members to view at their convenience.

	Barriers: • Initial outreach calls to members conducted by the dietitian to schedule in-person classes resulted in a low reach rate, but further investigation revealed important results. • Members who refused the classes initially were interested in learning more about diabetes to improve their health and wellness, but an in-person face-to face class didn't work for their lifestyle. CalViva Health needed to bring this type of training to the members in a variety of formats that will work for different lifestyles. **Lessons Learned**: • Members are more likely to engage and receive ancillary support if they have flexible options to choose from, such as virtual and/or hybrid classes. • Not all members will be interested in accepting resources for managing their diabetes and will continue to remain noncompliant, leading to poorer health as well as higher risks. • Although there was a smaller target population for Cycle 2 of this PDSA intervention, CalViva Health was able to focus more on engaged members to provide resources as needed and gather anecdotal feedback about how their lifestyles affect management of their chronic illness. This allowed CalViva Health to identify areas of opportunity moving forward to engage more of our diabetic members with poor control and offer support as needed to address SDoH barriers they may face in daily life.
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**	A. Schneider, Director, CalViva Health Medical Management	**Secondary**	R. Dick, Sr. QI Specialist, Health Net QI Department

Rationale and Aim(s) of Initiative

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

Rationale: Finding breast cancer early and getting state-of-the-art cancer treatment are the most important strategies to prevent deaths from breast cancer. Breast cancer that is found early, when it is small and has not spread, is easier to treat successfully. Getting regular screening test is the most reliable way to find breast cancer early. Breast cancers found during screening exams are more likely to be smaller and still confined to the breast. The size of a breast cancer and how far it has spread are some of the most important factors in predicting the prognosis of a woman with this disease (American Cancer Society, 2021). The COVID-19 pandemic has resulted in many elective procedures being put on hold, and this has led to a substantial decline in cancer screening. Health care facilities are providing cancer screening during the pandemic with many safety precautions in place (American Cancer Society, 2021).[1]

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 reported barriers were perceived pain from the screening and embarrassment. Lack of physician recommendation was the most identified social barrier (Miller et al., 2019).[2]

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 (Kue et al., 2014).[3]

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[1]American Cancer Society (2021). American Cancer Society Recommendations for the Early Detection of Breast Cancer. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations

[2] 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
[3] 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 2021 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 28.46% to a goal rate of 47.8%.

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 Southeast Asian BCS non-compliant CalViva Health members. The educational event will be held at the cultural center, which will include a video in the Hmong language to address health literacy barriers among the Hmong population, testimonials of breast cancer survivors, transportation presentation, and raffle items. CalViva Health will continue to implement a Member Friendly Approach by providing a warm welcoming atmosphere at the event that addresses cultural and language issues, and other potential barriers. The educational event was discontinued to pursue other BCS activities.	M	Q1-Q4	CVH/HN
Update Key Driver Diagram with potential interventions (Module 4).	P/M	Q1-Q4	CVH/HN

Implement and test interventions with the clinic which includes PDSA cycles (Complete 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 support gap closure and improve HEDIS rates for BCS.	P	Q1-Q4	CVH/HN
Implement member incentive for breast cancer screening to support mammogram completion.	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: mobile mammography with on-site interpreters, and transportation services (Member Friendly Approach) at clinic sites.	M	Q1-Q4	CVH/HN
Members will receive a $25 VISA Gift Card Incentive upon completion of the BCS Screening.	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 2022, CalViva Health led a Breast Cancer Screening (BCS) Performance Improvement Team in collaboration with one clinic with 3 sites at Greater Fresno Health Organization (GFHO), which is a high volume, low compliance clinic; 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 determine the current process, identify potential barriers, and establish a plan for improvement to address potential barriers with the project. • In Q2 2022, the Southeast Asian educational event intervention was abandoned due to low BCS completion rates and replaced with Mobile Mammography Events.	• In Q3 and Q4, CalViva Health Medical Management team continued to collaborate with the Greater Fresno Health Organization (GFHO), which is comprised of a high volume/low compliance clinic, and a Hmong cultural center in Fresno County. • In Q3 and Q4, CalViva Health Medical Management staff continued the multidisciplinary meetings and identified any potential barriers and established a plan for improvement to address any potential barriers with the project. • In Q2, Q3, and Q4 2022, mobile mammography events were implemented. • Key Driver diagram was updated to include Mobile Mammography.

• In Q1 2022, the Key Driver diagram was updated to include Mobile Mammography (Module 4). • In Q2 2022, video testimonials were developed to address health literacy barriers among the Southeast Asian population from three breast cancer survivors in Hmong, Laotian, and English languages. CalViva Health Medical Management is currently discussing where to show the videos: potentially in medical office waiting rooms, YouTube sites, Hmong TV, The Fresno Center, and community events to raise awareness of breast cancer. • In Q1 and Q2 2022, Health Education distributed educational materials on the importance of breast cancer screening to members at the mobile mammography events, cultural center, and women's imaging center. • In Q1 and Q2 2022, Provider incentives were given to support gap closures and improve HEDIS rates for BCS. Provider Tip Sheets were developed and made available through the Provider Portal. The tip sheet outlines HEDIS® Specifications, best practices, and recommended screening guidelines. • In Q1 and Q2 2022, members were given a VISA gift card upon completion of the BCS exam. • In Q1 2022, a mobile mammography event was implemented: 54 members completed the BCS exam, and 74 members were scheduled (73.0%) compliance rate. • In Q2 2022, another mobile mammography event was held, 18 members completed the BCS exam out of 24 scheduled (75.0%) compliance rate. CalViva Health will continue to implement a Member Friendly Approach by having provided a warm welcoming atmosphere at the event that addresses cultural and language issues, and other potential barriers.	• In Q2 2022, video testimonials were developed to address health literacy barriers among the Southeast Asian Population from three breast cancer survivors in Hmong, Laotian, and English languages. The videos were shown on prime time on Hmong TV, The Fresno Center, and provider offices to raise awareness of breast cancer. • In Q3 and Q4, 2022, Health Education distributed educational materials on the importance of breast cancer screening to members at the mobile mammography events, and cultural center. • In Q3 and Q4, 2022, members were given a VISA/Wal-Mart gift card and a 25 lb. bag of rice upon completion of the BCS exam. • In Q3 and Q4, 2022, provider incentives were given to support gap closures and improve HEDIS rates for BCS. Provider tip sheets were developed and made available through the provider portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended screening guidelines. • In Q3 and Q4, two additional mobile mammography events were held, and 40 members completed the BCS exam, and 72 members were scheduled (54.79%) compliance rate. A total of 112 breast cancer screenings exams were completed with the mobile mammography events; CalViva Health met and exceeded the goal**.** CalViva Health will continue to implement a member friendly approach by having provided a warm welcoming atmosphere at the event that addresses cultural and language issues, and other potential barriers. Additional BCS events are being planned outside of this project for 2023. • The Performance Improvement Project BCS ended December 31, 2022. The PIP Conclusion-Module 4 and the PIP/PDSA worksheet are due to DHCS in April 2023.

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 2022)					
Measure(s)	**Specific Goal**	**Rate MY 2020**	**Rate MY 2021**	**Baseline Source**	**Baseline Value**
HEDIS Breast Cancer Screening – County Goal	Meet or Exceed the MPL (50th Percentile) 58.82%	Fresno: 55.26%	52.64%	MY 2021 HEDIS Data	58.82%
HEDIS Breast Cancer Screening – Provider Goal	Meet or Exceed SMART Aim Goal of 47.8%	Fresno: 46.0%	40.00%	MY 2021 Provider Results	38.4%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness with Barrier Analysis	**Successes:** • Mobile Mammography events were successful; CalViva Health exceed the goal for the project with 112 mammograms completed in 2022. • Videos testimonials in Hmong, Laotian and Cambodian were well received and aired in prime time on Hmong TV. The videos were also shown in various provider offices. **Barriers:** • It was critical to include Health Equity, Health Education, and Provider Relations on the team to address potential barriers in advance of the event. • Language barriers existed regarding some medical procedures; it may require several attempts for a member to understand what a mammogram is and why it is important. • Members that cannot be reached; phone disconnected; no voicemail and wrong number. • Fears of COVID and being exposed to the virus.

	Lessons Learned: • Culture and language are important factors to consider when planning a health screening event such as BCS. Preparation to support these factors is critical to appointment completion. • Flexibility is important. Often members do not arrive at their scheduled time and adjustments may be required to fit them in the schedule.
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:**	A. Schneider, Director, CalViva Health Medical Management	**Secondary:**	R. Dick, Sr. QI Specialist, 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: Childhood vaccines or immunizations can seem overwhelming when you are a new parent. Vaccine schedules recommended by agencies and organizations, such as the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians cover about 14 different diseases. Vaccinations not only protect your child from deadly diseases, such as polio, tetanus, and diphtheria, but they also keep other children safe by eliminating or greatly decreasing dangerous diseases that used to spread from child to child (Stanford Children's Hospital, 2021).

According to the U.S. Health and Human Services, there are 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, 2021).[2]

Centers for Disease Control and Prevention, (CDC), report released in May 2020 found a troubling drop in routine childhood vaccination because of families staying at home. CDC and the American Academy of Pediatrics (AAP) recommend that children stay on track with their well-child appointments and routine vaccinations even during the pandemic. As in-person learning, and play become more common, on-time vaccinations is even more urgent to help provide immunity against 14 serious diseases (CDC, 2021).[3]

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

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

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[1] Standford Children's Hospital. (2021). Why Childhood Immunizations Are Important
https://www.stanfordchildrens.org/en/topic/default?id=why-childhood-immunizations-are-important-1-4510

[2] United States Department of Health and Human Services. (2021). Five Important Reasons to Vaccinate Your Child.
https://www.hhs.gov/immunization/get-vaccinated/for-parents/five-reasons/index.html

[3] Centers for Disease Control and Prevention. (2021). NIIW (National Infant Immunization Week)
https://www.cdc.gov/vaccines/events/niiw/index.html

[4] 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.

This outcome measure will be monitored and reported for the targeted provider site and Fresno County using hybrid data.

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 CIS -10 interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Update Key Driver Diagram with potential interventions (Module 4).	P	Q1-Q4	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 to support completion of childhood immunization 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

Work with targeted provider to develop a second intervention: a Special Immunization Recurring Event. It will be convenient and culturally competent to support members in accessing childhood immunizations for children 0-2 years in Fresno County.	P/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 2022, CalViva Health led a Childhood Immunizations (CIS-10) Performance Improvement Team in collaboration with one high volume, low compliance clinic in Fresno County. • In Q2, 2022, the Key Driver Diagram was updated to include "Special IZ Re-occurring Event." • The Team determined that an intervention focused on education was needed to improve immunization completion rates. A significant number of parents admitted to having concerns and questions about childhood vaccinations. A provider based educational texting campaign with the clinic was implemented in Q1, 2022. • The clinic is working in collaboration with CalViva Health Education Department to develop content for the text messaging campaign. • In Q2, 2022, Health Education provided educational materials at the "Heroes for Health IZ Re-occurring events." • A member newsletter will be distributed to members in Q3 2022 to educate on the importance of childhood immunizations. • Members were given a $25 VISA gift card/diaper bags upon completion of their immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations. • Provider Tip Sheets were developed in Q3 2021 and made available through the Provider Portal. The tip sheet outlines HEDIS®	• In Q3 and Q4, CalViva Health Medical Management continued to collaborate with a high volume, low compliance clinic and conducted regular bi-weekly meetings. • Key Driver Diagram was updated to include the "Special IZ Re-occurring Events." • The clinic collaborated with CalViva Health Education Department and developed content for the text messaging campaign. • In Q3 and Q4, 2022, Health Education provided educational materials at the "Heroes for Health IZ Re-occurring events" The name was updated to "Journey to Health Immunization Event." • A member newsletter was distributed to members in Q3 2022 to educate parents on the importance of childhood immunizations. • Members were given a $25 VISA gift card/diaper bags filled with incentive items upon completion of their immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations. • Provider tip sheets were developed in Q3 2022 and made available through the Provider Portal. The tip sheet outlines HEDIS specifications, best practices, and recommended immunization guidelines.

Specifications, best practices, and recommended immunization guidelines. • Revised data capture issue with the clinic included HepB data causing the compliance rates to shift upwards based on the new data. The baseline rate increased from 26.00% to 28.00%; this update in the SMART Aim will be reported to HSAG. The SMART Aim based on this new baseline is 34.53%. • In Q2,2022 a second intervention is the "Heroes for Health IZ Re-occurring Events" was held at the pediatric clinic on Saturday which included interpreters, refreshments, and snacks. Two more events are being plan with the clinic in the fall.	• CIS-10 compliance rate was 34.3% with a goal rate of 34.53% and a baseline rate of 28.03%. Data on the two flu shots is pending but the compliance rate will be 44%. • The Performance Improvement Project CIS-10 ended December 31, 2022. The PIP Conclusion-Module 4 and the PIP/PDSA worksheet are due to DHCS in April 2023.

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 2022)

Measure(s)	Specific Goal	Rate MY 2020	Rate MY 2021	Baseline Source	Baseline Value
Childhood Immunization Combo 10 – County Goal	Meet or Exceed the MPL (50th Percentile) 38.20%	Fresno: 32.12%	35.04%	MY 2021 HEDIS Results	38.20%
Childhood Immunization Combo 10 – Provider Goal	Meet or Exceed SMART Aim Goal of 34.53%	Fresno: 33.82%	34.3%	MY 2021 Provider Results	28.03%

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

Analysis: Intervention Effectiveness with Barrier Analysis	**Successes:** • The clinic is affiliated with a Pediatric Residency Program, which provided the opportunity to influence and collaborate with new physicians in order to engage parents to promote timely and complete immunizations for the youngest members.

	• The clinic is well-established with sufficient staff to engage and participate on the project. • Effective collaboration and clinic engagement contributed to the success of the project. **Barriers:** • Members did not always understand the significance of receiving their immunizations. • Children missing one or more vaccines due to incomplete records or completed out of the required time frame. • No immunizations records received. • No immunizations were given. • Flu was the most consistent missing vaccine, and HepB. **Lessons Learned:** • Further explore ways to engage members who refuse exams in dialogue to help them understand the importance of childhood immunizations. • It is important to continue to provide health education materials to the members. • It is vital to capture HepB data information from the hospital.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members.	R. CalVa-Songco, Manager, Health Education	The PSG is being sent to members monthly via the new members' welcome packets.	☒	12/31/2022	Completed.
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	CalViva Health/HN J. Serratore Director, Clinical Programs	Annual review of CPG grid performed by corporate, a pproved at the June MAC meeting. Posted on healthnet.com website in June.	☒	July 2022	Completed.
3. Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	C. Patnuade, Director, Care Management	The CalViva Health Pregnancy Program remains in place. 2022 YTD through April, 493 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.	☒	12/31/22	The CalViva Health Pregnancy Program remained in place. For 2022 YTD, 803 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.
4. Promote Kick It California (formerly known as CA Smokers' Helpline) to smokers.	R. CalVa-Songco, Manager, Health Education	The tobacco cessation proposal was approved by DHCS on 7/1/2022. HED continues exploring new data sources to identify members who smoke or have nicotine dependence.	☐		Program proposal is being reviewed internally. However, promotion also continues through the annual Member Newsletter.
5. Promote Diabetes Prevention Program to members at risk of developing type 2 diabetes.	R. Calva-Songco, Manager,	Conducted member outreach mailing in Q2 to 11,638 at risk members.	☒	11/11/22 & 11/23/22	Promotion of the DPP program continued in Q4 through the all member

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
	Health Education				annual newsletter and a targeted member mailing reaching 1,298 at risk members.
6. Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016.	T. Demirjian, Manager, Quality Improvement	Introduce MedTox, point of care capillary lead screening kits, to pediatric providers already contracted with LabCorp. Connect with County Lead Poison Prevention Program to train providers and staff on lead poisoning and capillary point of care lead testing.	☐		On track.
DISEASE/CHRONIC CONDITIONS MANAGEMENT					
1. Monitor Chronic Conditions Management Program for appropriate member outreach.	M. Nuno, Clinical Accounts Manager; C. Jornado, Manager; Chronic Conditions Management	Assess opportunities for program redesign.	☐		Redesign proposal received in Q4 2022. Clarification and review of redesign changes is being conducted and is expected to be submitted for approval in Q1 2023.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report on Cultural and Linguistics.	D. Fang, Manager, Health Equity	On track, LAP report and Mid-Year Work Plan Evaluation will be completed on 9/9/2022 for Committee review.	☒	9/16/2022	LAP Mid-Year Report submitted on 9/16/2022. Mid-Year Work Plan Evaluation submitted on 9/9/2022.
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	P. Fuentes, PR Specialist, Access & Availability	Scheduled to begin in August through December and will be conducted by Sutherland Global.	☒	8/29/2022	MY 2022 survey were scheduled to go live 8/29-8/31/2022.

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date.	P. Fuentes, PR Specialist, Access & Availability	MY 2021 TAR Submitted timely.	☒	3/31/22	Completed. DMHC has moved filing date for MY 2022 TAR to May 1, 2023.
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	P. Fuentes, PR Specialist, Access & Availability	MY 2021 survey results were shared with CalViva Health at June Access Workgroup Ad-hoc meeting. MY 2021 CAPs is on track with revamping the process to create criteria to identify noncompliant PPGs and providers. Align PPG-level CAPs with DMHC proposed 70% compliance rate. Focus CAPs on urgent and non-urgent access metrics and after-hours.	☒	10/05/22	MY 2021 PAAS and After-Hours survey outcomes and Corrective Action Plan (CAP) results were presented during the October 5th Access Workgroup meeting. A total of 17 Tier 1 CAP packets were sent. CAP packet included PPG Report Card and Improvement Plan to be completed and returned. A total of 42 Tier 2 Ed packets were sent. Both Tier 1 & Tier 2 PPGs were required to complete an attestation form to be returned within 30 days of receipt.
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	P. Fuentes, PR Specialist, Access & Availability	Two sessions held in Q2 (June). There will be one session in Q3 (July) and three sessions in Q4 (December).	☒	12/28/22	Access and Availability team have conducted a total of ten provider webinars with 570 total participants including attendees from the CalViva Health service area. Webinar certifications are tracked. Self-study packet option was available to those unable to attend.
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	P. Fuentes, PR Specialist,	Due to the pandemic the survey was not conducted quarterly in 2021, but rather	☒	8/29/2022	MY 2022 survey was scheduled to go live 8/29-8/31/2022. This survey was

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
	Access & Availability	as an annual survey in December of 2021 by Sutherland Global. This will continue as an annual survey going forward.			incorporated with the non-DMHC PAAS.
7. DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey.	P. Fuentes, PR Specialist, Access & Availability	DHCS resumed the Timely Access QMRT survey in Q1 2022.	☒	12/31/22	The Department of Health Care Services (DHCS) has resumed conducting an annual Timely Access Survey Study to monitor member timely access to care. DHCS began their survey calls on January 1, 2022.
8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	D. Saldarriaga; Manager, A&G	A&G has worked with providers and internal departments, including tracking any potential trends through various committees and workgroups, as needed to help resolve member appeals and grievances.	☒	12/30/22	A&G task was completed in 2022 and CalViva Health will continue with the process in 2023.
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.	R. Calva-Songco, Manager, Health Education	Submitted to Plan's Compliance on 6/28/2022.	☒	6/30/22	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.	D. Fang, Manager, Health Equity	Geo Access report is conducted bi-yearly, the next report will be completed in Q3 of 2023.	☒	N/A	On track for 2023.

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
11. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	T. Demirjian, Manager, Quality Improvement	CalViva Health still under DHCS CAP for IHA. QI Project underway for high volume low performing providers. PE assessing IHA education calendar and potential barriers for these providers to determine next steps for project. Postcard outreach discontinued due to tagline requirement change. 2nd outreach call will be implemented to have 3 outreach attempts. Script for 2nd call is currently with DHCS for approval. Tentative implementation date of Q3 2022.	☒	10/25/2022	Scripts for 2nd call as the third outreach attempt were implemented in Q4 2022.
12. Engage with CalViva Health provider offices to complete MY 2022 MCAS training focused on best practices for closing care gaps.	A. Wittig, Director, Quality Improvement	Ongoing in collaboration with the Provider Engagement Team	☒	12/31/2022	Completed.
13. In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to complete interventions addressing systemic barriers to HEDIS performance.	A. Wittig, Director, Quality Improvement / Provider Engagement	Ongoing in collaboration with the Provider Engagement team.	☐		On track and ongoing.
QUALITY AND SAFETY OF CARE					
1. Integrated Care 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: ○ Readmission rates	C. Patnaude, Director, Care Management	The ImpactPro data remains incorporated into the Population Health Management Report used to identify high risk members. Outcomes demonstrate lower readmission rates, ED	☒	12/30/22	The ImpactPro data continues to be incorporated into the Population Health Management Report used to identify high risk members. Outcomes demonstrated lower readmission rates, ED utilization, and health care

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
○ ED utilization ○ Overall health care costs ○ Member Satisfaction		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.			costs post CM vs pre CM for members managed through Q3. 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.	Michael Catello, Manager, Credentialing	On track to meet year end metrics.	☒	12/15/2022	100% timely credentialing completed for the CalViva Health market. 100% timely recredentialing completed for the CalViva Health market. 100% of the assigned annual Delegation Oversight audits were completed on time for 2022.
2. PPG Delegates Credentialing/Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	Michael Catello, Manager Credentialing; Karen Bowling, Sr. Manager Delegation Oversight	On track to meet year end metrics.	☒	12/15/2022	100% of the assigned annual Delegation Oversight audits were completed on time and within metric scores for 2022.
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	M.Cashman, Sr. Director, QI MHN	MHN continues to attend/participate in QI/UM and Access Workgroup Meetings and submits BH Performance Indicator Reports timely. So far this	☐	12/19/22	MHN has presented Behavioral Health Performance Indicator Reports for the year through Q3 2022 as scheduled and

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
		year, no corrective action as a result of a Performance Indicator Report target being missed. Member and Provider satisfaction surveys are in flight and results/reports will be available after December 2022.			with no corrective actions required. The 2022 member and provider satisfaction surveys were completed and analyzed and will be presented to CalViva Health in 2023
2. MHN live calls to adult members (in Kings and Madera counties) that were newly prescribed an antidepressant medication, diagnosed with major depression, and demonstrating refill gaps between 15-50 days (supports COVID-19 QIP for BH)	A. Eng; Manager, Quality Improvement/ MHN	Ongoing as planned. For outreach from Jan-April 2022, the engaged (reach) rate, was 40% (4/10) for Kings County, and 18% (2/11) for Madera County. The top three reasons for not reaching members includes "leaving a voicemail," "unable to leave a voicemail," and "disconnected phone." The Antidepressant Medication Management (AMM) eligible population is not large, so the number of members identified for outreach, on a monthly basis, is not large. Due to technical difficulties with Pharmacy data, May and June outreach lists were not distributed and captured in the July outreach list.	☒	12/31/22	Completed. Technical difficulties with Pharmacy data persisted in Q3 and Q4 2022. One more list was distributed in July 2022. After July 2022, subsequent lists were postponed to resolve the technical difficulties. For calendar year 2022, the engaged (reached) rate was 36.36% (4/11) for Kings County, and 23% (3/13) for Madera County. The top three reasons for not reaching members remained "leaving a voicemail," "unable to leave a voicemail," and "disconnected phone." While the Antidepressant Medication Management (AMM) eligible population is not large, yielding a few members monthly basis, our analytics team will continue to resolve the technical

Activity	Activity Leader	Mid-Year Update	Year End (YE)		
			Complete?	Date	YE Update or Explanation *(if not complete)*
					issues. Once resolved, outreach will resume.
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.	P. Carpenter; Director, Quality Improvement	On track.	☒	12/31/22	Completed.
2. Complete all potential quality issues (PQIs) received within 90 day TAT to maintain compliance with regulatory requirements.	P. Carpenter; Director, Quality Improvement	On track.	☒	12/31/22	Completed.
3. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	A. Wittig, Director; T. Demirjian, Manager; Quality Improvement	In progress.	☐		On track.

Item #9

Attachment 9.A – 9.B

2022 Annual Utilization Management Case Management Workplan Evaluation

9.A Executive Summary
9.B Year End Evaluation

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Jennifer Lloyd, Vice President Medical Management
COMMITTEE DATE:	February 16, 2023
SUBJECT:	2022 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:

- 1.4 Periodic audits for compliance with regulatory standards
- 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 with the exception of workplan element 1.4, Periodic audits for compliance with regulatory standards.

a. **Periodic audits for compliance with regulatory standards** (Work plan element 1.4)

The Plan completed file reviews and audits as planned in 2022. As a result, it was identified that compliance with clear and concise letter requirements were not met in all periods in 2022 due to use of clinical verbiage. Additional training and individual coaching were completed in 2022 regarding use of clear and concise language. The Plan will incorporate a sample case review of denial letter language in 2023 in group meetings with UM Medical Directors to critique denial verbiage used.

II. Monitoring the Utilization Management Process

Monitoring of the utilization management process activities met objectives in 2022 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 2022. TAT was met with 99% or better in all areas and all quarters with the exception of PA Routine Deferrals; there was a dip starting in May 2022. It was identified that the work process did not specifically state to notify the member. The work process was updated, and re-trained and rolled out to staff in July 2022. Deferral Turn Around times were impacted in May and June, then again in October by the following:

1. Documented work process required update to include specific member notification steps
2. Staff not calculating deferral pend timeframe correctly
3. Not selecting all recipients for Deferral Letters
4. Retraining needed for all staff members

Teams addressed process gap and improvement occurred after work process updates and re-education to staff. Staff work was monitored. In addition, a remedy IT ticket was submitted to investigate if system issue is not accepting letter recipients' selection versus user related issue.

III. Monitoring Utilization Metrics

Monitoring of Utilization Metrics activities met objectives in 2022 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 2022 including daily UM huddles and weekly huddles with key hospitals.

Based on data through November 2022, results of our goals to reduce admissions by 5%, were below (met) target for all populations. The average length of stay target to reduce by 5% exceeded goal for the TANF population. Both SPD and MCE did not meet goal, by an insignificant amount of less than 1 day for each population.

The 30 day readmission rate is down in all 3 populations.

IV. Monitoring Coordination with Other Programs and Vendor Oversight

All Coordination with Other Programs and Vendor Oversight activities met objectives in 2022.

V. Monitoring Activities for Special Populations

All Monitoring Activities for Special Populations activities met objectives in 2022.

Next Steps:

We are continuing monitoring of 2022 activities and will be continuing appropriate activities into 2023.

CalViva Health
2022
Utilization Management (UM)/ Case Management (CM)
End Of Year Work Plan Evaluation

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 minimum 6 clinical 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.	Ongoing 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 2022: **Jan:** Management and Outcomes in Diffuse Large B-Cell Lymphoma **February:** Medication Adherence **March:** 1. Improving health outcomes and care coordination by screening for behavioral health conditions commonly seen in primary care settings, 2. What is Palliative Care? **May:** Preventing Preeclampsia **June:** The Importance of Testing and Care in Helping End the HIV Epidemic 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 2023**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in 2022 **Jan:** Management and Outcomes in Diffuse Large B-Cell Lymphoma **February:** Medication Adherence **March:** 1. Improving health outcomes and care coordination by screening for behavioral health conditions commonly seen in primary care settings, 2. What is Palliative Care? **May:** Preventing Preeclampsia **June:** The Importance of Testing and Care in Helping End the HIV Epidemic **August:** Transforming the Diagnosis and Management of Kidney Disease **September:** HEDIS Update for 2023 **October:** Care of the Incarcerated Individual when Released from Prison **December:** COPD 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)	2022 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** ☒ **CONTINUE ACTIVITY IN 2023**	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. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 through the Plan's online learning platform and reminded annually thereafter. 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 Centene University. A gap was identified in the assignment of the attestation for new hires. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	Assignment of the new hire attestation is not automated.	As a result of the attestation assignment gap the Plan will be taking steps in Q3 to ensure all Individuals involved in UM decision making refresh their 'Affirmative Statement about Incentives'.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and are reminded annually thereafter. Annual reminders were distributed to all staff in August 2022. A gap was identified in the assignment of the attestation for new hires. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	Assignment of the new hire attestation is not automated.	As a result of the attestation assignment gap the attestation was incorporated into the standardized new hire learning journey in Q3 to ensure all Individuals involved in UM decision making refreshed their 'Affirmative Statement about Incentives'.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 2022, July 2022, October 2022, 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 2023**	Ongoing monthly regulatory standard auditing continues. 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 to the Program Metrics Reporting (PMR) meeting and with CalViva Health. Compliance with clear and concise letter requirements were not met in all periods in 2022.	Use of clinical verbiage resulted in failure to consistently meet clear and concise letter requirements.	Additional training and individual coaching were completed in 2022 regarding use of clear and concise language. Additionally, the Plan will incorporate a sample case review of denial letter language in 2023 in group meetings with UM Medical Directors to critique denial verbiage used.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 2022. 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 2023**	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 identified	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 2022 UM and CM Program Descriptions. Write and receive CalViva approval of 2021 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2022 UMCM Work Plan. Write and receive CalViva approval of 2022 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 2022 Q 1 2022 Q 1 2022 Q 3 2022 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 2021 Year End UM/CM Work Plan Evaluation, 2022 UM/CM Work Plan, 2022 UM Program Description and the 2022 CM Program Description were submitted and approved in Q1 2022. 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 2023**	The 2021 Year End UM/CM Work Plan Evaluation, 2022 UMCM Work Plan, 2022 UM Program Description and the 2022 CM Program Description were submitted and approved in Q1-2022. The 2022 UMCM Work Plan Mid-Year Evaluation was submitted and approved in Q3-2022. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	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.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES**	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.			

	Authorization Volume		
Months	**Approved**	**Denied**	**Modified**
January	6093	820	56
February	5553	983	63
March	5851	1091	51
April	5629	1035	53
May	5884	1060	61
June	5852	1154	59
Totals	34,862	6143	343

☒ **CONTINUE ACTIVITY IN 2023**	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.			

	Authorization Volume		
Months	**Approved**	**Denied**	**Modified**
January	6093	820	56
February	5553	983	63
March	5851	1091	51
April	5629	1035	53
May	5884	1060	61
June	5852	1154	59
July	5583	989	49
August	5759	1212	65
September	5249	1086	59
October	5497	1076	59
November	6080	999	67
December	4839	938	39
2022 Totals	**67869**	**12443**	**681**

Prior year for comparison:

2021 Totals	**76,001**	**12,236**	**463**
2020 Totals	**71,516**	**12,236**	**369**
2019 Totals	**75,473**	**15,073**	**506**

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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

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

<table>
<tr>
<td>Mid-Year Report

☐ ACTIVITY ON TARGET

☒ TOO SOON TO TELL</td>
<td>The plan met all TAT goals of 95% or better in the first half of the year except for PreService Routine with Extension/Deferral. In Q2, 7 cases failed TAT for this metric.

<table>
<tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th></tr>
<tr><td>Pre-Service Routine</td><td>100%</td><td>100%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>100%</td><td>91.46%</td></tr>
<tr><td>Pre-Service Expedited</td><td>99.09%</td><td>99.09%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service with Extension/Deferral</td><td>NA</td><td>NA</td></tr>
<tr><td>Concurrent</td><td>100%</td><td>99.09%</td></tr>
</table>
</td>
<td>The root cause of the Q2 TAT below target was a process error by staff and a Work Process documentation error.</td>
<td>The Denial Compliance Unit Work Process was updated and staff were trained.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</td>
<td>The Plan monitored TAT as planned throughout 2022.TAT was met with 99% or better in all areas and all quarters with the exception of PA Routine Deferrals; there was a dip starting in May 2022. It was identified that the work process did not specifically state to notify the member. The work process was updated, and re-trained and rolled out to staff in July 2022.

<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>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>100%</td><td>91.46%</td><td>98.8%</td><td>96%</td></tr>
<tr><td>Pre-Service Expedited</td><td>99.09%</td><td>99.09%</td><td>99.1%</td><td>100%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Concurrent</td><td>100%</td><td>99.09%</td><td>100%</td><td>100%</td></tr>
</table>
</td>
<td>Deferral Turn Around times were impacted in May and June, then again in October by the following:

1. Documented work process required update to include specific member notification steps
2. Staff not calculating deferral pend timeframe correctly
3. Not selecting all recipients for Deferral Letters
4. Retraining needed for all staff members</td>
<td>Teams addressed process gap and improvement occurred after work process updates and re-education to staff.

Staff work was monitored.

In addition, a remedy IT ticket was submitted to investigate if system issue is not accepting letter recipients' selection vs. user related issue.</td>
<td>Ongoing</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 2022. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using Change Healthcare InterQual® IRR tool in Q3-4 2022.	Q3-4 2022 Q3-4 2022

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 2022	None identified	None Identified	12/31/2022
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	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. Final Pass Rate for InterQual IRR 2022 was 96.1%	None identified	Training to be provided to leadership Q1-2023 focused on CAP documentation and monitoring.	12/31/2022

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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. On a monthly basis appeal trends are reported via a monthly dashboard. Additionally, appeals will be analyzed for trends. This analysis and recommendations will be reported to CalViva Health QI/UM Committee. Pharmacy benefit appeals will be handled through Magellan and no longer processed by the plan which will decrease the overall Appeal count for dates of service beginning January 1, 2022. Ensure appeals are processed by specialty matched physicians, when appropriate which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21. The data from appeals and grievances is shared with the Provider Network Management, Adverse Action Team, and Utilization Management/ Quality Improvement (UMQI) committees and is aggregated and reviewed for additional actions and recommendations.	Ongoing

<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.

Not medically necessary (198) and Pharmacy (7) denial appeals remain two top trends during the review period. The top two subclassifications were diagnostic – MRI (60) and Diagnostic CCAT Scan with 18.

Turnaround Time Compliance for resolved expedited and standard appeals was 100% for all 210 cases.
<table>
<tr><th colspan="3">2022 Semi-Annual Count of Appeal Type</th></tr>
<tr><th>Appeal Type</th><th>Case Count</th><th>Percentage</th></tr>
<tr><td>Overturn</td><td>102</td><td>49%</td></tr>
<tr><td>Uphold</td><td>101</td><td>48%</td></tr>
<tr><td>Partial Uphold</td><td>4</td><td>2%</td></tr>
<tr><td>Withdrawal</td><td>3</td><td>1%</td></tr>
<tr><td>Case Total</td><td>210</td><td>100%</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</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 2022 Turnaround Time Compliance for Appeals = 99.8% or 1 out of 426 cases.
<table>
<tr><th colspan="3">2022 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>231</td><td>54%</td></tr>
<tr><td>Uphold</td><td>181</td><td>42%</td></tr>
<tr><td>Partial Uphold</td><td>8</td><td>2 %</td></tr>
<tr><td>Withdrawal</td><td>6</td><td>1%</td></tr>
<tr><td>Case Total</td><td colspan="2">426</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 2022 Goals: • 5% reduction in admissions over 2019 • 5% 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.

<table>
<tr><th>Metric</th><th>2019</th><th>2022 Q1-Q2</th><th>% Change</th></tr>
<tr><td>Bed Days PTMPY</td><td>382.15</td><td>348.4</td><td>-8.83%</td></tr>
<tr><td>Admits PTMPY</td><td>74.1</td><td>67.8</td><td>-8.46%</td></tr>
<tr><td>ALOS</td><td>5.16</td><td>5.14</td><td>-0.40%</td></tr>
<tr><td>Readmit 30 Day</td><td>13.32%</td><td>8.72%</td><td>-34.53%</td></tr>
</table>
</td>
<td>None</td>
<td>Monitoring of referral volume from Concurrent Review teams to Care Management will begin in Q3.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</td>
<td>The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout 2022 including daily UM huddles and weekly huddles with key hospitals.

Based on data through November 2022, results of our goals to reduce admissions by 5%, were below (met) target for all populations. The average length of stay target to reduce by 5% exceeded goal for the TANF population. Both SPD and MCE did not meet goal, by an insignificant amount of less than 1 day for each population.

The 30 Day readmission rate is down in all 3 populations.

2022 Admissions PTMPY through November
<table>
<tr><th>Product</th><th>YTD</th><th>Annual Goal</th><th>% Diff</th></tr>
<tr><td>TANF</td><td>48.58</td><td>51.11</td><td>-5.21 %</td></tr>
<tr><td>SPD</td><td>146.48</td><td>175.94</td><td>-20.11%</td></tr>
<tr><td>MCE</td><td>61.38</td><td>88.54</td><td>-44.25%</td></tr>
</table>
2022 Average Length of Stay through November
<table>
<tr><th>Product</th><th>YTD</th><th>Annual Goal</th><th>% Diff</th></tr>
<tr><td>TANF</td><td>2.93</td><td>3.81</td><td>-30.06%_</td></tr>
<tr><td>SPD</td><td>6.83</td><td>6.22</td><td>8.89%</td></tr>
<tr><td>MCE</td><td>5.74</td><td>4.85</td><td>15.47%</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 In addition, PPG metrics will include: 6. Specialty referrals for target specialties 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 2022 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. Reevaluate appropriate metrics to be included in the PPG dashboard. 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 joint operations meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard.	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>Quarterly PPG UM data presented at CalViva Management Oversight Meetings.
Shifts in utilization were reviewed in quarterly JOMs with PPGs.

Q1 2022 Utilization (Q2 not yet available)
<table>
<tr><th>Metric</th><th>Admits/K</th><th>Bed Days/K</th><th>ALOS</th><th>% 30-Day Readmit</th><th>ER/K</th></tr>
<tr><td>AHP</td><td>NA</td><td>NA</td><td>NA</td><td>NA</td><td>NA</td></tr>
<tr><td>CVMP</td><td>105.6</td><td>524.1</td><td>4.96</td><td>17.60%</td><td>463.1</td></tr>
<tr><td>FCMG</td><td>70.7</td><td>371.4</td><td>5.26</td><td>15.80%</td><td>393.4</td></tr>
<tr><td>IMG</td><td>12.8</td><td>28.1</td><td>2.19</td><td>0.00%</td><td>380.7</td></tr>
<tr><td>LSMA</td><td>56.8</td><td>298.8</td><td>5.26</td><td>11.80%</td><td>393.4</td></tr>
<tr><td>SCP</td><td>79.3</td><td>421.8</td><td>5.32</td><td>11.90%</td><td>428.5</td></tr>
</table>
Specialty referral performance with utilization of top specialty by PPG is compared to regional standards in the quarterly delegation oversight dashboard.</td>
<td>Meritage (formerly FCMG) is still new to Medi-Cal, contract negotiation currently underway. CVMP staffing and MSO changes. New RMD covering CalViva region: Dr. Shawn Hamilton.</td>
<td>Continue to share UM data at quarterly JOM’s including strategies to decrease avoidable ER visits. Establish Quarterly JOMs and quality strategy meetings with CVMP. Promoting nurse advice line to patients before ER visits.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</td>
<td>Quarterly PPG UM data presented at CalViva Management Oversight Meetings.
Quarterly JOMs with PPGs review utilization patterns quarterly and compared with region.</td>
<td>FCMG shifted to Meritage mid 2022 and is new to Medi-Cal. CVMP staffing and MSO changes. New RMD covering CalViva region: Dr. Ansul Dixit</td>
<td>Continue to share UM data at quarterly JOM’s including strategies to decrease avoidable ER visits. Establish Quarterly JOMs and quality strategy meetings with CVMP. Promoting nurse advice line to patients before ER visits.</td>
<td>Ongoing</td>
</tr>
</table>

Q1-Q3 2022 Utilization (Q4 not yet available):

Metric	Q	Admits/K	Bed Days/K	ALOS	% 30-Day Readmit	ER/K
CVMP	Q1	105.6	524.1	4.96	17.60%	463.1
	Q2	115.3	755.8	6.56	15.70%	479.5
	Q3	101.2	681.1	6.73	16.80%	539.7
FCMG / MMM	Q1	70.7	371.4	5.26	15.80%	393.4
	Q2	64.2	382.4	5.96	14.00%	393.2
	Q3	68.5	359.9	5.25	12.40%	445.5
IMG	Q1	12.8	28.1	2.19	0.00%	380.7
	Q2	13.5	73.2	5.44	11.10%	410.9
	Q3	15.5	64.8	4.18	0.00%	488.1
LSMA	Q1	56.8	298.8	5.26	11.80%	393.4
	Q2	55.1	281	5.1	11.40%	414.4
	Q3	53.8	269.4	5.01	10.00%	466.9
SCP	Q1	79.3	421.8	5.32	11.90%	428.5
	Q2	83.8	530.6	6.33	13.10%	467.2
	Q3	69.8	395.2	5.66	10.60%	449.4

Due to at risk status, we do not track AHP utilization.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The PPG Profile 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. Referral time to services by specialty are reported to Provider Network Management. 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**	Q1 2022 PPG Profile and Narrative was provided 05/27/22 and reviewed at MOM on 07/12/22 PPG's profile reports are made available quarterly. Q2 - 8/30/22 Q3 - 11/29/22, Q4 - TBD	Some PPGs experienced denial letter issues. PPGs had staffing turnover which required on-boarding training on denial letter review and process enhancements.	To address denial issues, Delegation Oversight provided on-going denial review training with all CalViva PPGs.	Ongoing

<table>
<tr>
<td>☐ TOO SOON TO TELL</td>
<td>Q1 & Q2 Annual Reviews
- La Salle Medical Providers had 1 CAPs for Denial issues.
- Central Valley Medical Providers had 2 CAPs for Denial and Timeliness 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 ensure actions are implemented, documented and followed to completion. Both PPGs have implemented an action plan to ensure compliance with denial letters/template.

Q1 2022 Prior Authorizations
<table>
<tr><th>PPG</th><th>AHP</th><th>CVMP</th><th>FCMG</th><th>IMG</th><th>LSMA</th><th>SCP</th></tr>
<tr><td>Total Auths</td><td>1,109</td><td>1,693</td><td>627</td><td>464</td><td>865</td><td>122</td></tr>
<tr><td>I-Net</td><td>1,041</td><td>1,671</td><td>595</td><td>459</td><td>861</td><td>83</td></tr>
<tr><td>OON</td><td>68</td><td>23</td><td>32</td><td>5</td><td>4</td><td>39</td></tr>
<tr><td colspan="7">TAT % Compliance</td></tr>
<tr><td>Urgent</td><td>99.75%</td><td>99.88%</td><td>99.41%</td><td>98.89%</td><td>99.64%</td><td>94.19%</td></tr>
<tr><td>Routine</td><td>99.98%</td><td>100%</td><td>99.51%</td><td>99.46%</td><td>99.90%</td><td>99.25%</td></tr>
</table>
</td>
<td></td>
<td>Delegation Oversight is also monitoring remediation plans initiated by the PPGs to ensure progression in resolving issues.</td>
<td></td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</td>
<td>Q1, Q2 & Q3 PPG Profile and Narrative were provided on 5/27/22, 8/30/22 & 11/29/2021.

Annual audit reviews
- La Salle Medical Providers had 1 CAPs for using incorrect denial template
- Central Valley Medical Providers had 2 CAPs for Denial and Timeliness issues which have been remediated
- Adventist Health Plan had 1 CAPs for Denials letter content.
- Meritage Medical network had 2 CAPS related to oversight of operations and care coordination and 3 need improvement CAPS for care coordination of public programs and COC
- Independence Medical Group had 2 CAPs for Timeliness, and letter readability for member letters.
- Santé Community Physicians had 2 CAPs for Timeliness and Denials issues.
Prior Authorizations:</td>
<td>Staffing shortage and turnover at the PPGs was a barrier that PPGs were challenged with. There was more stability in Q4 on resources compared to previous quarters.</td>
<td>1- Continue sampling max monthly up to 10 denial letters from each PPG to identify issues and educate the PPGs
2- For all non-compliance timeliness issues a root cause analysis is submitted by the PPG providing the root cause for each non-compliant authorization and the remediation action and completion date. These RCAs will continue monthly until the PPG becomes compliant.</td>
<td>Ongoing</td>
</tr>
</table>

Q1-2022 PTMPY

PPG	AHP	CVMP	FCMG	IMG	LSMA	SCP
Total Auths	**1,109**	**1,693**	**627**	**464**	**865**	**122**
I-Net	1,041	1,671	595	459	861	83
OON	68	23	32	5	4	39
TAT % Compliance						
Urgent	**99.75%**	**99.88%**	**99.41%**	**98.89%**	**99.64%**	**94.19%**
Routine	**99.98%**	**100%**	**99.51%**	**99.46%**	**99.90%**	**99.25%**

Q2-2022 PTMPY

PPG	AHP	CVMP	MMN	IMG	LSMA	SCP
Total Auths	**1,184**	**1,678**	**589**	**550**	**941**	**146**
I-Net	1,104	1,636	552	544	935	101
OON	80	41	37	6	5	45
TAT % Compliance						
Urgent	**100%**	**99.18%**	**99.30%**	**93.27%**	**99.74%**	**99.44%**
Routine	**99.90%**	**100%**	**99.72%**	**99.79%**	**99.77%**	**99.65%**

Q3-2022 PTMPY

PPG	AHP	CVMP	MMN	IMG	LSMA	SCP
Total Auths	**1,169**	**1,767**	**613**	**501**	**914**	**117**
I-Net	1,099	1,712	581	476	911	82
OON	70	54	32	16	3	35
TAT % Compliance						
Urgent	**99.88%**	**99.67%**	**99.51%**	**100.0%**	**99.90%**	**99.68%**
Routine	**99.90%**	**100%**	**99.86%**	**99.76%**	**100%**	**99.93%**

4. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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. Reviewing Member self-referrals to ECM and Community supports and creating an authorization for the ECM provider as appropriate. Members not meeting criteria will be referred to case management.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, LCSWs, Program Specialists, Program 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 2,014 and 573 members subsequently referred to Case Management through June. Total members managed through Q2 across physical, behavioral health, and Transitional Case Management programs was 1,739. 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 1/1/2022 & 3/31/2022 & remained eligible 90 days after case open date. 341 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 16% difference • Volume of ED claims/1000/year decreased by 364 • Total health care costs reduction primarily related to reduction in inpatient costs and outpatient services, and some increase in pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 95 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 2.4% improvement in ability to care for self/family post CM (100%) vs pre Case Management (97.6%); 100% (78/78) of respondents reported Case Management exceed their expectations.	None	None identified	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	Number of HIFs completed in January – December 2022 by member and returned or EPC outreach was 3,937; 1,241 members subsequently referred to CM. Total members managed through Q4 2022 across physical, behavioral health, and TCM programs was 3,501. 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 Q2 include members with active or closed case on or between 1/1/2022 & 6/30/2022 & remained eligible 90 days after case open date. 822 members met criteria. Results of members managed:	Decreased referrals from Concurrent Review to some programs due to COVID related complications for Members. Staffing constraints in Q2 and Q3.	Addressed staffing constraints with backfilled positions.	Ongoing

	• Number of admissions and readmissions was lower; 9.0% decrease in readmission rate. • Volume of ED claims/1000/year decreased by 316 • 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 140 members were successfully contacted Q1 through Q3 • 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 1.6% increase in ability to care for self/family post CM (100%) vs pre-CM (98.4%); 100% (123/123) of respondents reported CM exceeded their expectations			

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program. Measure program effectiveness based on the following measures: ○ Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals increased from 472 in Q1 to 599 in Q2. Through Q2 569 members managed in PCM program. Quarterly average engagement rate increased from 35%in Q1 to 40% in Q2 with YTD average 37%. 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 2022 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 1,528 members met the outcome inclusion criteria for visits; 194 members met preterm delivery criteria • Members enrolled in the High Risk Pregnancy Program demonstrated: o 3.3% greater compliance in completing the first prenatal visit within their first trimester, o 13.1% greater compliance in completing their post-partum visit 1.8% less pre-term deliveries in high risk members	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	Referrals – 1,784 Q1-Q4 2022 with average engagement rate 39%. Through Q4 882 members managed in PCM program; higher than number managed in 2021 (617). 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 Q2 2022 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 181 members met the outcome inclusion criteria for visits; 58 members met preterm delivery criteria • Members enrolled in the Pregnancy Program demonstrated:	None identified	None	Ongoing

	○ 3.6% greater compliance in completing the first prenatal visit within their first trimester ○ 3.4% greater compliance in completing their post-partum visit ○ 1.1% less pre-term deliveries in high-risk members Pregnancy Program mailings: January through December • NOP mailings 7,652 • Pregnancy mailings 1,200 • Post-delivery packets 537			

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management (CM) 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: ○ Readmission rates ○ ED utilization ○ Overall health care costs ○ Member Satisfaction	Dedicated staff of LCSWs, LMFT, and Program Specialist 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 295 in Q1 to 319 in Q2. Total members managed increased from 293 in Q1 to 359 in Q2. Total members managed through Q2 was 494. Calendar Year engagement rate 64%. Total Referrals to CM are monitored in the KIR which includes referrals from Impact Pro. 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 1/1/2022 & 3/31/2022 & 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 2023**	Data reported is a subset of information provided in 4.1. Referrals to behavioral health program Q1-Q4 2022 1,018. Total members managed increased in 2022 to 803 compared to 638 in 2021. Overall engagement rate 66.4%. 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 1/1/2022 & 9/30/2022 & 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)	2022 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Chronic Condition 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 Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Review prevalence data to affirm selection of Chronic Condition Management program offerings.	Ongoing 12/31/2022

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

<table>
<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment YTD = 330.

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.

Major conditions reviewed by prevalence and utilization across 12 months of claims. Asthma, diabetes and heart failure continue to be represented, here are the rankings:

<table>
<tr><th></th><th>Utilization</th><th>Prevalence</th></tr>
<tr><td>Asthma</td><td>1st</td><td>3rd</td></tr>
<tr><td>Diabetes</td><td>2nd</td><td>2nd</td></tr>
<tr><td>Heart Health</td><td>3rd</td><td>1st</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</td>
<td>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment at year end = 363.

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.</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2022 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	State Health Program (SHP) MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the injectable guidelines for medical benefit drugs 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.	Monthly report of PA requests.	Continued active engagement with pharmacy. Revised UMQI reporting based on Medical Benefit drug review. Revised DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	UMQI reporting was modified and updated for 2022 based on medical benefit drugs due to the Medi-Cal Rx implementation. CVS call center metrics report was retired. Key SHP Quarterly meeting topics include • Review of Medi-Cal Rx program updates and status post implementation. • DHCS audits completed • DMHC audits pending • A&G trends and concerns reviewed at SHP meeting. reporting modified for medical benefit drugs due to carve out of pharmacy benefit. IRR results for Q1 and Q2 2022 were presented and reports modified for Q3 to increase sample size. Targets and goal %'s updated to reflect medical benefit drug reviews and to correlate with other metric targets in other areas.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	• Medi-Cal RX program launched 1/1/22 and no ongoing issues to report • A&G cases for medical benefit pharmacy drugs tracked in 2022. There was a lower number of these cases compared to 2021 due to the Medi-Cal RX carve out. These cases were reviewed in the 4 quarterly SHP pharmacy meeting with no trends to report. • IRR process reviewed for Q4 2021 through Q3 2022. Results were not at threshold for Q1 2022 likely due to Medi-Cal Rx transition and changing workflows. 90% threshold met in Q2 and Q3 2022. Q4 2022 results are pending	None	• Medi-Cal RX issues will continue be tracked 2023 to assess impact on patient care • DUR programs in 2023 based on data from Medi-Cal RX and a new DUR vendor is being used • Revised UMQI reporting for pharmacy data will continue in 2023 based on 2022 modifications. • A&G data will continue to be tracked in 2023 based on the medical benefit drugs. • IRR was based on medical benefit drugs in 2022 and in Q2 and Q3 2022, sample size was increased and threshold and targets changed to align with other reporting.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 June 2022, MHN received 214 referrals from Fresno, Kings and Madera counties. MHN referred 3 members to the county for Specialty Mental Health or Substance Abuse Services.	None Identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	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. 1097 calls were received from members 1/1/22–12/31/22. There was a 21% increase in volume of calls. Of those calls, 358 were referred to MHN services, 14 referred to County Specialty Mental Health Services, 5 referred to County Substance Use Disorder Services, 118 referred to case management. The remaining referrals were unable to reach, declined services or ineligible. Behavioral health care managers continue to attend medical concurrent review rounds to ensure that 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.	None Identified	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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 2022, 14 of the 15 metrics met or exceeded their targets. In Q2 2022, 15 of the 15 metrics with targets met or exceeded their targets. The ABA authorization timeliness metric result was 99% and exceeded the threshold for action of 95%.	• There were 36 non-ABA reviews in Q1 2022. The overall performance rate was 91.7%., which did not meet the 100% target and below the threshold for action of 95%. • There were 35 Pre-Service-Non-Urgent cases and 33 (94.3%) were compliant with the timeliness standards. Two preservice cases were mishandled by a single staff person who misunderstood when the clock starts on these requests. • There was 1 Post-Service case and it was not compliant with the timeliness standard. Because of a system error, the case was held by MHN Claims for over 30 days before being forwarded to PSR for review. Therefore, PSR was unable to review it within timeliness standards (30 days).	The Management team coached and educated staff that the clock starts when any department receives the request. The system issue was resolved on 05/06/2022.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	In Q1 2022, 14 of the 15 metrics met or exceeded their targets. In Q2 2022, 15 of the 15 metrics with targets met or exceeded their targets. The ABA authorization timeliness metric result was 99% and exceeded the threshold for action of 95%. In Q3 2022, 14 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%. Q4 2022 data is not yet available.	• There were 36 non-ABA reviews in Q1 2022. The overall performance rate was 91.7%., which did not meet the 100% target and below the threshold for action of 95%. • There were 35 Pre-Service-Non-Urgent cases and 33 (94.3%) were compliant with the timeliness standards. Two preservice cases were mishandled by a single staff person who misunderstood when the clock starts on these requests. • There was 1 Post-Service case and it was not compliant with the timeliness standard. Because of a system error, the case was held by MHN Claims for over 30 days before being forwarded to PSR for review. Therefore, PSR was unable to review it within timeliness standards (30 days).	The Management team coached and educated staff that the clock starts when any department receives the request. The system issue was resolved on 05/06/2022.	Ongoing

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2022 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%.

2022 Monthly CCS Identification Rates
<table>
<tr><th>Month</th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>9.03%</td><td>7.97%</td><td>7.99%</td><td>8.33%</td></tr>
<tr><td>Feb</td><td>9.05%</td><td>7.95%</td><td>8.05%</td><td>8.35%</td></tr>
<tr><td>Mar</td><td>8.58%</td><td>7.67%</td><td>7.69%</td><td>7.98%</td></tr>
<tr><td>Apr</td><td>9.08%</td><td>8.10%</td><td>8.20%</td><td>8.46%</td></tr>
<tr><td>May</td><td>9.04%</td><td>8.04%</td><td>8.18%</td><td>8.42%</td></tr>
<tr><td>Jun</td><td>8.57%</td><td>7.70%</td><td>7.81%</td><td>8.03%</td></tr>
</table></td>
<td>Although Kings County CCS office staff is now available to answer the phone, they do not provide input when the CCS member status/SAR is not found in PEDI. This creates a potential backlog of pending cases.</td>
<td>1. Plan leadership engaged in conversations with CCS offices to establish a plan for issues and concerns as well as updates on pending cases.
2. Plan leadership identified an opportunity to engage the large facilities in the area to assist with communication on pending CCS cases and outcomes. These efforts have helped increase the plan's identification rates because it has produced faster turn-around-times with CCS determinations.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2023</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.

2022 Monthly CCS Identification Rates
<table>
<tr><th>Month</th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>9.03%</td><td>7.97%</td><td>7.99%</td><td>8.33%</td></tr>
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<tr><td>May</td><td>9.04%</td><td>8.04%</td><td>8.18%</td><td>8.42%</td></tr>
<tr><td>Jun</td><td>8.57%</td><td>7.70%</td><td>7.81%</td><td>8.03%</td></tr>
<tr><td>Jul</td><td>8.52%</td><td>7.64%</td><td>7.75%</td><td>8.36%</td></tr>
<tr><td>Aug</td><td>8.46%</td><td>7.65%</td><td>7.70%</td><td>8.30%</td></tr>
<tr><td>Sep</td><td>8.43%</td><td>7.62%</td><td>7.63%</td><td>8.27%</td></tr>
<tr><td>Oct</td><td>8.37%</td><td>7.56%</td><td>7.63%</td><td>8.21%</td></tr>
<tr><td>Nov</td><td>8.76%</td><td>7.80%</td><td>7.88%</td><td>8.57%</td></tr>
<tr><td>Dec</td><td>8.72%</td><td>7.74%</td><td>7.84%</td><td>8.53%</td></tr>
</table>
2022 Quarterly CCS Identification Rates
<table>
<tr><th>Quarter</th><th>2021</th><th>2022</th></tr>
<tr><td>Q1</td><td>8.24%</td><td>8.69%</td></tr>
<tr><td>Q2</td><td>8.24%</td><td>8.72%</td></tr>
<tr><td>Q3</td><td>8.37%</td><td>8.31%</td></tr>
<tr><td>Q4</td><td>8.40%</td><td>8.44%</td></tr>
</table></td>
<td>Kings County continues directing PPS to CCS liaisons when CCS member status/SAR are requested.</td>
<td>In 2023, additional meetings will be scheduled with all three county offices, starting with the Kings County CCS Office, to engage communication around member CCS statuses.</td>
<td>On-going</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2022 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 Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition 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 Integrated Case Management (ICM) as noted under 4.1. 636 Seniors and Persons with Disabilities (SPD) members (Supplemental Security Income Dual and Non-Dual) have been managed through Q2. This includes Physical Health Case Management, Behavioral Health Case Management, Transitional Case Management & Obstetrics Case Management, as well as both complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members for Q1 and Q2 (100% on time). 12,647 members were outreached from January through June 2022.	None identified.	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2023**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 1197 SPD members (SSI Dual and Non Dual) have been managed Q1-Q4 2022. 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 2022: 100% An additional 4,604 members were outreached in Q3 2022 (YTD reporting).	None None	None None	Ongoing Ongoing

Item #9

Attachment 9.C

2023 Utilization Management Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Marianne Armstrong Utilization Management

COMMITTEE DATE: February 16, 2023

SUBJECT: Utilization Management Program Description Change Summary

UM Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Updated year from 2022 to 2023
Throughout	Throughout	Updated formatting for consistency
ii-iii	Table of Contents	Page numbering and section headers updated to align with content
3	Information Systems and Analysis	- Changed "Medical Management" to "Population Health and Clinical Operations (PHCO)" - Removed Case Management
3, 11, 12	• Provider Network • Inpatient Facility Concurrent Review • Discharge Planning	Add "custodial care/long term care, intermediate care facility,"
5	Section 2 title	Changed "Mission" to "Purpose"
6	About Health Net	Clarified Health Net's mission and purpose statements.
6	State Health Programs UM Purpose	Corrected reference to Medi-Cal contract from Health Net to CalViva Health
6	State Health Programs UM Purpose	Changed bullet to: "Identify opportunities to improve the health of members through integration and coordination within PHCO and external Public Health Programs"
7, 11, 12, 19, 29, 31, 37	Multiple	Changed "case management" references to "care management"
7	Goals and Objectives	Changed "Provider" to "Delegation" Oversight.
9, 30	• Utilization and Care Management • PHCO Resources	Added LLC to Health Net reference related to Chief Medical Officer
9	Scope of UM	Updated services not requiring prior authorization
10	Direct referrals	- Updated services not requiring prior authorization - Removed specific specialist types
10	Preauthorization	Edited references to referrals
10	Inpatient Facility Concurrent Review	Deleted "hospitalized"
11, 12, 15, 16, 26, 27, 32	Multiple	Changed MHN references to "the behavioral health administrator" or similar

11	Inpatient Facility Concurrent Review	Reworded, delegated partners participate in rather than conduct concurrent review.
12	Discharge Planning	Added "including Community Supports and Complex Care Management" to assessment of continuity of care.
13	Retrospective Review	Removed reference to timeframes and product line
13	Second Opinion	Changed medical to utilization management
14	Coordination with Quality Improvement Programs	Added Peer Review Investigation Team and Peer Review Committee references and roles
14	Coordination with Internal Programs	Added Long Term Services and Supports and Waiver Programs
16	Pharmacy	Changed corporate pharmacy division reference to Centene Pharmacy Services
17-18	Continuity and Coordination of Care	Added clarifying language
18-21	Health Promotion Programs	- Removed references to "Be In Charge!℠" (except Weight Management) - Clarified health education resources are offered rather than "classes and programs", removed "in specific counties" and "healthy pregnancy - Corrected nurse advise line from providing education to "support" - Chronic condition management conditions added "including but not limited to" - Weight management programs clarified the Fit Families For Life offering is self-guided and removed reference to community classes. - Changed California Smoker's Helpline to describe new Kick It California program. - Diabetes prevention program updated to remove reference to "yearlong evidence based". - Healthy Hearts Health Lives updated to include exercise band and clarification that fitness videos are online rather than DVD. - Removed "Know your Numbers Community Classes and Screening Events." Section - Health education request form order removed "pre-stamped" - Member newsletter, clarified annual rather than regular.
21-22	Over and Under Utilization	- Edited references to monitoring: o removed duplicative verbiage and o added reference to provider prescribing patterns including medication utilization metrics o Added behavioral health o Added monitoring and metrics
24	Separation of Medical Decisions from Fiscal and Administrative Management	Changed Health Net CMO VP title
24	Consistency of application of the Utilization Decision Criteria	- Removed "regional" - Updated rounds to weekly - Updated description of Interrater reliability review process

24	Standards of Timeliness of UM Decision Making	- Updated "Medical Programs Manager" to "Delegation Oversight" - Added monitoring is monthly
25	Denials	Added Health to ICE (name change)
26	Satisfaction with the UM Process	Corrected reports are presented to CalViva Health QI/UM Committee rather than HN
29	CalViva Health QI/UMC	Added committee description
29	PHCO Resources	Changed to PHCO from former Medical Management
29-30	Health Net LLC CMO	- Added LLC - Removed reporting to the Board of Directors - Edited Medical Management to PHCO - Changed national to California
30	HN CMO VP MD	- Updated title - Added reporting to Board of Directors
31	Senior VP PHCO	Combined Senior VP and VP PHCO positions
31	Director PHCO	Changed title
32	Health Net UM Clinical Staff	Moved "Monitoring effectiveness of delegated entities and contracted providers" to Additional resources.
32	Additional Resources	Added "Referral of members to LTSS and Waiver programs."
33	HN CS QIHEC	- Updated Committee name - Changed Medical management to PHCO - Removed "for this program" - Updated CMO VP title
35	Delegation	Added "Summary reports are provided to CalViva Health's monthly Management Oversight Meeting."
38	UM Program Work plan	Updated titles
41	HN Approval	Updated Jennifer Lloyd title

2023

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, custodial care/long term care, intermediate care facility, 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
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

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

Purpose

About Health Net

Health Net provides access to high-quality health care, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

Purpose

Transforming the health of the community, one person at a time.

Mission

Better health outcomes at lower costs.

State Health Programs UM Purpose

The 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 CalViva Health 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 integration and coordination within PHCO and external 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 care 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, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation 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, LLC 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 services, family planning services, preventive services, basic prenatal care, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective pregnancy termination, biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer 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 services, family planning services (including abortion), preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing 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.

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, 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 tracking process to track and monitor referrals requiring prior authorization. Health Net's authorization tracking system includes authorized, denied, deferred and/or modified authorizations. The process of authorization 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 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 health care 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 health care 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 the behavioral health administrator, care 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 conduct and delegated partners participate in onsite or telephonic concurrent review of patients admitted to hospitals, rehabilitation units, custodial care/long term care, intermediate care facility, 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 care management and disease/ chronic condition management needs and refer such cases to Care Management for

evaluation. Concurrent Review Nurses collaborate with Care Managers on all members identified in active care management.

CCR goals include supporting the member and member's health care 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 health care 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 the behavioral health administrator, care 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, custodial care/long term care, intermediate care facility or acute rehabilitation).

HN Concurrent Review nurses identify potential care management cases and refer such cases to Care 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, including Community Supports and Complex Care Management 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 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 utilization 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 Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve member 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, Long Term Services and Supports (LTSS), waiver programs 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 disease/chronic condition management Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

The behavioral health administrator administers the Medi-Cal mild to moderate mental health services carved into the Managed Care Plans.

The behavioral health administrator 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.

The behavioral health administrator 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 the behavioral health administrator, will be referred to the County Specialty MHP.

The behavioral health administrator's utilization management decisions are based on Change Healthcare's InterQual Level of Care Criteria; the behavioral health administrator's evidence-based internal criteria; and the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The behavioral health administrator'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). the behavioral health administrator 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 NQTL under the definitions of the federal rules. The behavioral health administrator 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 the behavioral health administrator 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 the behavioral health administrator 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, the behavioral health administrator 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 behavioral health administrator utilization management program provides clinical review for services requiring authorization. The bulk of the outpatient services provided by the behavioral health administrator do not require authorization. All behavioral health administrator staff making utilization management decisions are appropriately licensed Care Managers and Medical Directors. The behavioral health administrator staff providing services to CalViva members are located at the behavioral health administrator offices in California.

The behavioral health administrator coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications:

Medical Benefit Drug Prior Authorization, Education programs for physicians and members, and Pharmaceutical Safety.

A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered 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.

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

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan members with pre-existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

- Members/Providers who make a continuity of care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.

- The continuity of care process is facilitated by licensed nurses based on member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.

- Care Managers are patient advocates and assist members to ensure that they receive timely and uninterrupted medical care during the transition process.

<u>Primary Care Physician responsibility:</u>

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 a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and availability standards through our network relationships, member and provider education and triage services.

Health Promotion Programs

CalViva Health provides 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 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 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.

Programs include:

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

Nurse Advice Line

The nurse advice line provides immediate symptom assessment and member support 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.

Chronic Condition Management

The Chronic Condition Management Program increases awareness of self-care strategies and empowers participants to better manage their disease. The program targets members with high-risk chronic conditions including, but not limited to: chronic asthma, diabetes and heart failure conditions. It encourages them to participate in the 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 chronic condition management are multichannel and come through provider, Care 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 self-guided, 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. Providers can 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 or members can request the information directly.

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.

- Kick It California – Kick It California (formerly known as the California Smokers' Helpline) is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Telephonic coaching is available Monday-Friday, 7am-9pm, and Saturday from 9am-5pm by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org. CalViva offers members 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 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, an exercise band, and online fitness videos) 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.
- Community Health Education Classes - Free classes are available 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 an order 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 an annual 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

Health Net's Utilization Management Department and the behavioral health administrator facilitates the delivery of health care services and monitors the impact of the UM Program to detect and correct potential under- and over-utilization through these comprehensive monitoring efforts:

- Establishing thresholds for compliance and measures compliance to guidelines
- Monitoring utilization data collected to detect potential under- and over-utilization.
- Routinely analyzing all data collected to detect under- or over-utilization.
- Analysis occurs on a semi-annual basis at minimum to ensure appropriate service and to identify opportunities for improvement.
- Tracks performance against established goals
- Implementing appropriate interventions when problems are identified.
- Educates and addresses variances from agreed upon clinical criteria
- Monitors provider prescribing patterns including medication utilization metrics
- Conducts provider outreach programs to modify performance
- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

Examples of data types and metrics identified that are relevant to provision of medically necessary services for all members. Examples:

- For outpatient services, units/1000.
- For outpatient services, unique patients/1000.
- For outpatient services, units/unique patient.
- Report likely driving factors for the above patterns of utilization.
- Dental anesthesia data is analyzed to identify and mitigate issues that may adversely impact the provision of medically necessary services received by members.
- In addition, suspected fraud, waste and abuse of medical services is monitored and reported.

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 Health Net SHP CMO/VP 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 Medical Director, Care Managers and CalViva Health's Chief Medical Officer participate in weekly 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:

Annual IRR InterQual (IQ) testing is conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. All staff must score 90% or greater for any subset category. If a staff scores < 90% for any subset the staff must attend retraining and successfully retest within 30 days of retraining. Any staff with final score of < 90% for any subset category will have a Corrective Action Plan (CAP) implemented. Staff are required to test on the IQ products applicable to their role. All staff must score 90% or greater for any subset category. If a staff scores < 90% for any subset the staff must attend retraining and successfully retest within 30 days of retraining. Any staff with final score of < 90% for any subset category will have a Corrective Action Plan (CAP) implemented. IRR results are reported annually at the CalViva Health Quality Improvement/Utilization Management (QI/UM) 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. Health Net Delegation Oversight, monitors the compliance of each medical group monthly and 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 Health Industry Collaboration Effort (HICE).

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, the behavioral health administrator 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.

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 CalViva Health QI/UM Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the CalViva Health QI/UM Committee.

Communication Services

The Plan, the behavioral health administrator 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, the behavioral health administrator 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 is 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

CalViva Health Quality Improvement/Utilization Management Committee

The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.

The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity. Members of the committee are appointed by the RHA Commission Chairperson. The Committee is chaired by the CalViva Chief Medical Officer ("CMO"). Committee size is determined by the RHA Commission with the advice of the CMO.

The QI/UM Committee is composed of Participating health care providers, including physicians, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

Health Net Organizational Structure and Resources

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

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO'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.

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

The CMO's responsibilities include, but are not limited to: leading the health plan in California PHCO 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.

Health Net CMO / Vice President (VP) Medical Director, State Health Programs

The Health Net CMO/VP Medical Director, State Health Programs (SHP), is responsible for Utilization Management and Care Management activities for Medi-Cal. In addition, the CMO/VP Medical Director is responsible for QI activities for these programs. The CMO/VP 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 CMO/VP Medical Director reports to HN's CMO.

This position makes recommendations to the Health Net Community Solutions Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and care 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 Population Health and Clinical Operations (VP PHCO)

The Senior VP PHCO is a registered nurse with experience in utilization management and care management activities. The Senior VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management Programs. The Senior VP PHCO reports to the Plan Chief Operating Officer. The Senior VP PHCO, in collaboration with the CMO/VP 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.

The Senior VP PHCO is responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and care/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.

Utilization Management (UM) Resources

Director, PHCO

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 Care/Chronic Condition Management when appropriate,
- Management of out-of-area cases, and
- All UM LVN, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of members to County CCS offices when eligible
- Referral of members to LTSS and Waiver Programs
- 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
- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health Administrator Medical Director and Medical Staff

The behavioral health 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 behavioral health program and clinical policies, the behavioral health administrator 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 behavioral health administrator 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 behavioral health administrator 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 behavioral health administrator QI Committee and to the Health Net Quality Improvement Committees. The behavioral health administrator 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 behavioral health administrator Quality Improvement Committee, and the behavioral health administrator Utilization Management Committee. Additionally, Health Net's Medical Directors and UM/QI staff sits on the behavioral health administrator'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 Quality Improvement/Health Equity Committee (QIHEC)

The Health Net Community Solutions Committee reports directly to the Health Net Board of Directors. The committee is charged with the monitoring of the PHCO 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 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. The Committee membership also includes practicing network physician representatives. The Health Net Community Solutions QIHEC is chaired by the CMO/VP Medical Director for SHP and meets quarterly.

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). Summary reports are provided to CalViva Health's monthly Management Oversight Meeting.

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 Care Management (UM/CM) Program Evaluation

UM/CM Program Evaluation

Health Net's Senior Vice President of PHCO 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 CMO/VP Medical Director and Senior Vice President 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
Senior Vice President of Population Health and Clinical Operations

Item #10

Attachment 10.A

2022 Annual Compliance Evaluation

CALVIVA HEALTH
2022 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, and Finance. The Compliance Program results are the collective achievements of dedicated Plan staff members, the Plan's Administrator (Health Net Community Solutions, Inc.), providers, and community-based organizations working together to meet the needs of CalViva Health members and the communities it serves.

In 2022, the Compliance Program was largely focused on implementing and complying with several of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAim) initiatives, submitting the 2024 Operational Readiness Contract requirements, and responding to the annual DHCS audit, and the triennial Department of Managed Care (DMHC) audit. In 2022, the Plan continued efforts to update its policies and oversight activities to be compliant with the state new initiatives and corresponding requirements. Overall, the Plan maintained its network adequacy, timely access standards, and implemented preparations for the carve-in of several new Medi-Cal Managed Care benefits.

In 2023, the Compliance Program will continue to focus on meeting the new regulatory requirements associated with the upcoming execution of the 2024 DHCS Contract, working with our Plan Administrator towards achieving NCQA Accreditation, and implementing a Dual-

Eligible (Exclusively Aligned) Special Needs Program (D-SNP) in our service area. The Plan, as always, will continue to focus on improving performance by maintaining overall operational effectiveness, ensuring regulatory compliance, and addressing any issues through the Corrective Action Plan (CAP) process.

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: DMHC's Knox-Keene license amendments (e.g., material modifications, annual timely access/annual network reports changes in commission/committee members); and DHCS contractual requirements (e.g., annual network certification, fraud waste and abuse case submissions, member-informing materials, new benefit-associated deliverables, and required policies and procedures).

In 2022, CalViva Health made over 221 regulatory filings to DMHC and DHCS. These filings do not include the various "routine" monthly/quarterly program data reports or audit-related information that are sent to the two agencies. In addition to regulatory filings and report submissions, the Plan underwent an annual audit by DHCS, a triennial medical audit by DMHC, a biennial financial audit by DMHC, and an annual DHCS HEDIS® audit. Any agency findings were all addressed by the Plan through the regulatory agency CAP process 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 CAP - The DHCS Audit CAP was closed on February 11, 2022 (Note: the DHCS did not officially notify the Plan until January 17, 2023).

b. 2022 DHCS Audit - The Plan received the DHCS' Final Report on November 17, 2022, and a corresponding CAP request on November 30, 2022. The CAP identified three audit findings: two concerned lack of documentation related to the provision of blood lead screening of young children, and one related to lack of documentation of a Physician Certification Statement (PCS) form for member's request for non-emergency medical transportation (NEMT). The Plan submitted its initial response to the CAP on December 30, 2022 and must continue to submit monthly updates until the CAP is closed.

c. DHCS -2020-2021 Performance Evaluation – On July 5, 2022 the Plan received DHCS' annual external quality review (EQR) Report and associated recommendations. There were three recommendations that focused on the following: working to resolve the finding s from the DHCS 2020 annual audit; updating its NCQA

methodology regarding dual-eligible Medi-Cal members; improving MY2020 HEDIS measures; The Plan submitted its response to how it would address the recommendations on August 1, 2022.

d. DHCS 2022 Encounter Data Validation (EDV) Study – The 2022 EDV study was completed on May 19, 2022. The Plan is waiting for HSAG to share the raw data, so the Plan can analyze how each score was calculated.

e. 2022 DHCS Annual Network Certification (ANC) - The Plan submitted the first part of the ANC in November of 2022. DHCS postponed the second phase related to the Accessibility Analysis until February 2023.

f. 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 submitted a CAP response and received DHCS approval on February 15, 2022.

g. DHCS Contract Amendments - Several Medi-Cal contract amendments were executed between DHCS and CalViva Health in 2022:

- Contract 10-8750 A18 – This amendment incorporated the calendar year 2021 new Base Language.

- Contract 10-8750 A20 – This amendment adjusted the 2021 calendar year capitation rates and added Base rate language.

- Contract 10-8750 A23 – This amendment incorporated the COVID Vaccination Incentive Program.

- Contract 10-8750 A24 – This amendment incorporated the new calendar year capitation rates, and added changes which included the addition of Mandatory Managed Care Enrollment (Phase 1), Major Organ Transplant benefit, the Enhanced Care Management (ECM) and Community Supports benefits, and the Rapid Whole Genome Sequencing benefit; removal of pharmacy benefits for Medi-Cal Rx transition; and updates existing requirements for telehealth, vision, CBAS, PCP assignment for Members with Other Health Coverage (OHC), and Exhibit G.

- Contract 10-8750 A27 – This amendment extends the contract term to December 31, 2023.

- Contract 10-8750 A28 – This amendment incorporated new requirements for Population Health Management, Dyadic Care Services, Risk Sharing Mechanisms, and adds new aid codes, and carved in Long-Term Care services.

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

i. DHCS 2024 Operational Readiness Work Plan & Contract - In June of 2022, the DHCS issued its 2024 Procurement Contract "Operational Readiness Work Plan". The work plan contained 238 Deliverables that must be submitted during different phases. The Plan made several monthly submissions in 2022 and will continue to do so in 2023.

2. Department of Managed Health Care (DMHC):

a. Measurement Year (MY) 2021 Timely Access Report (TAR): The Plan submitted its annual MY2021 TAR filing in April of 2022. The Plan is awaiting the DMHC's findings report/approval.

b. March 2021 DMHC 18-Month Follow-Up 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. The Plan believes the DMHC will provide comment on this outstanding issue as part of the 2022 DMHC Audit which took place in September 2022.

c. September 2022 DMHC Triennial Audit – The Plan filed all the Pre-audit document requests by June 3, 2022. The DMHC's on-site audit was conducted virtually from September 19, 2022 to September 21, 2022, and the Plan continued to respond to the DMHC's post-onsite audit requests for additional information until December 2022. The Plan is awaiting the DMHC's preliminary report.

c. March 2022 DMHC Routine Financial Exam – On March 15, 2022. DMHC issued a CAP for two deficiencies, one of which was regarding unfair payment pattern and one regarding provider dispute resolution (PDR) acknowledgment. The Plan submitted a response to the CAP and it was accepted on August 11, 2022. The Audit was closed by DMHC on August 30, 2022.

C. DHCS Fraud, Waste and Abuse Required Reporting:

In 2022, 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 and all four cases were referred to the DHCS via the MC609 process. All four cases were provider-related:

- One (1) was a provider specializing in Community Based Adult Services (CBAS) that was not providing updated Individual Plan of Care documentation for members;
- Two (2) were contracted DME providers that were unable to substantiate they provided supplies;
- One (1) was a vascular surgery provider identified as an outlier compared to peers for billing a particular HCPCS code;

The DHCS has closed 3 out of the 4 cases. All cases were promptly reported to DHCS within the ten (10) working days requirement. Additionally, the Plan had one (1) case that was initially referred to the DHCS in 2021 but was subsequently referred in 2022 to the CA Board of Pharmacy upon receipt of the SIU's Final Investigation Report. That case referral was previously reported to the Compliance Committee and the Commission in 2021.

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 2022:

- 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) through the receipt and assessment of privacy incident reports (PIRs). 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, however the latter company's contract terminated in September 2022 and the Plan did not renew it

In 2023, 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, engaging in ongoing risk management activities, and reviewing and updating program documents related to HIPAA.

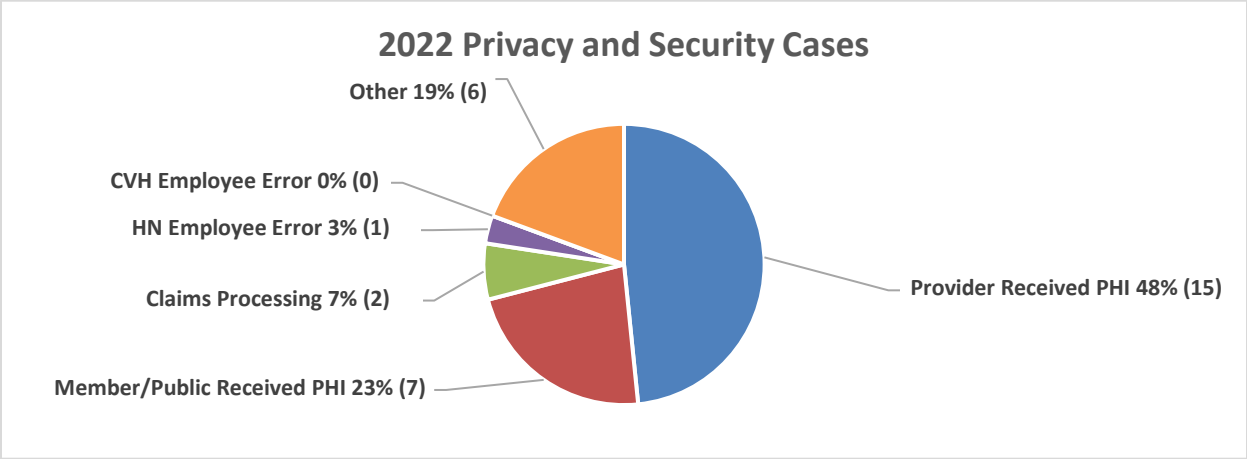
2. Reports of Possible Privacy and Security Incidents/Breaches

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.

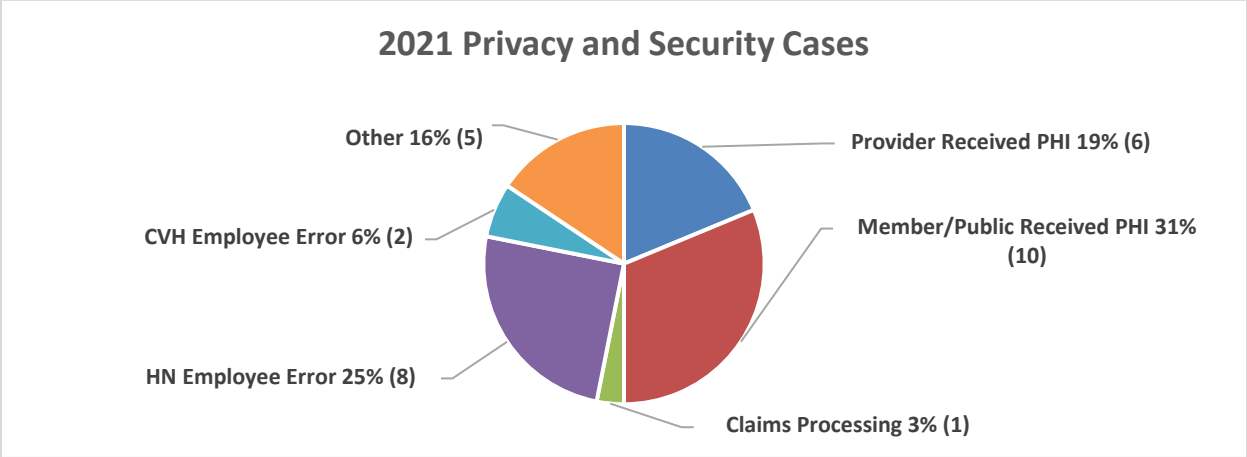
In 2022, thirty-one (31) privacy and security incidents were reported to the DHCS. Zero (0) incidents occurred within CalViva Health. All thirty-one (31) incidents involved the Plan's Administrator, and all cases were deemed low risk or no risk after the completion of a risk assessment. Nine (9) cases did not require completion of a risk assessment as there were zero (0) individuals affected by the privacy incidents. All cases have been closed by DHCS.

The first pie chart provides a high-level overview of the types of incidents which occurred in 2022. The second pie chart provides high-level overview of the types of incidents which occurred in 2021 for comparison purposes:

2022 Privacy and Security Cases



2021 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 2022 (31 incidents), with only a 3% increase in 2022. The number of incidents involving providers receiving PHI

had increased by 60% between 2021 and 2022. The number of incidents involving CalViva Health employee error had decreased to zero (0).

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 2022, 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 or Expanded Benefits, Waivers and Other Programs:

1. Enhanced Care Management (ECM) and Community Supports (CS) – The Plan continued to develop Models of Care for the populations of focus (POF) that went live or would go live as of July 1, 2022 and January 1, 2023.

2. Community Health Worker (CHW) Services – CHW Services are preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. In preparation for the January 1, 2023 effective date, the Plan submitted policies and procedures.

3. Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) - Effective October 1, 2022, ERS is a temporary provision and reimbursement of CBAS in alternate settings or via telehealth to allow for immediate response to address the continuity of care needs of CBAS participants when an emergency restricts or prevents them from receiving services at their center.

4. Long Term Care (LTC) – In preparation for the January 1, 2023 carve-in of Skilled Nursing Facility (SNF) long-term care into managed care, the Plan submitted and received approval of its SNF Network, and also submitted several key policy deliverables to DHCS for approval.

5. MMCE Phase II - Effective January 1, 2023, DHCS will be transitioning dual aid code groups, including LTC aid codes for both non-dual and dual beneficiaries in managed care. Plans will be required to submit daily, weekly, and then monthly post-transition monitoring reports to DHCS

6. Doula Services – Effective January 1, 2023, the Plan will be required to provide doula services for prenatal, perinatal and postpartum Members. This benefit will assist

members in childbirth, lactation consulting, behavioral health services, transportation etc. The Plan will be submitting all applicable Policies and Procedures.

7. Cognitive Health Assessment – Effective July 1, 2022, the Plan must cover an annual cognitive health assessment for Members who are 65 years or older and who do not Medicare coverage. A Cognitive Health Assessment is intended to identify whether a patient has signs of Alzheimer's disease or related dementias. The Plan will be submitting all applicable Policies and Procedures.

8. Medical Expansion - Effective May 1, 2022, full-scope Medi-Cal eligibility was expanded to individuals 50 years of age and older, and who do not have satisfactory immigration status or are unable to establish immigration status.

III. Compliance Program Activities

In May of 2022, the Plan notified DMHC and DHCS on its decision to close its downtown Fresno satellite location as member visits to that location were not significant.

A. Program Document Reviews/Updates:

In 2022, the Plan transitioned to a new document management system called HealthSTream.

CalViva Health continued to operate a comprehensive Compliance Program in 2022. The Plan's Compliance Program includes the following written descriptions which were reviewed and updated as necessary in 2022.

- 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.

1. Delegation Oversight Audits and CAPS

The table below lists the Plan's 2022 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

Claims	Provider Disputes	Emergency Services
Continuity of Care	Utilization Management*	Provider Network

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

2. Periodic Monitoring of Health Net

During 2022, 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
  - NEMT and NMT Transportation
- On-going oversight of subdelegated functions through report dashboards of comprehensive performance metrics accompanied by narrative reports explaining outlier data or issues.

C. 2022 CalViva Internal Audit

During 2022, 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 2022, the Plan conducted training for three 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 2022, 45 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 2022 Annual Mailing was distributed to members for calendar year 2022. A 2023 Member Handbook/Evidence of Coverage (EOC) is in production now and will be mailed to members in late Q1, 2023.

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 2022, contracted providers were sent approximately 214 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 17 informational letter templates and 5 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 2022. There were 1,530 provider "touches" and 5,754 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 2022, 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	74	74	100 % (74)
Standard Grievances	1107	1106	99.91% (1105)
Expedited Appeals	42	42	100% (42)
Standard Appeals	403	415	99.76 % (414)
Total:	**1626**	**1637**	**99.88% (1635)**
SPD Appeals & Grievances *	455	474	100% (474)
Exempt Grievances #	2429	2429	100%

† Total will not match as some cases received in December 2022 may remain open at the start of 2023, and the resolved case number may include some cases received in December 2021 and resolved in 2022.

* 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 2022. All cases were submitted within the required turnaround times.

Cases Received	2022 Total	% Cases Submitted w/in the TAT
DMHC Cases	**45**	**100%**
DHCS State Hearings	**28**	**100%**
Total:	**73**	**100%**

IV. 2023 ACTIVITIES

In 2023, 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 becoming effective in 2023.

The Plan will continue its efforts to implement ECM/CS in Fresno, Kings and Madera counties by submitting updated Models of Care (MOCs) that include updated reports of new POFs transitioning into ECM and expanding provider capacity for CS.

In 2023, the Compliance Program will also continue to focus on meeting the regulatory

requirements associated with the upcoming execution of the 2024 DHCS Contract, working with our Plan Administrator towards achieving NCQA Accreditation, and implementing a Dual-Eligible Special Needs Program (D-SNP) in our service area.

In 2023, CalViva will once again be audited by DHCS, and will continue to submit all required documentation in fulfillment of the Operational Readiness Contract.

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
- Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
- Behavioral Health
- 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:

			February 16, 2023
		Date:	
Name:	Mary Lourdes Leone		
Title:	Chief Compliance Officer		
		Date:	**February 16, 2023**
Name:	Jeffrey Nkansah		
Title:	Chief Executive Officer		

Date: **February 16, 2023**

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Item #11

Attachment 11.A

Emergency Preparedness & Crisis Response Plan

EMERGENCY PREPAREDNESS & CRISIS RESPONSE PLAN

For inquiries regarding this Plan, please contact:

Mary Lourdes Leone, CHC
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
MLLeone@CalVivahealth.org
(559) 540-7856

TABLE OF CONTENTS

EMERGENCY PREPAREDNESS & CRISIS RESPONSE PLAN

I. INTRODUCTION

A. OVERVIEW

The Fresno-Kings-Madera Regional Health Authority ("RHA"), dba CalViva Health (the "Plan") is a licensed full-service health care service plan contracted with the DHCS to offer health care services to enrollees in its Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. The Medi-Cal Managed Care Plan is the only product line offered by CalViva Health.

The RHA has a Capitated Provider Services Agreement ("CPSA") with Health Net Community Solutions, Inc. ("HNCS" or "Health Net") for the provision of health care services to CalViva Health members through the HNCS network of contracted providers. The RHA also has an Administrative Services Agreement ("ASA") with HNCS to provide certain administrative services on the Plan's behalf. Health Net is the Plan's "Administrator". Although the CPSA with HNCS covers a significant portion of the Plan's network, the RHA also maintains direct contracts with three (3) federally qualified health centers ("FQHC") in Fresno, Kings and Madera counties. HNCS provides the same administrative services for the Plan's direct contracted providers as it does for Health Net's contracted provider network.

As the Plan's Administrator, Health Net maintains the systems typical of health plan operations, including those used for CalViva Health operations, including systems for enrollment, claims, utilization, appeals/grievances, member/provider call center operations, and stores CalViva Health files and case records (e.g. credentialing files, prior authorization and case management files, claim files, etc.). CalViva Health does not interact with the Plan Administrator's systems but nevertheless relies on those systems to provide services to its members and providers.

B. PURPOSE

The purpose of this Emergency Preparedness and Crisis Response Plan is to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack related emergencies. The Plan is reviewed annually, and any changes are conveyed to the Plan's Governing Board (i.e., RHA Commission) and other applicable stakeholders.

In fulfilling the Plan's commitment to providing high quality and cost-effective care to members and a safe environment to staff under any condition, this Emergency Preparedness and Crisis Response Plan supports the Plan's business continuity by facilitating continuous service. This Emergency Preparedness and Crisis Response Plan documents processes and delineates resources that will be used by The Plan and the Plan's Administrator to ensure

continuity of business operations, delivery of essential care to members, and mitigate potential harm caused by emergencies, such as natural or manmade disaster or public health crisis.

C. TYPES OF EMERGENCIES

The Plan's executive management has identified and assessed potential public health crises and natural or man-made Emergencies, including but not limited to epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any of the Plan's business locations, including those of its Administrator.

The Plan also reviews our service areas when an emergency occurs and how that may disrupt business operations. In addition, the Plan reviews any essential supply chain impacts that may disrupt business operations during or after the Emergency.

The Plan reviews its assessment as changes occur, but at least annually.

In this document several words are defined as:

- "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

- "**Emergency Preparedness**" means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor's Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

- **"Emergency Preparedness and Response Plan"** means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

As a result of a crisis or disaster, the following are examples of ways the Plan's workspaces can be affected:

- **Full building closure** – temporary shutdown or reduced operation of a building for a minimum of one day or longer. This would include an incident that would seriously

affect the ability to conduct "business as usual," in the building. An example would be nearby smoke that infiltrated the building.

- **Building inaccessible to employees** – incident that would not seriously affect the ability to conduct "business as usual," in the building, but the employees are not able to access the building. Example would include: employees can't get to the office due to a road closure.

- **Long term building closure** – a situation that seriously impairs the Plan's ability to conduct "business as usual" in an office building. The coordinated effort of an office-wide closure is required to effectively control the situation. Examples may include: a pandemic, severe property damage, etc.

- **Emergency evacuation while employees are working** – situations that will require an evacuation of the workplace. The extent of evacuation may vary for different types of situations. Examples include a nearby explosion, civil disturbances, and workplace violence while employees are working in the building.

D. CONSTITUENTS

Constituents represent the various groups that may be impacted in an emergency. In the Functional Area Responses section below, the various areas provide their processes to address potential impacts to each of these constituents.

- **Members**
  The Emergency Preparedness and Crisis Response identifies plans and processes to ensure that members are informed of support resources that will assist them in responding to a natural disaster or emergency in their area. This includes mechanisms for ensuring information is available proactively to prepare members in the event of a disaster as well as reliable channels of communication and what to expect during a disaster.

- **Providers**
  The Emergency Preparedness and Crisis Response is designed to address provider questions and concerns regarding member access to services and work to resolve barriers to care prior to, during, and immediately following a disaster or emergency event. Additionally, there will be coordination with facilities and vendors in real time to prevent a delay in needed services per the regulator's guidelines.

- **Employees**
  The Emergency Preparedness and Crisis Response outlines plans and procedures to adequately prepare employees to educate and inform members and providers with the latest emergency or disaster information and respective recovery details as well as the Plan's directives. This includes the support of employees who are personally affected by

emergency situations and addressing challenges related to the redistribution of workload and office availability.

- **Regulators**
  The Emergency Preparedness and Crisis Response outlines a plan and process to provide required documentation to the Plan's various regulators, and also to proactively provide regular communication with the regulators during a disaster or crisis, to ensure the regulator is aware of the Plan's progress.

- **Community**
  If there are emergencies that could impact the surrounding community, the community becomes an important audience. Community outreach may include coordination with public safety officials to develop protocols and procedures for advising the public of any hazards. Community outreach may also include providing food, drinking water and other supplies as needed.

- **Elected Government Officials**
  The Emergency Preparedness and Crisis Response will include regular communication with the elected government officials during a disaster or crisis to ensure the elected government officials are aware of the Plan's progress. Elected government officials may request assistance from the Plan in the form of in person support at evacuation sites and/or donations to assist impacted members/community.

- **Vendors**
  The Plan will coordinate and communicate with vendors to implement their emergency process in the event of an emergency that affects the vendor's operations.

- **RHA Commission**
  As the governing board of the Plan, the RHA Commission has ultimate authority over the Plan's management of its operations. The Emergency Preparedness and Crisis Response will include informing the RHA Commission of any disaster and/or emergency that impacts the Plan's operations, and the Plan's actions taken to appropriately respond to the crisis.

II. Disaster & Emergency Preparedness Protocol

The preparation phase occurs before a disaster or emergency event takes place. This process includes the Plan's evaluation of how a potential disaster or emergency impacts the Plan's overall ability to maintain business continuity and ensure members access to care. Impacts to productivity, communities, a provider's or vendor's ability to deliver care, as well as standard processes for accessing available resources and timely information are also evaluated. This method of preparation is designed to ensure that the Plan possesses a

thorough understanding of any potential impact to any constituents and the Plan's role in mitigating risk.

The Plan will maintain Emergency contact information, telephone numbers, and other contact information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, and key Plan Administrator Management staff.

A. Emergency Response Leadership Team

The Emergency Response Leadership Team (ERLT) is notified at the first sign of a potential disaster or emergency event. The ERLT then assesses the disaster or emergency event and determines whether to activate this work plan.

The Plan's Executive staff will constitute the Emergency Response Leadership Team (ERLT):

- Jeffrey Nkansah, Chief Executive Officer
- Mary Lourdes Leone, Chief Compliance Officer
- Patrick Marabella, M.D., Chief Medical Officer
- Daniel Maychen, Chief Financial Officer

The ERLT will maintain contact with key Plan Administrator counterparts in order to communicate and evaluate current or potential disaster impacts, and actions to mitigate to the following:

- Plan Administrator's management information systems (MIS)
- Provider availability
- Members access to care
- Plan's management information systems (MIS)
- Plan' staff's access to the workplace and/or connectivity to Plan's MIS

Oversight of the Emergency Preparedness & Crisis Response

The following Plan executives will have oversight of the following functional areas:

Jeffrey Nkansah	Facilities, Community & Government Relations, Human Resources, Information Technology, Marketing and Communications, & Security
Mary Lourdes Leone	Call Center / Member Services, Compliance, Marketing and Communications, Provider Network, Privacy & Security
Patrick Marabella, M.D.	Population Health, Utilization Management, Pharmacy, Appeals & Grievances, Provider Network

Daniel Maychen	Facilities, Claims, Information Technology, Enrollment,

B. Policies and Procedures

CalViva Health has established a set of policies and procedures. The Policies and Procedures are available to employees and other valuable stakeholders in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Emergency Preparedness and Crisis Response Plan.

In cases where policies and procedures have not been directly established by CalViva Health, CalViva Health has reviewed and approved the use of a Plan and/or policies and procedures by a delegate responsible for activities under the emergency preparedness and crises response plan.

C. Monitoring Functional Area Responses

CalViva Health is committed to responding quickly and appropriately during and emergency and/or crises.

In the event of an emergency and/or crisis, the ERLT will collaborate as needed and as appropriate so the following actions are completed and made available for reporting:

- Actions taken to identify the nature, scope and magnitude of the event's impact
- Actions taken to mitigate and or resolve the event's impacts
- Actions needed to be maintained during the Recovery phase, if needed
- Actions taken to fulfill required regulatory filings to the DMHC (i.e., within 48 hours of the Declaration of an emergency.
- Actions taken to fulfill required regulatory filings to the DHCS (i.e., within 24 hours of a federal, state, or county declared state of Emergency located within the Plan's Service Area, the Plan will notify DHCS if the Plan has experienced or expects to experience any disruption to its operations.)
- Actions taken to update the Plan's Emergency Preparedness and Crises Plan including, but not limited to any training which is conducted, reviewed, and/or updated.

III. FUNCTIONAL AREA RESPONSES

A. Appeals and Grievances

Health Net administers the day-to-day operation of the Appeals and Grievance System on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Health Net Appeals and Grievances Department shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services by taking action, including but not limited to the following:

1. Extended filing deadline for Grievances and requests for Appeals in accordance with Exhibit A, Attachment III, Section 4.6 Member Grievance and Appeal System.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

B. Call Center (Member and Provider Services)

Health Net administers the day-to-day operation of the Call Center on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Health Net Call Center Department shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by taking action, including but not limited to the following:

1. Requirements may be relaxed to better serve members during a crisis.
2. Adding emergency messaging or pointing to a shared resource if appropriate to triage calls.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

C. Claims

Health Net administers the day-to-day operation of claims processing activities on CalViva Health's behalf. Upon the official notification that there is an emergency or

disaster impacting the function, the Health Net Claims Department shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Adjusting work schedules to meet the need of the member or provider and direction from regulatory departments.
2. Working with Information Technology departments to perform Claims adjudication system enhancements which may be required to support/implement state requirements.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

D. Community and Government Relations

CalViva Health understands the role of the public affairs and government relations team is to communicate the Plan's activities during the disaster to local elected officials, key stakeholders, and community-based organizations.

CalViva Health's Chief Executive Officer, along with the support of CalViva Health's Director of Community Relations & Marketing will work collaboratively together as appropriate to ask people and organizations, which may include Health Net, on modalities to amplify information on where Plan members can get continued care such as pharmacy benefits or help coping with the disaster.

In some cases, the Plan may provide financial support and or Plan resources to providers and/or Community Based Organizations in the region.

CalViva Health also requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work on an appropriate response to the emergency and/or disaster.

E. Compliance

CalViva Health Compliance is responsible for receiving and disseminating any regulatory requirements specific to any Emergency Declaration in place. Compliance provides guidance to support implementation / change management processes to sustain compliance with all regulatory requirements. Compliance will review the Business Continuity and Emergency and Member Preparedness Response Plan on an annual basis.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Ensuring Compliance has the ability and resources to maintain interactions with regulatory agencies to respond to any requests or questions that are related to how the Plan is accommodating its membership impacted by the State of Emergency or disaster.
2. Reporting the status of its operations once a day to regulatory agencies or as directed by regulatory agencies.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

F. Enrollment

CalViva Health is responsible for receiving enrollment eligibility files from the State and transferring it securely to Health Net. Health Net administers the day-to-day operation of timely and accurate execution of enrollment processing to avoid member and provider disruption on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Allowing data systems to be available through remote connectivity capabilities to allow the continued transfer of files during an emergency and/or crises.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

G. Facilities

CalViva Health has one building facility. The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer and the Office Director regarding any emergency crises which impact the CalViva Health office.

Health Net has a Facilities team which will respond to an emergency or crisis. The facilities team will report the number of Plan offices that are closed on a daily basis to the appropriate parties. Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Allowing systems and resources to be available through remote connectivity capabilities

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

H. Human Resources

The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer and the Human Resources Director regarding any

emergency crises which impact the CalViva Health office. Health Net has a Human Resources team which will respond to an emergency or crisis.
Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Ensuring the Plan's staff are clear on policies and procedures and any interpretation based on nuances of emergency/disaster needs.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

I. Information Technology

CalViva Health works with an Information Technology ("IT") Vendor which provides hardware and software systems necessary for virtualization of Microsoft Windows Server Operating System, compatible Application software and storing of data. Servers are backed up daily and can be restored from the previous backup. Environmental protection systems (i.e., UPS battery backups, power generators, etc.) are in place to protect data systems. On an annual basis, the Plan's Business Continuity and Disaster Recovery Protocols are tested. Every other year a Cybersecurity Assessment which includes penetration testing, vulnerability scanning, phishing simulations, force entry, etc.) are conducted.

Lessons learned are incorporated into updated versions of the Plan's overall Emergency Preparedness and Crises Plan.

The CalViva Health Chief Executive Officer works collaboratively with the IT vendor regarding any emergency crises which impact the CalViva Health office.

Health Net Information Technology capability consists of over 200 IT security and risk personnel assigned all aimed at recovering as quickly as possible, including those related to member care and provider payment services within 24 hours from the time the disaster is declared.

Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Allowing systems and resources to be available through remote connectivity capabilities.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

J. Marketing and Communications

CalViva Health understands there is a need to develop and distribute communications to key audiences when an emergency or disaster arises.

CalViva Health's Chief Executive Officer, Chief Compliance Officer, along with the support of CalViva Health's Director of Community Relations & Marketing will work collaboratively together and as appropriate to:

1. Distribute communications to members that are mandated by regulations, laws and/or contracts.
2. Distribute communications focused on actions that employees need to take to ensure their safety and/or to continue butines operations in the crisis-impacted areas
3. Distribute communications to providers that are mandated by regulations, laws and/or contracts.
4. Distribute communications to news media outlets and for posting to company-owned social media platforms.

CalViva Health also requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work on an appropriate response to the emergency and/or disaster.

K. Pharmacy

Health Net administers the day-to-day operation of ensuring member's have access to their medications on CalViva Health's behalf. In cases which are not related to Physician-Administered Drugs, the responsibility will also be shared with the State as a result of Medi-Cal RX which became effective 1/1/2022. Upon the official notification that there is an emergency or disaster impacting the function, the Health Net Pharmacy team shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. If applicable, entering claim overrides in the pharmacy claims processing system.
2. If applicable, lifting certain prior authorization procedures.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

L. Population Health and Utilization Management

Health Net administers the day-to-day operation of population health and utilization management activities on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Population Health and Utilization Management Team(s) shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Identifying members with special health care needs in the affected area using a data driven risk stratification approach.
2. Establishing cooperative arrangements with other local health care organizations to assist and provide mutual aid during an Emergency when business operations are affected.
3. Reviewing prior authorization requests from members and providers in impacted areas to ensure determinations are reviewed and determined quickly.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

M. Provider Network

Health Net administers the day-to-day operation of ensuring appropriates teams are aware of the impact to the delivery system in the affected area(s) on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Provider Network Team shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Verify impact on providers in affected disaster areas.
2. Educate providers on the Plan's Emergency policies and procedures and ensuring they are following requirements and aware of any temporary requirements published by regulations.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

N. Security

CalViva Health has a Security Management Process to ensure it has implemented the appropriate security measures to reduce risks and vulnerabilities. The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer, Chief Compliance Officer, Chief Medical Officer, IT Vendor, and the Office Director regarding any emergency crises which impact the CalViva Health office.

Health Net has a Physical Security team which will secure facilities during a natural disaster or emergency. Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Working with all parties to ensure safety after an event including building walks, assessments, deployment of security officers as necessary for compliance, security or health and safety concerns.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

IV. References

1. Health Net Emergency Preparedness and Crises Response Plan
2. CalViva Health Policies and Procedures related to the following Functional Areas:

Administration	Health Education
Appeals and Grievances	Member Services
Case Management	Pharmacy
Claims	Privacy and Security
Compliance	Provider Services
Cultural and Linguistics	Public Health
Finance	Quality Improvement
Human Resources	Utilization Management

APPROVAL:

		Date:	**February 16, 2023**
Name:	Mary Lourdes Leone		
Title:	Chief Compliance Officer		
		Date:	**February 16, 2023**
Name:	Jeffrey Nkansah		
Title:	Chief Executive Officer		
		Date:	**February 16, 2023**
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Program Description History		
Date	**Section #**	**Comment(s)**
2/16/2023		New Program Description

Item #12

Attachment 12.A

Financials as of December 31, 2022

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of December 31, 2022

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	172,436,396.50
5	Total Bank Accounts	$ 172,436,396.50
6	Accounts Receivable	
7	Accounts Receivable	118,538,487.97
8	Total Accounts Receivable	$ 118,538,487.97
9	Other Current Assets	
10	Interest Receivable	445,061.02
11	Investments - CDs	0.00
12	Prepaid Expenses	868,626.35
13	Security Deposit	54,373.36
14	Total Other Current Assets	$ 1,368,060.73
15	Total Current Assets	$ 292,342,945.20
16	Fixed Assets	
17	Buildings	6,050,715.76
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	64,931.56
21	Total Fixed Assets	$ 9,277,066.42
22	Other Assets	
23	Investment -Restricted	300,653.05
24	Lease Receivable	3,499,077.52
25	Total Other Assets	$ 3,799,730.57
26	TOTAL ASSETS	$ 305,419,742.19
27	LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	194,531.28
32	Accrued Admin Service Fee	4,595,426.00
33	Capitation Payable	98,876,804.90
34	Claims Payable	25,949.01
35	Directed Payment Payable	1,509,230.45
36	Total Accounts Payable	$ 105,201,941.64
37	Other Current Liabilities	
38	Accrued Expenses	1,098,409.08
39	Accrued Payroll	51,046.20
40	Accrued Vacation Pay	303,768.99
41	Amt Due to DHCS	8,476,570.48
42	IBNR	83,937.71
43	Loan Payable-Current	0.00
44	Premium Tax Payable	0.00
45	Premium Tax Payable to BOE	6,051,267.18
46	Premium Tax Payable to DHCS	45,718,750.00
47	Total Other Current Liabilities	$ 61,783,749.64
48	Total Current Liabilities	$ 166,985,691.28
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	$ 167,011,598.07
54	Deferred Inflow of Resources	3,124,828.85
55	Equity	
56	Retained Earnings	127,950,997.92
57	Net Income	7,332,317.35
58	Total Equity	$ 138,408,144.12
59	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 305,419,742.19

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2022 - December 2022

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Income	1,916,442.59	169,998.00	1,746,444.59
3	Premium/Capitation Income	662,549,693.84	616,501,916.00	46,047,777.84
4	**Total Income**	**664,466,136.43**	**616,671,914.00**	**47,794,222.43**
5	Cost of Medical Care			
6	Capitation - Medical Costs	531,530,000.77	490,414,937.00	41,115,063.77
7	Medical Claim Costs	687,699.66	540,000.00	147,699.66
8	**Total Cost of Medical Care**	**532,217,700.43**	**490,954,937.00**	**41,262,763.43**
9	**Gross Margin**	**132,248,436.00**	**125,716,977.00**	**6,531,459.00**
10	Expenses			
11	Admin Service Agreement Fees	27,316,641.00	26,103,000.00	1,213,641.00
12	Bank Charges	0.00	3,600.00	(3,600.00)
13	Computer/IT Services	103,580.96	116,736.00	(13,155.04)
14	Consulting Fees	10,625.00	150,000.00	(139,375.00)
15	Depreciation Expense	143,374.14	162,150.00	(18,775.86)
16	Dues & Subscriptions	103,497.76	102,600.00	897.76
17	Grants	2,955,909.10	2,955,909.10	0.00
18	Insurance	95,785.49	96,333.00	(547.51)
19	Labor	1,623,760.24	1,788,141.00	(164,380.76)
20	Legal & Professional Fees	48,342.33	95,400.00	(47,057.67)
21	License Expense	587,891.32	586,980.00	911.32
22	Marketing	618,453.30	835,000.00	(216,546.70)
23	Meals and Entertainment	14,733.31	17,150.00	(2,416.69)
24	Office Expenses	44,572.25	46,000.00	(1,427.75)
25	Parking	120.39	780.00	(659.61)
26	Postage & Delivery	1,507.08	2,040.00	(532.92)
27	Printing & Reproduction	595.85	2,400.00	(1,804.15)
28	Recruitment Expense	36,009.73	21,000.00	15,009.73
29	Rent	0.00	6,000.00	(6,000.00)
30	Seminars and Training	4,786.93	13,300.00	(8,513.07)
31	Supplies	5,232.32	5,700.00	(467.68)
32	Taxes	91,437,253.47	91,437,500.00	(246.53)
33	Telephone	15,020.88	19,950.00	(4,929.12)
34	Travel	10,142.55	13,000.00	(2,857.45)
35	**Total Expenses**	**125,177,835.40**	**124,580,669.10**	**597,166.30**
36	**Net Operating Income/ (Loss)**	**7,070,600.60**	**1,136,307.90**	**5,934,292.70**
37	Other Income			
38	Other Income	261,716.75	330,000.00	(68,283.25)
39	**Total Other Income**	**261,716.75**	**330,000.00**	**(68,283.25)**
40	**Net Other Income**	**261,716.75**	**330,000.00**	**(68,283.25)**
41	**Net Income/ (Loss)**	**7,332,317.35**	**1,466,307.90**	**5,866,009.45**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2023 vs FY 2022

		Total	
		July 2022 - December 2022 (FY 2023)	July 2021 - December 2021 (FY 2022)
1	Income		
2	Interest Income	1,916,442.59	132,953.46
3	Premium/Capitation Income	662,549,693.84	694,615,959.43
4	Total Income	**664,466,136.43**	**694,748,912.89**
5	Cost of Medical Care		
6	Capitation - Medical Costs	531,530,000.77	576,461,059.57
7	Medical Claim Costs	687,699.66	510,729.20
8	Total Cost of Medical Care	**532,217,700.43**	**576,971,788.77**
9	Gross Margin	**132,248,436.00**	**117,777,124.12**
10	Expenses		
11	Admin Service Agreement Fees	27,316,641.00	25,725,304.00
12	Bank Charges	0.00	119.35
13	Computer/IT Services	103,580.96	91,684.91
14	Consulting Fees	10,625.00	0.00
15	Depreciation Expense	143,374.14	143,142.87
16	Dues & Subscriptions	103,497.76	83,248.70
17	Grants	2,955,909.10	2,356,818.20
18	Insurance	95,785.49	91,115.02
19	Labor	1,623,760.24	1,917,191.88
20	Legal & Professional Fees	48,342.33	40,592.02
21	License Expense	587,891.32	398,537.58
22	Marketing	618,453.30	631,829.78
23	Meals and Entertainment	14,733.31	14,156.09
24	Office Expenses	44,572.25	29,812.95
25	Parking	120.39	206.95
26	Postage & Delivery	1,507.08	1,602.05
27	Printing & Reproduction	595.85	1,138.02
28	Recruitment Expense	36,009.73	1,698.65
29	Rent	0.00	0.00
30	Seminars and Training	4,786.93	9,448.88
31	Supplies	5,232.32	4,594.34
32	Taxes	91,437,253.47	83,125,000.00
33	Telephone	15,020.88	17,365.18
34	Travel	10,142.55	7,704.46
35	Total Expenses	**125,177,835.40**	**114,692,311.88**
36	Net Operating Income/ (Loss)	**7,070,600.60**	**3,084,812.24**
37	Other Income		
38	Other Income	261,716.75	163,381.45
39	Total Other Income	**261,716.75**	**163,381.45**
40	Net Other Income	**261,716.75**	**163,381.45**
41	Net Income/ (Loss)	**7,332,317.35**	**3,248,193.69**

Item #12

Attachment 12.B

Compliance Report

Regulatory Filings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 YTD Total
# of DHCS Filings													
Administrative /Operational	12*	16*	16*	10	12	17*	16	19	25	12	10	11	176
Member Materials Filed for Approval;	1	5	4	4	2*	4*	3	3*	5*	3*	2	1	37
Provider Materials Reviewed & Distributed	22	11	11	12	15	29	16	14	22	13	7	18	190
# of DMHC Filings	4	4	5	5	5	4	2	3	5	2	3	3	45

DHCS Administrative/Operational filings include ad-hoc reports, policies & procedures, Commission changes, Plan and Program documents, etc.

* Numbers with asterisks were updated to reflect the correct number of filings .

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	6	4	1	1	5	6	1	1	2	1	2	1	29
High-Risk	0	0	0	0	0	0	0	0	0	0	0	0	0

Fraud, Waste, & Abuse Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 YTD Total
# of New MC609 Cases Submitted to DHCS	1	0	0	0	0	1*	0	1	0	0	1	0	4
# of Cases Open for Investigation (Active Number)	21	22	22	20	19	17	15	15	15	14	11	11	

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 11/15/22 Compliance Regulatory Report to the Commission, there have been no new MC609 cases filed.

*** NOTE**: This case was filed in June but was inadvertently left off the 9/15/22 Commission Compliance Report. This case involved a member complaint about billing they received from a DME provider when they had not seen the provider since 2018.

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: Credentialing, Fraud, Waste & Abuse, and the Member Call Center. The following audits have been completed since the last Commission report: Access & Availability, Emergency Services, Utilization Management (CAP)
Regulatory Reviews/Audits and CAPS	**Status**
2021 Department of Managed Health Care ("DMHC") 18-Month Follow-Up Audit	The Plan is still awaiting the DMHC's final determination on our 2021 CAP response.
Department of Health Care Services ("DHCS") 2020 Medical Audit - CAP	The DHCS closed the CAP on February 11, 2022 however they did not notify the Plan until January 17, 2023.
Department of Health Care Services ("DHCS") 2022 Medical Audit	The Plan received the DHCS' Final Report on November 17, 2022, and a corresponding CAP request on November 30, 2022. The CAP identified three audit findings: two concerned lack of documentation related to the provision of blood lead screening of young children, and one related to lack of documentation of a Physician Certification Statement (PCS) form for member's request for non-emergency medical transportation (NEMT). The Plan submitted its initial response to the CAP on December 30, 2022, and the first monthly follow-up report on February 1, 2023. The Plan must continue to submit monthly updates until the CAP is closed.

Department of Managed Health Care ("DMHC") 2022 Medical Audit	The DMHC "on-site" audit was conducted via teleconference on 9/19/22 and 9/20/22. The Plan is awaiting DMHC's Preliminary Report.
New Regulations / Contractual Requirements/DHCS Initiatives	**Status**
California Advancing and Innovating Medi-Cal (CalAIM)	**Long-Term Care (LTC) Carve-In:** **Effective 1/1/23**, Medi-Cal Managed Care Plans became responsible for authorizing and covering medically necessary SNF services. The Plan has submitted all 15 of the DHCS-required policy deliverables associated with this carve-in and has received 14 approvals with one still pending. **Effective 1/1/24,** the remaining LTC residents receiving care from adult and pediatric Subacute facilities and Intermediate Care Facilities for the Developmentally Disabled will be required to enroll in managed care.
Member Handbook/Evidence of Coverage	The Plan began providing the 2023 Member Handbook to members on 1/1/2023.
Plan Administration	
DHCS 2024 Operational Readiness Work Plan & Contract	On 6/30/22, the DHCS issued its 2024 Procurement Contract "Operational Readiness Work Plan". The work plan contains 238 deliverables that must be submitted during the following phases: • Phase 1: August 12, 2022 – December 8, 2022 • Phase 2: December 15, 2022 - March 31, 2023 • Phase 3: April 20, 2023 - July 31, 2023 The Plan has completed the monthly filings of the various policies and other documents through January 2023, and has received approvals on most but is still responding to additional DHCS information requests for some of the items.
Committee Report	
Public Policy Committee	The next meeting will be held on March 1, 2023 at 11:30am in the Plan's Administrative Office.

Item #12

Attachment 12.C

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2022

Current as of End of the Month: December
Revised Date: 1/14/2023

CalViva - 2022																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2022 YTD**	**2021 YTD**
Expedited Grievances Received	4	4	8	16	5	7	9	21	5	9	4	18	8	6	5	19	74	110
Standard Grievances Received	75	58	102	235	75	90	101	266	84	117	110	311	111	91	93	295	1107	997
Total Grievances Received	**79**	**62**	**110**	**251**	**80**	**97**	**110**	**287**	**89**	**126**	**114**	**329**	**119**	**97**	**98**	**314**	**1181**	**1107**
Grievance Ack Letters Sent Noncompliant	2	1	0	3	0	1	0	1	0	1	0	1	0	0	0	0	5	3
Grievance Ack Letter Compliance Rate	**97.3%**	**98.3%**	**100.0%**	**98.7%**	**100.0%**	**98.9%**	**100.0%**	**99.6%**	**100.0%**	**99.1%**	**100.0%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.55%**	**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	4	4	8	16	4	8	8	20	6	8	5	19	8	6	5	19	74	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	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Standard Grievances Resolved Compliant	79	60	67	206	98	79	92	269	94	108	107	309	110	118	93	321	1105	1033
Standard Grievance Compliance rate	**98.7%**	**100.0%**	**100.0%**	**99.5%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.91%**	**100.0%**
Total Grievances Resolved	**84**	**64**	**75**	**223**	**102**	**87**	**100**	**289**	**100**	**116**	**112**	**328**	**118**	**124**	**98**	**340**	**1180**	**1144**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**62**	**31**	**48**	**141**	**73**	**59**	**67**	**199**	**69**	**77**	**88**	**234**	**82**	**93**	**77**	**252**	**826**	**878**
Access - Other - DMHC	15	5	9	29	14	18	24	56	10	18	19	47	16	17	11	44	176	63
Access - PCP - DHCS	6	3	11	20	7	4	6	17	6	6	10	22	10	5	11	26	85	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	3	1	3	7	13	5	4	22	4	6	0	10	4	9	5	18	57	48
Administrative	10	5	7	22	10	8	3	21	17	7	17	41	13	14	8	35	119	191
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	14	7	6	27	10	5	6	21	7	8	16	31	7	9	7	23	102	82
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	1	7	12	12	5	12	29	13	10	8	31	9	10	10	29	101	80
Pharmacy/RX Medical Benefit	5	0	1	6	0	1	0	1	0	0	1	1	0	1	0	1	9	51
Transportation - Access	3	1	2	6	4	3	4	11	3	10	8	21	13	17	13	43	81	116
Transportation - Behaviour	2	5	2	9	2	8	7	17	9	6	5	20	6	8	6	20	66	100
Transportation - Other	0	3	0	3	1	2	1	4	0	6	4	10	4	3	6	13	30	37
Quality Of Care Grievances	**22**	**33**	**27**	**82**	**29**	**28**	**33**	**90**	**31**	**39**	**24**	**94**	**36**	**31**	**21**	**88**	**354**	**266**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	1	0	0	1	3	4
Access - PCP - DHCS	0	1	1	2	1	0	0	1	0	2	0	2	0	3	1	4	9	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	0	0	0	0	3	0	0	3	0	0	0	0	0	0	1	1	4	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	3	5	10	0	6	5	11	7	2	2	11	6	2	3	11	43	56
PCP Care	4	10	6	20	14	5	11	30	7	9	5	21	7	9	6	22	93	95
PCP Delay	6	9	7	22	6	10	10	26	6	12	12	30	11	10	5	26	104	42
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	4	5	7	16	5	6	6	17	9	8	2	19	7	2	5	14	66	46
Specialist Delay	4	5	1	10	0	1	1	2	2	7	3	12	4	5	0	9	33	15
Exempt Grievances Received	280	201	200	**681**	236	235	166	**637**	161	267	130	**558**	142	131	280	**553**	**2429**	2877
Access - Avail of Appt w/ PCP	4	7	4	**15**	7	6	2	**15**	1	9	1	**11**	4	3	5	**12**	**53**	93
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	1	**1**	1	0	0	**1**	0	0	0	**0**	**2**	2
Access - Avail of Appt w/ Other	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Wait Time - wait too long on telephone	7	1	1	**9**	0	4	1	**5**	1	2	1	**4**	1	1	5	**7**	**25**	35
Access - Wait Time - in office for appt	1	1	1	**3**	3	0	3	**6**	0	0	0	**0**	1	0	0	**1**	**10**	17
Access - Panel Disruption	1	2	5	**8**	4	0	1	**5**	3	0	2	**5**	1	0	6	**7**	**25**	57
Access - Shortage of Providers	0	0	0	**0**	0	1	0	**1**	0	2	0	**2**	0	0	0	**0**	**3**	1
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	1	0	**1**	**2**	0
Access - Geographic/Distance Access PCP	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	1	0	2	**3**	**5**	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	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**2**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	2	0	0	**2**	0	3	0	**3**	0	0	1	**1**	0	0	0	**0**	**6**	17
Attitude/Service - Provider	59	39	23	**121**	19	13	8	**40**	11	9	4	**24**	3	2	8	**13**	**198**	285
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	12
Attitude/Service - Vendor	0	0	4	**4**	0	0	1	**1**	2	3	1	**6**	0	3	1	**4**	**15**	11
Attitude/Service - Health Plan	1	1	1	**3**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**5**	11
Authorization - Authorization Related	2	0	1	**3**	1	1	0	**2**	0	2	1	**3**	1	1	4	**6**	**14**	25
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	6
Eligibility Issue - Member not eligible per Provider	2	4	8	**14**	3	6	2	**11**	0	3	1	**4**	2	1	12	**15**	**44**	37
Health Plan Materials - ID Cards-Not Received	35	18	13	**66**	26	32	14	**72**	16	24	8	**48**	12	14	31	**57**	**243**	235
Health Plan Materials - ID Cards-Incorrect Information on Card	2	0	0	**2**	1	1	0	**2**	0	0	0	**0**	1	0	2	**3**	**7**	7
Health Plan Materials - Other	0	1	2	**3**	0	1	0	**1**	0	0	0	**0**	1	0	1	**2**	**6**	3
Mental Health Related	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	NA
PCP Assignment/Transfer - Health Plan Assignment - Change Request	54	36	41	**131**	59	51	40	**150**	42	81	38	**161**	39	40	108	**187**	**629**	1162
PCP Assignment/Transfer - HCO Assignment - Change Request	60	51	36	**147**	51	33	43	**127**	41	80	34	**155**	26	29	49	**104**	**533**	156
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	1	0	0	**1**	0	1	0	**1**	0	0	2	**2**	**4**	0

CalViva Health Appeals and Grievances Dashboard 2022

PCP Assignment/Transfer - PCP Transfer not Processed	3	1	2	**6**	1	0	2	**3**	0	2	1	**3**	2	1	5	**8**	**20**	19
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	**2**	45
PCP Assignment/Transfer - Mileage Inconvenience	5	3	4	**12**	6	4	0	**10**	1	0	1	**2**	1	1	6	**8**	**32**	58
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	45
Transportation - Access - Provider No Show	14	11	14	**39**	15	15	16	**46**	12	10	6	**28**	9	6	5	**20**	**133**	24
Transportation - Access - Provider Late	4	4	9	**17**	13	12	9	**34**	9	6	1	**16**	6	3	1	**10**	**77**	52
Transportation - Behaviour	10	5	17	**32**	10	22	11	**43**	14	13	14	**41**	8	11	4	**23**	**139**	119
Transportation - Other	1	5	0	**6**	0	3	0	**3**	1	1	0	**2**	1	0	0	**1**	**12**	12
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0	6	**7**	**7**	7
Claims Complaint - Balance Billing from Provider	10	10	14	**34**	14	25	12	**51**	6	16	15	**37**	21	14	16	**51**	**173**	161

CalViva Health Appeals and Grievances Dashboard 2022

Appeals	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**June**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**YTD**
Expedited Appeals Received	0	3	7	10	4	1	2	7	2	8	8	18	3	1	3	7	42	115
Standard Appeals Received	32	27	34	93	38	36	29	103	30	43	51	124	30	23	30	83	403	918
Total Appeals Received	**32**	**30**	**41**	**103**	**42**	**37**	**31**	**110**	**32**	**51**	**59**	**142**	**33**	**24**	**33**	**90**	445	**1033**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	2	0	0	**2**	1	0	0	**1**	0	0	0	**0**	3	3
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**94.7%**	**100.0%**	**100.0%**	**98.1%**	**96.7%**	**100.0%**	**100.0%**	**99.2%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.26%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Resolved Compliant	0	2	6	**8**	6	1	2	**9**	1	8	9	**18**	3	1	3	7	42	114
Expedited Appeals Compliance Rate	**0.0%**	**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%**	**99.1%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0
Standard Appeals Resolved Compliant	53	30	31	114	25	36	36	97	22	36	41	99	47	27	30	104	414	916
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%**	**97.9%**	**100.0%**	**100.0%**	**99.0%**	**99.76%**	**100.0%**
Total Appeals Resolved	**53**	**32**	**37**	**122**	**31**	**37**	**38**	**106**	**23**	**44**	**50**	**117**	**51**	**28**	**33**	**112**	**457**	**1031**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**53**	**32**	**36**	**121**	**31**	**37**	**38**	**106**	**23**	**43**	**49**	**115**	**51**	**28**	**33**	**112**	**454**	1029
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	1	2	2	0	0	2	0	1	0	1	2	0	0	2	7	17
DME	2	1	4	7	3	8	6	17	6	4	5	15	2	4	4	10	49	47
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	1	1	0	0	1	1	0	0	0	0	2	2
Advanced Imaging	20	18	22	60	18	22	23	63	13	25	23	61	23	17	20	60	244	488
Other	5	6	3	14	3	2	1	6	1	5	2	8	2	2	1	5	33	67
Pharmacy/RX Medical Benefit	21	2	0	23	3	4	5	12	1	2	9	12	5	2	4	11	58	362
Surgery	4	5	6	15	2	1	2	5	2	6	9	17	17	3	4	24	61	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**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**2**	**0**	**0**	**0**	**0**	**3**	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	1	1	0	0	0	0	1	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	1	1	0	0	0	0	0	1	0	1	0	0	0	0	2	1
Pharmacy/RX Medical Benefit	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	21	15	17	**53**	16	17	21	54	11	23	21	55	16	8	10	34	196	577
Uphold Rate	**39.6%**	**46.9%**	**45.9%**	**43.4%**	**51.6%**	**45.9%**	**55.3%**	**50.9%**	**47.8%**	**52.3%**	**42.0%**	**47.0%**	**31.4%**	**28.6%**	**30.3%**	**30.4%**	**42.9%**	**56.0%**
Overturns - Full	26	16	20	**62**	13	18	17	**48**	12	21	27	**60**	34	19	21	**74**	244	432
Overturn Rate - Full	**49.1%**	**50.0%**	**54.1%**	**50.8%**	**41.9%**	**48.6%**	**44.7%**	**45.3%**	**52.2%**	**47.7%**	**54.0%**	**51.3%**	**66.7%**	**67.9%**	**63.6%**	**66.1%**	**53.4%**	**41.9%**
Overturns - Partials	2	0	0	**2**	2	1	0	**3**	0	0	1	**1**	1	1	1	**3**	9	12
Overturn Rate - Partial	**3.8%**	**0.0%**	**0.0%**	**1.6%**	**6.5%**	**2.7%**	**0.0%**	**2.8%**	**0.0%**	**0.0%**	**2.0%**	**0.9%**	**2.0%**	**3.6%**	**3.0%**	**2.68%**	**2.0%**	**1.2%**
Withdrawal	4	1	0	**5**	0	1	0	**1**	0	0	1	**1**	0	0	1	1	**8**	10
Withdrawal Rate	**7.5%**	**3.1%**	**0.0%**	**4.1%**	**0.0%**	**2.7%**	**0.0%**	**0.9%**	**0.0%**	**0.0%**	**2.0%**	**0.9%**	**0.0%**	**0.0%**	**3.0%**	**0.9%**	**1.8%**	**1.0%**
Membership	398,468	399,433	401,429		403,065	405,014	405,014		410,130	411,852	413,576		413,576	417,000	417,000			########
Appeals - PTMPM	0.13	0.08	0.09	0.10	0.08	0.09	0.09	0.09	0.06	0.11	0.12	0.09	0.12	0.07	0.08	0.09	0.09	0.24
Grievances - PTMPM	0.21	0.16	0.19	0.19	0.25	0.21	0.25	0.24	0.24	0.28	0.27	0.27	0.29	0.30	0.24	0.27	0.24	0.27

CalViva Health Appeals and Grievances Dashboard 2022 (Fresno County)

Fresno County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2022 YTD**	**2021 YTD**
Expedited Grievances Received	3	4	6	13	4	5	7	16	3	9	2	14	8	5	3	16	59	142
Standard Grievances Received	65	48	91	204	65	81	85	231	69	99	86	254	100	71	72	243	932	1123
Total Grievances Received	**68**	**52**	**97**	**217**	**69**	**86**	**92**	**247**	**72**	**108**	**88**	**268**	**108**	**76**	**75**	**259**	**991**	**1265**
Grievance Ack Letters Sent Noncompliant	2	0	0	2	0	1	0	1	0	1	0	1	0	0	0	0	4	4
Grievance Ack Letter Compliance Rate	**96.9%**	**100.0%**	**100.0%**	**99.0%**	**100.0%**	**98.8%**	**100.0%**	**99.6%**	**100.0%**	**99.0%**	**100.0%**	**99.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**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	3	4	6	13	3	6	6	15	4	8	3	15	8	5	3	16	59	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	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Standard Grievances Resolved Compliant	66	53	54	173	87	72	79	238	82	92	86	260	87	102	72	261	932	894
Standard Grievance Compliance rate	**98.5%**	**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%**	**99.9%**	**100.0%**
Total Grievances Resolved	**70**	**57**	**60**	**187**	**90**	**78**	**85**	**253**	**86**	**100**	**89**	**275**	**95**	**107**	**75**	**277**	**992**	**987**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**50**	**27**	**38**	**115**	**63**	**53**	**56**	**172**	**57**	**68**	**69**	**194**	**67**	**79**	**59**	**205**	**686**	**758**
Access - Other - DMHC	10	4	6	20	12	14	22	48	7	14	14	35	14	12	10	36	139	56
Access - PCP - DHCS	5	3	10	18	6	3	3	12	5	6	9	20	9	4	9	22	72	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	3	1	1	5	11	5	3	19	3	5	0	8	4	8	3	15	47	38
Administrative	8	4	4	16	9	8	3	20	13	6	16	35	10	10	6	26	97	162
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	12	6	6	24	9	4	5	18	6	7	14	27	7	8	6	21	90	73
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	1	7	12	10	5	9	24	11	9	4	24	6	10	7	23	83	61
Pharmacy/RX Medical Benefit	4	0	0	4	0	1	0	1	0	0	0	0	0	1	0	1	6	40
Transportation - Access	2	1	2	5	3	3	3	9	3	10	5	18	9	16	8	33	65	104
Transportation - Behaviour	2	5	2	9	2	8	7	17	9	6	4	19	4	7	5	16	61	90
Transportation - Other	0	2	0	2	1	2	1	4	0	5	3	8	4	3	5	12	26	33
Quality Of Care Grievances	**20**	**30**	**22**	**72**	**27**	**25**	**29**	**81**	**29**	**32**	**20**	**81**	**28**	**28**	**16**	**72**	**306**	**229**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	1	0	0	1	3	3
Access - PCP - DHCS	0	1	1	2	1	0	0	1	0	2	0	2	0	3	1	4	9	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	0	0	0	0	2	0	0	2	0	0	0	0	0	0	1	1	3	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	3	4	8	0	4	5	9	6	1	2	9	4	2	3	9	35	48
PCP Care	4	9	5	18	13	5	9	27	6	6	3	15	5	8	3	16	76	83
PCP Delay	6	9	7	22	6	9	8	23	6	12	11	29	8	8	4	20	94	37
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	4	4	5	13	5	6	6	17	9	7	1	17	6	2	4	12	59	38
Specialist Delay	3	4	0	7	0	1	1	2	2	4	3	9	4	5	0	9	27	12

CalViva Health Appeals and Grievances Dashboard 2022 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	1	6	7	3	0	1	4	2	7	8	17	3	0	2	5	33	96
Standard Appeals Received	28	22	29	79	33	30	20	83	25	28	39	92	24	20	28	72	326	789
Total Appeals Received	**28**	**23**	**35**	**86**	**36**	**30**	**21**	**87**	**27**	**35**	**47**	**109**	**27**	**20**	**30**	**77**	359	**885**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	2
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**96.0%**	**100.0%**	**100.0%**	**98.9%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Resolved Compliant	0	0	5	5	5	0	1	6	1	8	8	17	3	0	2	5	33	95
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**98.9%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	1	0
Standard Appeals Resolved Compliant	47	27	22	96	23	31	31	**85**	14	27	30	**71**	36	21	27	**84**	336	785
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%**	**97.2%**	**100.0%**	**100.0%**	**98.8%**	**99.7%**	**100.0%**
Total Appeals Resolved	**47**	**27**	**27**	**101**	**28**	**31**	**32**	**91**	**15**	**35**	**38**	**88**	**40**	**21**	**29**	**90**	**370**	**881**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**47**	**27**	**26**	**100**	**28**	**31**	**32**	**91**	**15**	**35**	**37**	**87**	**40**	**21**	**29**	**90**	**368**	**880**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	1	2	2	0	0	2	0	1	0	1	2	0	0	2	7	15
DME	2	1	4	7	3	6	5	14	3	4	3	10	2	3	4	9	40	38
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	1	1	0	0	1	1	0	0	0	0	2	2
Advanced Imaging	18	15	14	47	16	21	21	58	10	18	21	49	16	13	16	45	199	436
Other	5	5	2	12	2	1	1	4	1	5	2	8	2	2	1	5	29	58
Pharmacy/RX Medical Benefit	19	1	0	20	3	3	3	9	0	2	5	7	4	0	4	8	44	291
Surgery	2	5	5	12	2	0	1	3	1	5	5	11	14	3	4	21	47	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**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**2**	**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	1	1	0	0	0	0	1	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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Pharmacy/RX Medical Benefit	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	20	13	13	**46**	14	15	18	**47**	8	18	15	**41**	14	7	9	**30**	164	497
Uphold Rate	**42.6%**	**48.1%**	**48.1%**	**45.5%**	**50.0%**	**48.4%**	**56.3%**	**51.6%**	**53.3%**	**51.4%**	**39.5%**	**46.6%**	**35.0%**	**33.3%**	**31.0%**	**33.3%**	**44.3%**	**56.4%**
Overturns - Full	21	13	14	**48**	12	14	14	**40**	7	17	21	**45**	25	13	18	**56**	189	364
Overturn Rate - Full	**44.7%**	**48.1%**	**51.9%**	**47.5%**	**42.9%**	**45.2%**	**43.8%**	**44.0%**	**46.7%**	**48.6%**	**55.3%**	**51.1%**	**62.5%**	**0.0%**	**0.0%**	**62.2%**	**51.1%**	**41.3%**
Overturns - Partials	2	0	0	**2**	2	1	0	**3**	0	0	1	**1**	1	1	1	**3**	9	12
Overturn Rate - Partial	**4.3%**	**0.0%**	**0.0%**	**2.0%**	**7.1%**	**3.2%**	**0.0%**	**3.3%**	**0.0%**	**0.0%**	**2.6%**	**1.1%**	**2.5%**	**4.8%**	**3.4%**	**3.3%**	**2.4%**	**1.4%**
Withdrawal	4	1	0	**5**	0	1	0	**1**	0	0	1	**1**	0	0	1	**1**	8	8
Withdrawal Rate	**8.5%**	**3.7%**	**0.0%**	**5.0%**	**0.0%**	**3.2%**	**0.0%**	**1.1%**	**0.0%**	**0.0%**	**2.6%**	**1.1%**	**0.0%**	**0.0%**	**3.4%**	**1.1%**	**2.2%**	**0.9%**
Membership	321,656	322,473	324,116		325,345	326,706	326,706		330,629	331,857	333,152		333,152	335,572	335,572			**1700076**
Appeals - PTMPM	0.15	0.08	0.08	0.10	0.09	0.09	0.10	0.09	0.05	0.11	0.11	0.09	0.12	0.06	0.09	0.00	0.07	0.19
Grievances - PTMPM	0.22	0.18	0.19	0.19	0.28	0.24	0.26	0.26	0.26	0.30	0.27	0.28	0.29	0.32	0.22	0.00	0.18	0.21

CalViva Health Appeals and Grievances Dashboard 2022 (Kings County)

Kings County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2022 YTD	2021 YTD
Expedited Grievances Received	1	0	1	2	0	0	0	0	0	0	0	0	0	1	0	1	3	15
Standard Grievances Received	3	3	2	8	5	4	2	11	8	12	11	31	7	9	8	24	74	84
Total Grievances Received	**4**	**3**	**3**	**10**	**5**	**4**	**2**	**11**	**8**	**12**	**11**	**31**	**7**	**10**	**8**	**25**	**77**	**99**
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	0	1	2	0	0	0	0	0	0	0	0	0	1	0	1	3	15
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**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	7	2	4	13	2	4	5	11	1	10	15	26	9	8	8	25	75	80
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	**8**	**2**	**5**	**15**	**2**	**4**	**5**	**11**	**1**	**10**	**15**	**26**	**9**	**9**	**8**	**26**	78	**95**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**7**	**1**	**4**	**12**	**2**	**3**	**3**	**8**	**1**	**5**	**12**	**18**	**5**	**8**	**6**	**19**	**57**	**82**
Access - Other - DMHC	3	0	2	5	0	1	1	2	0	1	2	3	2	3	0	5	15	14
Access - PCP - DHCS	1	0	0	1	1	1	1	3	0	0	0	0	0	1	0	1	5	8
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	2	2	1	0	0	1	0	1	0	1	0	1	2	3	7	8
Administrative	1	0	0	1	0	0	0	0	1	0	1	2	0	1	0	1	4	8
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	0	0	0	0	1	0	1	0	1	2	3	0	0	0	0	4	4
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	1	3	4	2	0	2	4	8	5
Pharmacy/RX Medical Benefit	1	0	0	1	0	0	0	0	0	0	1	1	0	0	0	0	2	2
Transportation - Access	1	0	0	1	0	0	1	1	0	0	2	2	0	1	0	1	5	16
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	3	4	17
Transportation - Other	0	1	0	1	0	0	0	0	0	1	0	1	0	0	1	1	3	0
Quality Of Care Grievances	**1**	**1**	**1**	**3**	**0**	**1**	**2**	**3**	**0**	**5**	**3**	**8**	**4**	**1**	**2**	**7**	**21**	**13**
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	1	0	0	1	0	0	0	0	0	1	0	1	2	0	0	2	4	3
PCP Care	0	0	1	1	0	0	0	0	0	1	1	2	1	0	0	1	4	3
PCP Delay	0	0	0	0	0	1	2	3	0	0	1	1	0	1	1	2	6	4
Pharmacy/RX Medical Benefit	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	0	3	1	4	1	0	1	2	6	2
Specialist Delay	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1

CalViva Health Appeals and Grievances Dashboard 2022 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Standard Appeals Received	1	1	0	2	1	1	1	3	1	3	2	6	4	0	0	4	15	44
Total Appeals Received	**1**	**1**	**0**	**2**	**1**	**1**	**1**	**3**	**1**	**3**	**2**	**6**	**4**	**0**	**0**	**4**	15	**48**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**-100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	0	2	0	2	0	2	1	3	0	1	3	4	1	4	0	5	14	47
Standard Appeals Compliance Rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**0**	**2**	**0**	**2**	**0**	**2**	**1**	**3**	**0**	**1**	**3**	**4**	**1**	**4**	**0**	**5**	**14**	**54**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**2**	**0**	**2**	**0**	**2**	**1**	**3**	**0**	**1**	**3**	**4**	**1**	**4**	**0**	**5**	**14**	**54**
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	5
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	4
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	0	2	0	2	0	0	0	0	0	0	0	0	1	2	0	3	5	13
Other	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	4
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	1	1	0	0	1	1	0	1	0	1	3	26
Surgery	0	0	0	0	0	1	0	1	0	1	2	3	0	0	0	0	4	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/RX Medical Benefit	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	0	1	0	**1**	0	1	1	**2**	0	0	2	**2**	0	0	0	**0**	5	27
Uphold Rate	**0.0%**	**50.0%**	**0.0%**	**50.0%**	**0.0%**	**50.0%**	**100.0%**	**66.7%**	**0.0%**	**0.0%**	**66.7%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**35.7%**	**50.0%**
Overturns - Full	0	1	0	**1**	0	1	0	**1**	0	1	1	**2**	1	4	0	**5**	9	23
Overturn Rate - Full	**0.0%**	**50.0%**	**0.0%**	**50.0%**	**0.0%**	**50.0%**	**0.0%**	**33.3%**	**0.0%**	**100.0%**	**33.3%**	**50.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**64.3%**	**42.6%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.7%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.7%**
Membership	34,008	34,122	34,280		34,457	34,780	34,780		35,216	35,453	35,619		35,619	36,051	36,051			**259758**
Appeals - PTMPM	-	0.06	-	0.02	-	0.06	0.03	0.03	-	0.03	0.08	0.04	0.03	0.11	-	0.05	0.03	0.15
Grievances - PTMPM	0.24	0.06	0.15	0.15	0.06	0.12	0.14	0.11	0.03	0.28	0.42	0.24	0.25	0.25	0.22	0.24	0.18	0.28

Madera County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2022 YTD	2021 YTD
Expedited Grievances Received	0	0	1	1	1	2	2	5	2	0	2	4	0	0	2	2	12	15
Standard Grievances Received	7	7	9	23	5	5	14	24	7	6	13	26	4	11	13	28	101	109
Total Grievances Received	**7**	**7**	**10**	**24**	**6**	**7**	**16**	**29**	**9**	**6**	**15**	**30**	**4**	**11**	**15**	**30**	**113**	**124**
Grievance Ack Letters Sent Noncompliant	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**85.7%**	**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	0	1	1	1	2	2	5	2	0	2	4	0	0	2	2	12	15
Expedited Grievance Compliance rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**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	1
Standard Grievances Resolved Compliant	6	5	9	20	9	3	8	20	11	6	6	23	14	8	13	35	98	110
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	**6**	**5**	**10**	**21**	**10**	**5**	**10**	**25**	**13**	**6**	**8**	**27**	**14**	**8**	**15**	**37**	**110**	**126**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**5**	**3**	**6**	**14**	**8**	**3**	**8**	**19**	**11**	**4**	**7**	**22**	**10**	**6**	**12**	**28**	**83**	**100**
Access - Other - DMHC	2	1	1	4	2	3	1	6	3	3	3	9	0	2	1	3	22	17
Access - PCP - DHCS	0	0	1	1	0	0	2	2	1	0	1	2	1	0	2	3	8	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	0	0	0	0	1	0	1	2	1	0	0	1	0	0	0	0	3	13
Administrative	1	1	3	5	1	0	0	1	3	1	0	4	3	3	2	8	18	19
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	2	1	0	3	1	0	1	2	1	0	0	1	0	1	1	2	8	11
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	2	0	3	5	2	0	1	3	1	0	1	2	10	3
Pharmacy/RX Medical Benefit	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	3
Transportation - Access	0	0	0	0	1	0	0	1	0	0	1	1	4	0	5	9	11	11
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	17
Transportation - Other	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0
Quality Of Care Grievances	**1**	**2**	**4**	**7**	**2**	**2**	**2**	**6**	**2**	**2**	**1**	**5**	**4**	**2**	**3**	**9**	**27**	**26**
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	1	0	0	1	0	0	0	0	0	0	0	0	1	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	1	1	0	2	0	2	1	0	0	1	0	0	0	0	4	7
PCP Care	0	1	0	1	1	0	2	3	1	2	1	4	1	1	3	5	13	10
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	3	1	0	4	4	5
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	1	2	3	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Specialist Delay	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	1

CalViva Health Appeals and Grievances Dashboard 2022 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	2	1	3	1	1	1	3	0	1	0	1	0	1	1	2	9	13
Standard Appeals Received	3	4	5	12	4	5	8	17	4	12	10	26	2	3	2	7	62	81
Total Appeals Received	**3**	**6**	**6**	**15**	**5**	**6**	**9**	**20**	**4**	**13**	**10**	**27**	**2**	**4**	**3**	**9**	71	**94**
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	0	2	1	3	1	1	1	3	0	0	1	1	0	1	1	2	9	13
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**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	6	1	9	16	2	3	4	**9**	8	8	8	**24**	10	2	3	**15**	64	81
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	**6**	**3**	**10**	**19**	**3**	**4**	**5**	**12**	**8**	**8**	**9**	**25**	**10**	**3**	**4**	**17**	**73**	**94**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**6**	**3**	**10**	**19**	**3**	**4**	**5**	**12**	**8**	**7**	**9**	**24**	**10**	**3**	**4**	**17**	**72**	**94**
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	0
DME	0	0	0	0	0	2	1	3	3	0	2	5	0	0	0	0	8	5
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	2	1	8	11	2	1	2	5	3	7	2	12	6	2	4	12	40	39
Other	0	1	1	2	1	0	0	1	0	0	0	0	0	0	0	0	3	3
Pharmacy/RX Medical Benefit	2	1	0	3	0	1	1	2	1	0	3	4	1	1	0	2	11	44
Surgery	2	0	1	3	0	0	1	1	1	0	2	3	3	0	0	3	10	3
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**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**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	1	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	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	1	4	**6**	2	1	2	**5**	3	5	4	**12**	2	1	1	**4**	27	57
Uphold Rate	**16.7%**	**33.3%**	**40.0%**	**31.6%**	**66.7%**	**25.0%**	**40.0%**	**41.7%**	**37.5%**	**62.5%**	**44.4%**	**48.0%**	**20.0%**	**33.3%**	**25.0%**	**23.5%**	**37.0%**	**60.6%**
Overturns - Full	5	2	6	**13**	1	3	3	**7**	5	3	5	**13**	8	2	3	**13**	46	34
Overturn Rate - Full	**83.3%**	**66.7%**	**60.0%**	**68.4%**	**33.3%**	**75.0%**	**60.0%**	**58.3%**	**62.5%**	**37.5%**	**55.6%**	**52.0%**	**80.0%**	**66.7%**	**75.0%**	**76.47%**	**63.0%**	**36.2%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.1%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.1%**
Membership	42,804	42,838	43,033		43,263	43,528	43,528		44,285	44,542	44,805		44,805	45,377	45,377			**328873**
Appeals - PTMPM	0.14	0.07	0.23	0.15	0.07	0.09	0.11	0.09	0.18	0.18	0.20	0.19	0.22	0.07	0.09	0.13	0.14	0.21
Grievances - PTMPM	0.14	0.12	0.23	0.16	0.23	0.11	0.23	0.19	0.29	0.13	0.18	0.20	0.31	0.18	0.33	0.27	0.21	0.28

CalViva SPD only																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2022 YTD**	**2021 YTD**
Expedited Grievances Received	1	2	2	5	2	1	3	6	4	3	1	8	4	1	1	6	25	59
Standard Grievances Received	20	22	29	71	23	25	36	84	26	41	35	102	34	29	30	93	350	504
Total Grievances Received	**21**	**24**	**31**	76	**25**	**26**	**39**	**90**	**30**	**44**	**36**	**110**	**38**	**30**	**31**	**99**	**375**	**563**
Grievance Ack Letters Sent Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Grievance Ack Letter Compliance Rate	**95.0%**	**100.0%**	**100.0%**	**98.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**	**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	1	2	2	5	2	1	2	5	5	3	1	9	4	1	1	6	25	59
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	27	18	23	68	28	25	26	79	34	33	35	102	36	39	32	107	356	505
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	**28**	**20**	**25**	**73**	**30**	**26**	**28**	**84**	**39**	**36**	**36**	**111**	**40**	**40**	**33**	**113**	381	**564**
Grievance Descriptions - Resolved Cases	**28**	**20**	**25**	**73**	**30**	**26**	**28**	**84**	**39**	**36**	**36**	**111**	**40**	**40**	**33**	**113**	381	**564**
Access to primary care	2	5	3	10	0	8	1	9	8	8	5	21	5	3	3	11	51	32
Access to specialists	5	2	3	10	3	2	1	6	1	11	18	30	2	10	14	26	72	45
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	5	6	7	18	12	4	12	28	10	4	2	16	10	10	7	27	89	186
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	4	1	2	7	7	3	6	16	5	2	2	9	6	2	1	9	41	74
QOS Non Access	12	6	10	18	8	9	8	25	15	11	9	35	17	15	8	40	118	210
Exempt Grievances Received	10	7	2	**19**	8	6	1	**15**	125	4	2	**131**	5	5	5	**15**	**180**	78
Access - Avail of Appt w/ PCP	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**2**	0
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**1**	1
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	1	0	0	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**2**	1
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	3	0	0	**3**	0	0	0	**0**	**3**	0
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	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	3
Attitude/Service - Provider	2	0	0	**2**	0	0	0	**0**	11	0	0	**11**	2	0	0	**2**	**15**	6
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Vendor	0	0	1	**1**	0	0	0	**0**	2	0	0	**2**	0	1	0	**1**	**4**	1
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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**	0
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	1
Health Plan Materials - ID Cards-Not Received	2	2	0	**4**	3	1	0	**4**	16	1	0	**17**	0	0	1	**1**	**26**	16
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	2	**2**	**2**	3
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
PCP Assignment/Transfer - Health Plan Assignment - Change Request	3	0	1	**4**	3	3	0	**6**	42	1	0	**43**	2	3	0	**5**	**58**	20
PCP Assignment/Transfer - HCO Assignment - Change Request	1	2	0	**3**	1	1	0	**2**	41	1	2	**44**	0	0	1	**1**	**50**	6
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	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	1
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	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**	0
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**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	10
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0

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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
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**	0
Claims Complaint - Balance Billing from Provider	1	1	0	**2**	1	0	1	**2**	6	1	0	**7**	1	1	0	**2**	**13**	4

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	0	2	2	1	0	0	1	1	0	0	1	4	0	0	0	4	20
Standard Appeals Received	8	5	10	23	12	8	6	26	6	14	7	27	0	6	8	0	76	200
Total Appeals Received	**8**	**5**	**12**	**25**	**13**	**8**	**6**	**27**	**7**	**14**	**7**	**28**	**0**	**6**	**8**	**0**	80	**220**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**91.7%**	**100.0%**	**100.0%**	**96.2%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**98.7%**	**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	0	7	1	8	2	0	0	2	0	1	0	1	0	0	0	0	11	19
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	14	0	8	22	6	12	8	**26**	4	6	15	**25**	7	2	7	**16**	89	185
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**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**	**0**	**9**	**23**	**8**	**12**	**8**	**28**	**4**	**7**	**15**	**26**	**7**	**2**	**7**	**16**	**93**	**203**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**10**	**7**	**9**	**26**	**8**	**12**	**8**	**28**	**4**	**7**	**15**	**26**	**7**	**2**	**7**	**16**	**96**	**204**
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	1	0	0	1	1	7
DME	2	1	2	5	2	6	4	12	3	1	3	7	0	0	2	2	26	35
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	2
Advanced Imaging	3	4	5	12	5	5	3	13	1	4	4	9	2	2	5	9	43	59
Other	3	0	0	3	0	1	0	1	0	2	1	3	1	0	0	1	8	13
Pharmacy/RX Medical Benefit	1	0	0	1	1	0	1	2	0	0	3	3	0	0	0	0	6	84
Surgery	1	2	2	5	0	0	0	0	0	0	3	3	3	0	0	3	11	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**	**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/RX Medical Benefit	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	1	2	**8**	3	5	3	**11**	2	2	4	**8**	1	1	2	**4**	31	96
Uphold Rate	**35.7%**	**0.0%**	**22.2%**	**34.8%**	**37.5%**	**41.7%**	**37.5%**	**39.3%**	**50.0%**	**28.6%**	**26.7%**	**30.8%**	**14.3%**	**50.0%**	**28.6%**	**25.0%**	**33.3%**	**47.3%**
Overturns - Full	9	6	7	**22**	4	6	5	**15**	2	5	9	**16**	6	1	5	**12**	65	99
Overturn Rate - Full	**64.3%**	**0.0%**	**77.8%**	**95.7%**	**50.0%**	**50.0%**	**62.5%**	**53.6%**	**50.0%**	**71.4%**	**60.0%**	**61.5%**	**85.7%**	**50.0%**	**71.4%**	**75.0%**	**69.9%**	**48.77%**
Overturns - Partials	0	0	0	**0**	1	1	0	**2**	0	0	1	**1**	0	0	0	**0**	3	6
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**12.5%**	**8.3%**	**0.0%**	**7.1%**	**0.0%**	**0.0%**	**6.7%**	**3.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.2%**	**3.0%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	1	3
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.7%**	**3.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.1%**	**1.5%**
Membership	34,882	34,376	35,147		35,225	35,420	35,420		35,896	36,243	36,243		36,243	36,589	36,589			**69295**
Appeals - PTMPM	0.40	-	0.26	0.00	0.23	0.34	0.23	0.00	0.11	0.19	0.41	0.24	0.19	0.05	0.19	0.15	0.10	0.29
Grievances - PTMPM	0.80	0.58	0.71	0.00	0.85	0.73	0.79	0.00	1.09	0.99	0.99	1.02	1.10	1.09	0.90	1.03	0.51	0.80

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/RX Medical Benefit	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/RX Medical Benefit	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/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, 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/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, 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 #12

Attachment 12.D

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 12/01/2022 to 12/31/2022

Report created 2/3/2023

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

Exhibits:

Contact Information

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

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 12/01/2022 to 12/31/2022
Report created 2/3/2023

ER utilization based on Claims data	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Qtr Trend	CY- 2021	YTD-2022	YTD-Trend
MEMBERSHIP														Quarterly Averages									Annual Averages		
Expansion Mbr Months	106,575	107,230	108,176	109,207	109,922	110,761	112,682	113,691	114,675	115,404	116,298	116,368		96,859	99,807	102,249	104,190	107,327	109,963	113,683	116,023		100,776	111,749	
Family/Adult/Other Mbr Mos	267,472	267,639	268,581	268,984	270,176	270,908	272,096	272,799	273,318	273,807	275,215	276,086		258,489	260,623	262,266	263,450	267,897	270,023	272,738	275,036		261,207	271,423	
SPD Mbr Months	36,205	36,237	36,332	36,428	36,617	36,824	36,990	37,109	37,226	37,348	37,488	37,496		35,231	35,313	35,577	36,044	36,258	36,623	37,108	37,444		35,541	36,858	
COUNTS																									
Admits - Count	2,233	1,927	2,262	2,101	2,234	2,151	2,274	2,307	2,369	2,266	2,297	2,155		2,043	2,193	2,280	2,264	2,141	2,162	2,317	2,239		2,195	2,215	
Expansion	626	533	654	626	705	667	715	671	691	675	641	600		560	620	648	614	604	666	692	639		611	650	
Family/Adult/Other	1,083	933	1,112	969	1,008	999	1,048	1,136	1,152	1,145	1,210	1,118		1,005	1,034	1,124	1,130	1,043	992	1,112	1,158		1,073	1,076	
SPD	518	459	490	505	521	482	507	498	517	444	441	435		469	534	504	515	489	503	507	440		506	485	
Admits Acute - Count	1,615	1,383	1,611	1,543	1,624	1,526	1,580	1,561	1,654	1,567	1,657	1,493		1,401	1,566	1,599	1,583	1,536	1,564	1,598	1,572		1,538	1,568	
Expansion	559	466	569	531	602	568	598	559	577	563	538	481		479	539	558	526	531	567	578	527		526	551	
Family/Adult/Other	570	487	590	540	540	507	507	535	600	589	699	599		491	532	583	586	549	529	547	629		548	564	
SPD	486	429	452	471	482	451	475	467	476	415	418	413		431	495	458	471	456	468	473	415		464	453	
Readmit 30 Day - Count	229	214	207	190	213	212	237	223	223	228	189	162		218	234	220	228	217	205	228	193		225	211	
Expansion	89	88	85	70	90	75	97	93	90	89	72	54		76	78	78	84	87	78	93	72		79	83	
Family/Adult/Other	44	45	38	35	52	39	41	37	46	52	47	26		48	43	52	44	42	42	41	42		47	42	
SPD	96	81	84	85	71	98	99	93	87	87	70	82		93	113	91	101	87	85	93	80		100	86	
**ER Visits - Count	14,074	11,232	14,092	13,736	16,605	15,040	14,229	14,027	13,933	14,188	14,515	8,149		10,013	13,167	14,274	12,785	13,133	15,127	14,063	12,284		12,560	13,652	
Expansion	3,925	3,006	3,738	3,613	4,200	4,069	4,131	4,002	3,634	3,581	3,415	1,920		3,019	3,524	3,582	3,052	3,556	3,961	3,922	2,972		3,294	3,603	
Family/Adult/Other	8,674	6,997	8,893	8,576	10,635	9,333	8,411	8,368	8,706	8,946	9,468	5,445		5,595	7,435	8,160	7,390	8,188	9,515	8,495	7,953		7,145	8,538	
SPD	1,446	1,193	1,441	1,478	1,725	1,622	1,662	1,633	1,576	1,641	1,609	774		1,205	1,415	1,387	1,243	1,360	1,608	1,624	1,341		1,313	1,483	
PER/K																									
Admits Acute - PTMPY	47.2	40.4	46.8	44.6	46.7	43.7	44.9	44.2	46.7	44.1	46.3	41.6		43.0	47.5	48.0	47.1	44.8	45.0	45.3	44.0		46.4	44.8	
Expansion	62.9	52.1	63.1	58.3	65.7	61.5	63.7	59.0	60.4	58.5	55.5	49.6		59.3	64.8	65.5	60.6	59.4	61.9	61.0	54.5		62.6	59.2	
Family/Adult/Other	25.6	21.8	26.4	24.1	24.0	22.5	22.4	23.5	26.3	25.8	30.5	26.0		22.8	24.5	26.7	26.7	24.6	23.5	24.1	27.4		25.2	24.9	
SPD	161.1	142.1	149.3	155.2	158.0	147.0	154.1	151.0	153.4	133.3	133.8	132.2		146.8	168.1	154.5	156.7	150.8	153.3	152.8	133.1		156.5	147.5	
Bed Days Acute - PTMPY	267.3	221.0	228.4	230.1	244.1	227.6	228.6	217.7	232.9	224.7	238.0	210.0		245.1	236.1	270.4	259.3	238.9	233.9	226.4	224.2		252.8	230.8	
Expansion	342.9	310.7	356.0	317.9	359.4	323.2	339.4	301.4	353.6	348.3	334.7	285.0		361.1	339.8	409.6	371.4	336.5	333.5	331.5	322.6		370.8	330.9	
Family/Adult/Other	109.2	88.2	90.3	90.0	100.3	92.4	80.0	79.9	93.3	87.7	113.2	97.5		107.6	100.0	124.5	112.3	95.9	94.2	84.4	99.5		111.1	93.5	
SPD	1,213.8	936.2	870.6	1,001.4	960.2	936.6	985.2	975.0	886.8	848.6	853.4	806.8		936.0	948.2	946.6	1,009.9	1,006.7	966.0	948.9	836.2		960.4	938.7	
ALOS Acute	5.7	5.5	4.9	5.2	5.2	5.2	5.1	4.9	5.0	5.1	5.1	5.0		5.7	5.0	5.6	5.5	5.3	5.2	5.0	5.1		5.4	5.2	
Expansion	5.4	6.0	5.6	5.4	5.5	5.3	5.3	5.1	5.9	6.0	6.0	5.7		6.1	5.2	6.3	6.1	5.7	5.4	5.4	5.9		5.9	5.6	
Family/Adult/Other	4.3	4.0	3.4	3.7	4.2	4.1	3.6	3.4	3.5	3.4	3.7	3.7		4.7	4.1	4.7	4.2	3.9	4.0	3.5	3.6		4.4	3.8	
SPD	7.5	6.6	5.8	6.5	6.1	6.4	6.4	6.5	5.8	6.4	6.4	6.1		6.4	5.6	6.1	6.4	6.7	6.3	6.2	6.3		6.1	6.4	
Readmit % 30 Day	10.3%	11.1%	9.2%	9.0%	9.5%	9.9%	10.4%	9.7%	9.4%	10.1%	8.2%	7.5%		10.7%	10.7%	9.7%	10.1%	10.1%	9.5%	9.8%	8.6%		10.3%	9.5%	
Expansion	14.2%	16.5%	13.0%	11.2%	12.8%	11.2%	13.6%	13.9%	13.0%	13.2%	11.2%	9.0%		13.6%	12.5%	12.0%	13.7%	14.5%	11.8%	13.5%	11.2%		12.9%	12.7%	
Family/Adult/Other	4.1%	4.8%	3.4%	3.6%	5.2%	3.9%	3.9%	3.3%	4.0%	4.5%	3.9%	2.3%		4.8%	4.2%	4.6%	3.9%	4.1%	4.2%	3.7%	3.6%		4.4%	3.9%	
SPD	18.5%	17.6%	17.1%	16.8%	13.6%	20.3%	19.5%	18.7%	16.8%	19.6%	15.9%	18.9%		19.9%	21.2%	18.0%	19.5%	17.8%	16.8%	18.3%	18.1%		19.7%	17.8%	
**ER Visits - PTMPY	411.5	327.8	409.3	397.4	477.9	431.0	404.6	397.2	393.0	398.9	405.8	227.3		307.5	399.1	428.0	379.9	382.9	435.5	398.2	343.8		379.0	389.8	
Expansion	441.9	336.4	414.7	397.0	458.5	440.8	439.9	422.4	380.3	372.4	352.4	198.0		374.0	423.7	420.4	351.5	397.6	432.2	414.0	307.4		392.3	386.9	
Family/Adult/Other	389.2	313.7	397.3	382.6	472.4	413.4	370.9	368.1	382.2	392.1	412.8	236.7		259.8	342.3	373.4	336.6	366.8	422.8	373.8	347.0		328.3	377.5	
SPD	479.3	395.1	475.9	486.9	565.3	528.6	539.2	528.1	508.0	527.3	515.0	247.7		410.3	481.0	467.7	413.9	450.1	527.0	525.1	429.9		443.1	482.9	
Services	TAT Compliance Goal: 100%													TAT Compliance Goal: 100%									TAT Compliance Goal: 100%		
Preservice Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		99.3%	100.0%	88.0%	98.0%	100.0%	100.0%	100.0%	100.0%				
Preservice Urgent	100.0%	98.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		98.0%	99.3%	98.7%	98.7%	99.3%	99.1%	99.1%	100.0%				
Postservice	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.7%	100.0%	99.3%	98.0%	100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	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%	100.0%	99.3%	100.0%	99.1%	100.0%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	100.0%	88.9%	87.9%	95.5%	100.0%	100.0%	93.3%	96.0%	100.0%		98.5%	100.0%	85.7%	98.4%	100.0%	91.5%	98.8%	96.0%				
Deferrals - Urgent	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	N/A	100.0%	100.0%	N/A	100.0%	N/A		100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	null	null	null	null	null	null	null	null	null	null	null	null		null	null	null	null	null	null	null	null				
	CCS ID RATE													CCS ID RATE									CCS ID RATE		
CCS %	8.82%	8.84%	8.40%	8.89%	8.85%	8.41%	8.36%	8.30%	8.27%	8.21%	8.57%	8.53%		8.24%	8.24%	8.28%	8.40%	8.69%	8.72%	8.31%	8.44%		8.27%	8.54%	
	Perinatal Case Management													Perinatal Case Management									Perinatal Case Management		
Total Number Of Referrals	147	147	178	190	199	209	130	184	162	148	126	112		549	398	413	450	472	598	476	386		1,810	1,932	
Pending	0	0	0	1	1	0	0	0	1	0	0	21		0	0	2	7	0	2	1	21		9	24	
Ineligible	6	9	3	7	15	10	2	5	3	6	7	6		38	32	7	19	18	32	10	19		96	79	
Total Outreached	141	138	175	182	183	199	128	179	158	142	119	85		511	366	404	424	454	564	465	346		1,705	1,829	
Engaged	35	49	73	75	73	76	37	62	84	63	46	28		119	99	102	71	157	224	183	137		391	701	
Engagement Rate	25%	36%	42%	41%	40%	38%	29%	35%	53%	44%	39%	33%		23%	27%	25%	17%	35%	40%	39%	40%		23%	38%	
New Cases Opened	35	49	73	75	73	76	37	62	84	63	46	28		119	99	102	71	157	224	183	137		391	701	
Total Cases Managed	225	227	270	283	309	311	313	314	344	337	327	280		344	354	336	307	344	432	496	410		621	887	
Total Cases Closed	44	30	62	46	73	35	61	52	69	56	73	51		95	114	104	118	136	154	182	180		431	652	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 12/01/2022 to 12/31/2022
Report created 2/3/2023

ER utilization based on Claims data	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Qtr Trend	CY- 2021	YTD-2022	YTD-Trend
Cases Remained Open	170	188	199	221	231	263	247	256	263	278	249	224		225	115	166	180	199	263	263	224		180	224	
Integrated Case Management																									
Total Number Of Referrals	90	83	115	137	135	231	190	223	209	221	158	150		352	305	372	284	288	503	622	529		1,313	1,942	
Pending	0	0	1	0	1	0	0	0	0	3	1	19		0	0	2	12	1	1	0	23		14	25	
Ineligible	9	4	3	4	10	12	11	17	14	14	8	10		35	17	26	29	16	26	42	32		107	116	
Total Outreached	81	79	111	133	124	219	179	206	195	204	149	121		317	288	344	243	271	476	580	474		1,192	1,801	
Engaged	48	52	85	84	85	172	153	150	142	133	97	98		224	192	205	169	185	341	445	328		790	1,299	
Engagement Rate	59%	66%	77%	63%	69%	79%	85%	73%	73%	65%	65%	81%		71%	67%	60%	70%	68%	72%	77%	69%		66%	72%	
Total Screened and Refused/Decline	4	4	11	14	17	15	13	18	23	28	17	15		28	34	39	26	19	46	54	60		127	179	
Unable to Reach	29	23	15	35	22	32	13	38	30	43	35	8		65	62	100	48	67	89	81	86		275	323	
New Cases Opened	48	52	85	84	85	172	153	150	142	133	97	98		224	192	205	169	185	341	445	328		790	1,299	
Total Cases Closed	78	46	57	64	82	92	101	128	104	129	143	123		171	184	222	238	181	238	333	395		815	1,147	
Cases Remained Open	233	235	267	293	287	368	414	437	471	469	429	411		330	166	224	258	267	368	471	411		258	411	
Total Cases Managed	322	296	334	366	386	475	535	581	590	616	588	540		526	537	566	516	458	622	900	818		1104	1579	
Critical-Complex Acuity	39	38	35	40	38	43	42	53	59	61	60	52		74	64	61	53	44	60	73	70		120	120	
High/Moderate/Low Acuity	283	258	299	326	348	432	493	528	535	555	528	488		452	473	505	463	414	562	827	748		984	1459	
Transitional Case Management																									
Total Number Of Referrals	86	91	75	75	115	136	141	115	180	125	133	105		573	663	354	279	252	326	436	363		1,869	1,377	
Pending	0	0	0	0	0	0	0	0	0	0	0	5		0	0	0	5	0	0	0	5		5	5	
Ineligible	6	10	5	4	5	15	8	5	8	3	7	8		70	84	41	28	21	24	21	18		223	84	
Total Outreached	80	81	70	71	110	121	133	110	172	122	126	92		503	579	313	246	231	302	415	340		1,641	1,288	
Engaged	53	54	51	49	82	82	124	105	146	107	92	65		275	408	236	178	158	213	375	264		1,097	1,010	
Engagement Rate	66%	67%	73%	69%	75%	68%	93%	95%	85%	88%	73%	71%		55%	70%	75%	72%	68%	71%	90%	78%		67%	78%	
Total Screened and Refused/Decline	1	3	0	1	5	6	3	1	14	5	9	11		52	26	11	8	4	12	18	25		97	59	
Unable to Reach	26	24	19	21	23	33	6	4	12	10	25	16		176	145	66	60	69	77	22	51		447	219	
New Cases Opened	53	54	51	49	82	82	124	105	146	107	92	65		275	408	236	178	158	213	375	264		1,097	1,010	
Total Cases Closed	49	30	59	46	60	114	82	120	136	113	106	82		247	387	315	186	138	220	338	301		1,135	997	
Cases Remained Open	45	75	71	70	80	56	100	83	87	75	55	45		92	60	40	50	71	56	87	45		50	45	
Total Cases Managed	106	113	133	123	158	188	200	217	245	206	180	135		366	487	388	242	214	297	579	372		1214	1127	
High/Moderate/Low Acuity	106	113	133	123	158	188	200	217	245	206	180	135		366	487	388	242	214	297	579	372		1214	1127	
Palliative Care																									
Total Number Of Referrals	7	7	10	9	10	13	9	21	21	17	7	15		42	42	34	37	24	32	51	39		155	146	
Pending	0	0	0	0	0	0	0	0	0	0	0	3		0	0	0	3	0	0	0	3		3	3	
Ineligible	3	6	2	2	1	4	1	8	8	5	0	6		14	12	10	18	11	7	17	11		54	46	
Total Outreached	4	1	8	7	9	9	8	13	13	12	7	6		28	30	24	16	13	25	34	25		98	97	
Engaged	3	1	5	6	5	8	5	11	7	7	6	6		20	20	20	12	9	19	23	19		72	70	
Engagement Rate	75%	100%	63%	86%	56%	89%	63%	85%	54%	58%	86%	100%		71%	67%	83%	75%	69%	76%	68%	76%		73%	72%	
Total Screened and Refused/Decline	0	0	2	0	1	1	1	0	4	4	0	0		6	6	3	3	2	2	5	4		18	13	
Unable to Reach	1	0	1	1	3	0	2	2	2	1	1	0		2	4	1	1	2	4	6	2		8	14	
New Cases Opened	3	1	5	6	5	8	5	11	7	7	6	6		20	20	20	12	9	19	23	19		72	70	
Total Cases Closed	11	9	3	6	1	5	4	7	4	7	9	3		15	19	20	21	23	12	15	19		75	69	
Cases Remained Open	80	74	73	74	77	82	83	86	92	87	86	92		91	46	71	83	73	82	92	92		83	92	
Total Cases Managed	94	84	79	84	83	90	89	96	97	99	96	95		114	116	118	111	99	97	114	111		166	167	
Behavioral Health Case Management																									
Total Number Of Referrals	73	100	122	110	107	101	90	111	69	70	65	79		251	262	292	305	295	318	270	214		1,110	1,097	
Pending	0	0	0	0	0	0	0	0	0	0	0	8		0	0	0	14	0	0	0	8		14	8	
Ineligible	8	13	4	4	4	10	4	8	1	0	2	4		12	7	13	12	25	18	13	6		44	62	
Total Outreached	65	87	118	106	103	91	86	103	68	70	63	67		239	255	279	279	270	300	257	200		1,052	1,027	
Engaged	44	50	70	71	73	59	56	74	45	46	43	51		115	122	151	149	164	203	175	140		537	682	
Engagement Rate	68.0%	57.0%	59.0%	67.0%	71.0%	65%	65%	72%	66%	66%	68%	76%		48%	48%	54%	53%	61%	68%	68%	70%		51%	66%	
Total Screened and Refused/Decline	0	2	9	4	3	5	7	4	2	4	4	1		5	1	1	2	11	12	13	9		9	45	
Unable to Reach	21	35	39	31	27	27	23	25	21	20	16	15		119	132	127	128	95	85	69	51		506	300	
New Cases Opened	44	50	70	71	73	59	56	74	45	46	43	51		115	122	151	149	164	203	175	140		537	682	
Total Cases Closed	35	43	56	39	51	52	73	73	71	61	55	32		105	107	148	155	134	142	217	148		515	641	
Cases Remained Open	123	133	149	176	200	212	171	193	171	151	145	160		101	80	91	116	149	212	171	160		116	160	
Total Cases Managed	172	187	216	227	261	267	273	276	248	222	202	199		220	236	280	278	293	359	444	316		640	809	
Critical-Complex Acuity	12	11	12	13	12	12	12	7	9	9	11	7		11	15	12	14	18	15	17	12		28	30	
High/Moderate/Low Acuity	160	176	204	214	249	255	261	269	239	213	191	192		209	221	268	264	275	344	427	304		612	779	

Item #12

Attachment 12.E

Executive Dashboard

	2021	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022
Month	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
CVH Members													
Fresno	317,500	321,656	322,473	324,116	325,345	326,706	328,315	330,629	331,857	333,152	334,058	335,572	336,359
Kings	33,378	34,008	34,122	34,280	34,457	34,780	34,935	35,216	35,453	35,619	35,804	36,051	36,208
Madera	42,247	42,804	42,838	43,033	43,263	43,528	43,819	44,285	44,542	44,805	44,997	45,377	45,484
Total	393,125	398,468	399,433	401,429	403,065	405,014	407,069	410,130	411,852	413,576	414,859	417,000	418,051
SPD	34,783	34,882	34,976	35,147	35,225	35,420	35,710	35,896	36,079	36,243	36,409	36,589	36,848
CVH Mrkt Share	69.20%	68.85%	68.79%	68.74%	68.66%	68.61%	68.58%	68.41%	68.39%	68.38%	68.34%	68.29%	68.23%
ABC Members													
Fresno	128,522	132,511	133,212	134,230	135,210	136,115	137,062	139,004	139,689	140,370	141,093	142,029	142,820
Kings	22,078	22,652	22,758	22,853	22,985	23,185	23,312	23,622	23,735	23,794	23,857	24,011	24,185
Madera	24,366	25,154	25,242	25,470	25,754	26,023	26,168	26,745	26,935	27,089	27,242	27,552	27,692
Total	174,966	180,317	181,212	182,553	183,949	185,323	186,542	189,371	190,359	191,253	192,192	193,592	194,697
Default													
Fresno	642	770	690	803	762	707	576	566	693	630			
Kings	100	158	143	136	144	186	138	133	159	144			
Madera	87	126	106	106	110	106	82	101	128	90			
County Share of Choice as %													
Fresno	57.80%	56.40%	56.50%	59.80%	58.30%	62.40%	61.80%	65.10%	64.80%	62.60%			
Kings	47.90%	54.20%	44.70%	51.50%	52.70%	57.10%	56.50%	47.90%	58.90%	55.40%			
Madera	56.80%	54.40%	53.50%	56.30%	58.60%	64.00%	69.50%	61.60%	73.30%	72.40%			
Voluntary Disenrollment's													
Fresno	477	439	346	405	464	481	458	389	448	414			
Kings	21	52	44	45	36	60	35	48	46	63			
Madera	42	64	48	50	66	79	53	53	43	60			

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	**5 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communications and Systems. Servers were succesfully upgraded in December 2022 and January 2023. No significant concerns arised after the upgrade. The upgrade of the spam filters are still in progress. Ongoing risk management activities are also being deployed on an ongoing basis.		

Member Call Center CalViva Health Website		**Year**	**2021**	**2021**	**2022**	**2022**	**2022**	**2022**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**28,736**	**26,972**	**31,993**	**26,858**	**26,747**	**24,875**
		# of Calls Answered	**28,391**	**26,570**	**31,509**	**26,465**	**26,495**	**24,707**
		Abandonment Level (Goal < 5%)	**1.20%**	**1.50%**	**1.50%**	**1.50%**	**0.90%**	**0.70%**
		Service Level (Goal 80%)	**87%**	**92%**	**95%**	**94%**	**88%**	**96%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,182**	**1,076**	**1,365**	**1,511**	**1,082**	**602**
		# of Calls Answered	**1,166**	**1,068**	**1,352**	**1,490**	**1,066**	**596**
		Abandonment Level (Goal < 5%)	**1.40%**	**0.70%**	**1.00%**	**1.40%**	**1.50%**	**1.00%**
		Service Level (Goal 80%)	**85%**	**90%**	**89%**	**88%**	**86%**	**92%**
	Transportation Call Center	**# of Calls Received**	**7,364**	**7,768**	**6,737**	**8,470**	**8,062**	**9,278**
		# of Calls Answered	**7,209**	**7,628**	**6,663**	**8,411**	**8,014**	**9,241**
		Abandonment Level (Goal < 5%)	**1.60%**	**1.30%**	**0.80%**	**0.40%**	**0.50%**	**0.20%**
		Service Level (Goal 80%)	**61%**	**61%**	**75%**	**85%**	**85%**	**88%**
	CalViva Health Website	**# of Users**	**26,000**	**22,000**	**28,000**	**25,000**	**32,000**	**12,000**
		Top Page	**Main Page**	**Main Page**	**Provider Search**	**Provider Search**	**Provider Search**	**Do You Qualify?**
		Top Device	**Mobile (65%)**	**Mobile (62%)**	**Mobile (62%)**	**Mobile (59%)**	**Mobile (60%)**	**Mobile (57%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 1 minute**
Message from the CEO	Q3 2022 numbers and Q4 2022 numbers are being presented. During Q3 2022 there was an increase in members visiting the CalViva Health website. During this same quarter, approximately 22K of the 32K landed on our Do you Qualify page. The Plan's website vendor is continuing to validate the Q4 2022 numbers to identify potential reasons for the volume drop.							

Provider Network & Engagement Activities	**Year**	**2022**	**2022**	**2022**	**2022**	**2022**	**2022**	**2022**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Hospitals	**11**	**11**	**11**	**11**	**11**	**11**	**11**
	Clinics	**154**	**155**	**155**	**155**	**156**	**156**	**156**
	PCP	**379**	**390**	**387**	**390**	**391**	**391**	**386**
	PCP Extender	**264**	**267**	**277**	**280**	**277**	**284**	**284**
	Specialist	**1435**	**1430**	**1337**	**1332**	**1324**	**1335**	**1284**
	Ancillary	**261**	**256**	**242**	**242**	**241**	**242**	**240**
	Year	**2021**	**2021**	**2021**	**2022**	**2022**	**2022**	**2022**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Behavioral Health	**412**	**430**	**447**	**472**	**497**	**530**	**472**
	Vision	**44**	**45**	**43**	**39**	**39**	**25**	**30**
	Urgent Care	**12**	**13**	**13**	**14**	**10**	**11**	**11**
	Acupuncture	**8**	**6**	**5**	**5**	**6**	**4**	**4**
	Year	**2021**	**2021**	**2021**	**2021**	**2022**	**2022**	**2022**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**95%**	**96%**	**95%**	**95%**	**95%**	**95%**	**92%**
	% Of Specialists Accepting New Patients - Goal (85%)	**96%**	**96%**	**96%**	**96%**	**97%**	**98%**	**97%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**97%**	**96%**	**96%**	**97%**	**97%**	**97%**	**97%**
	Year	**2022**	**2022**	**2022**	**2022**	**2022**	**2022**	**2022**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Providers Touched by Provider Relations	**128**	**133**	**121**	**139**	**79**	**112**	**160**
	Provider Trainings by Provider Relations	**198**	**523**	**538**	**448**	**432**	**549**	**411**
	Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
	Total Providers Touched	**2,604**	**2,786**	**2,552**	**1,932**	**3,354**	**1,952**	**1,530**
	Total Trainings Conducted	**530**	**762**	**808**	**1,353**	**257**	**3,376**	**5,754**
Message From the CEO	Although not reflected in the counts due to timing, at the very end of the year, a hospital closed in Madera County. The Plan is continuing to monitor, assess, and evaluate the provider network impact as a result of the closure.							

Claims Processing	**Year**	**2021**	**2021**	**2021**	**2021**	**2022**	**2022**	**2022**
	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	99% / 99% N/A	99% / 99% N/A	96% / 99% N/A	98% / 99% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	99% / 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		
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 99% NO	99% / 99% NO		
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	95% / 99% NO	93% / 99% NO	97% / 99% YES	97% / 99% YES	99% / 100% YES	96% / 99% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	91% / 98% NO	91% / 100% NO	84% / 93% NO	88% / 95% NO	80% / 95% NO	78% / 87% YES	81% / 89% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 99% NO	89% / 99% NO	96% / 99% YES	63% / 99% YES	95% / 99% YES	79% / 95% YES	55% / 89% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	98% / 100% YES	98% / 100% YES	98% / 99% YES	97% / 100% NO	88 / 100% YES	98% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	93% / 98% NO	100% / 100% NO	99% / 99% YES	99% / 100% YES	97% / 97% NO	98% / 100% NO	100% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% YES	99% / 100% YES	98% / 100% YES	84% / 89% NO	100% / 100% NO	99% / 100% YES
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% NO	96% / 100% NO	95% / 100% NO	91% / 96% NO	94% / 100% YES	99% / 99% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 100% NO	93% / 100% NO	98% / 100% NO	73% / 98% NO	89% / 96% NO	99% / 99% NO	99% / 100% NO
Message from the CEO	Q2 2022 and Q3 2022 numbers are available. Management is working with their Administrator surrounding the performance for PPG 2 and PPG 3. Management discovered a reporting issue occurred with Acupuncture, Vision, and Transportation Claims Timeliness data. Management is further discussing with its Administrator.							

Provider Disputes	**Year**	**2021**	**2021**	**2021**	**2021**	**2022**	**2022**	**2022**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	99%	99%	99%	99%	98%	97%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A		
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%		
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	100%	N/A		
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	95%	99%	96%	94%	97%	100%	100%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	35%	66%	96%	99%	97%	97%	45%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	99%	100%	100%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	99%	97%	100%	97%	97%	86%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	N/A
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	98%	79%	39%	91%	43%	96%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	N/A	100%	100%	100%
Message from the CEO	Q2 2022 and Q3 2022 numbers are available. Management is working with their Administrator surrounding the performance for PPG 3, PPG 5, and PPG 7. Management discovered a reporting issue occurred with Acupuncture, Vision, and Transportation Claims Timeliness data. Management is further discussing with its Administrator.							

Item #12

Attachment 12.F

Medi-Cal Procurement Update

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 16, 2023

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Medi-Cal Procurement Final Update

BL #: 23-003
Agenda Item 12
Attachment 12.F

BACKGROUND:

1. On February 9, 2022 the California Department of Health Care Services ("DHCS") released a RFP for its commercial Medi-Cal managed care plan (MCP) contractors that will redefine how care is delivered to more than 12 million Californians.

    a. Commercial Managed Care Plan Proposals were due April 11, 2022
    b. DHCS expects to award contracts to selected plans in August 2022
    c. New Contracts will become effective on January 1, 2024
    d. Local Plans, for example CalViva Health, do not have to participate in the RFP in accordance with current State Law, however, they will be subject to the same contractual requirements.

2. On February 4, 2022, DHCS proposed to enter into a direct contract with Kaiser Permanente ("Kaiser") as a Medi-Cal Managed Care Plan within new geographic regions of the State, effective January 1, 2024 for a five year contract term, with potential contract extensions.

INFORMATION:

On August 25, 2022, DHCS announced the results of the RFP for its Commercial Medi-Cal Managed Care Plan (MCP) contractors.

On December 30, 2022, in response to appeals, DHCS cancelled the RFP and announced the following entities were awarded contracts:

- Molina Health Care (Counties: ~~Los Angeles,~~ Riverside, San Bernardino, ~~Sacramento,~~ San Diego)
- *Blue Shield of California Promise Health Plan (Counties: San Diego)*
- Anthem Blue Cross Partnership Plan (Counties: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kern, Kings, Madera, Mono, Santa Clara, San Francisco, Sacramento, Tuolumne)
- Health Net (Amador, Calaveras, Inyo, *Los Angeles,* Mono, *Sacramento,* ~~San Diego~~, San Joaquin, Stanislaus, Tulare, Tuolumne) were awarded contracts.

- For Fresno, Kings, and Madera Counties, CalViva Health will remain the local plan available to **all Medi-Cal beneficiaries**. Anthem (Blue Cross) will remain the commercial plan available to **all Medi-Cal beneficiaries**. Kaiser will join effective January 1, 2024 and will be available to **limited Medi-Cal beneficiaries**.