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

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DATE: March 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, March 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 **13** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
March 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 Information	Attachment 3.A	**Kings County At-Large Commission Seat Application** • Kerry Hydash *Action: Commission to vote on reappointment of Commissioner*	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 Attachment 4.H Attachment 4.I Attachment 4.J Attachment 4.K Attachment 4.L Attachment 4.M	**Consent Agenda:** • Commission Minutes dated 2/16/23 • Finance Committee Minutes dated 11/17/22 • QI/UM Committee Minutes dated 11/17/22 • Public Policy Committee Minutes 9/7/22 • Public Policy Committee Minutes 12/7/22 • Compliance Report • 2022 Quality Improvement End of Year Executive Summary • 2022 Quality Improvement Work Plan End of Year Evaluation • 2022 UMCM WP EOY Executive Summary • 2022 Utilization Management Case Management Work Plan End of Year Evaluation • 2023 Utilization Management Program Description • 2023 UMCM Work Plan • 2023 Case Management Program Description *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5		**Closed Session:**	

		The Board of Directors will go into closed session to discuss the following item(s) 1) **Government Code section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation.** One (1) potential case.	
	Handout will be available at meeting	*PowerPoint Presentation will be used for item 6*	
6 Action	*Attachment 6.A* *Attachment 6.B*	***2023 Quality Improvement*** • *2023 Program Description* • *2023 Work Plan* *Action: Approve 2023 Quality Improvement Program Description, and Work Plan.*	P. Marabella, MD, CMO
7 Action		**Standing Reports**	
		Finance Report	
	Attachment 7.A	• Financials as of January 31, 2023	D. Maychen, CFO
		Medical Management	
	Attachment 7.B	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 7.C	• Key Indicator Report	
	Attachment 7.D	• Credentialing Sub-Committee Quarterly Report	
	Attachment 7.E	• Peer Review Sub-Committee Quarterly Report	
	Attachment 7.F	• QIUM Charter	
		Executive Report	J. Nkansah, CEO
	Attachment 7.G	• Executive Dashboard	
		Action: Accept Standing Reports	
8		**Final Comments from Commission Members and Staff**	
9		**Announcements**	
10		**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.*	
11		**Adjourn**	D. Hodge, MD, Chair

Supporting documents will be posted on our website 72 hours prior to the meeting.

If you have any questions, please notify the Clerk to the Commission at: Churley@calvivahealth.org

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

Next Meeting scheduled for May 18, 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

Kings County At-large Commission
Seat Application

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

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

Name of Applicant: Kerry L. Hydash
Home Address: 250 West 5th St. City: Hanford Zip: 93230
Current Employer: Family HealthCare Network
Business Address: 305 E. Center Ave City: Visalia Zip: 93291
Home Phone: 559-972-4097 Work Phone: 559-737-4731 E-mail Address: khydash@fhcn.org

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

I was appointed to the Workforce Investment Board of Tulare County in 2009. I am currently serving as the Board Chair.

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

NA

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

I serve as Family HealthCare Network's President & CEO. Family HealthCare Network has 40 sites in three counties where we serve over 230,000 unique users, of which 178,000 are Medi-Cal managed care lives.

List community organizations to which you belong:

I am currently involved in a number of local organizations, including the Visalia Chamber of Commerce, Workforce Investment Board of Tulare County, Downtown Visalians, and Tulare County Office of Education's Innovate Tulare County Initiative. I also serve on the California Primary Care Association Board, the Clinic Mutual Insurance Board, the Central Valley Health Network Board, California Partnership for Health Board, Advocates for Community Health Board, and the Best Practices, LLC Board. I am a past board member of the Visalia Symphony and National Center for Farmworker Health.

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

NA

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

NA

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

1. Name: Jason Vega
   Affiliation: Principal for Vega Public Affairs, LLC
   Contact Phone Number: 916-995-9450

2. Name: Paulo Soares
   Affiliation: Chief Executive Officer for Camarena Health
   Contact Phone Number: 559-250-5636

3. Name: Steve Nelson
   Affiliation: Vice Mayor of Visalia, Executive Director for Downtown Visalians
   Contact Phone Number: 559-280-1637

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

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

_____ (Signature)

2/28/23 (Date)

COMPLETE FORM AND RETURN TO:

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

Applications will be kept on file for a year.

Item #4

Attachment 4.A

Commission Minutes
Dated 2/16/23

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
February 16, 2023

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 1:30 pm. A quorum was present.	
#2 Roll Call Cheryl Hurley, Clerk to the Commission	A roll call was taken for the current Commission Members.	*A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 Reappointed Board of Supervisors Commissioners **Action** J. Nkansah, CEO	Fresno County has re-appointed Supervisor Sal Quintero as Commissioner, and Supervisor Brian Pacheco as alternate. Kings County has re-appointed Supervisor Joe Neves as Commissioner and Supervisor Rusty Robinson as alternate. Madera County has re-appointed Supervisor David Rogers as Commissioner and Supervisor Jordan Wamhoff as alternate.	***Motion**: Ratify reappointment of County BOS Commissioners* *13 – 0 – 0 – 4* *(Neves / Soares)* *A roll call was taken*
#4 Consent Agenda a) Commission Minutes dated 11/17/22 b) Finance Committee Minutes dated 9/15/22 c) QI/UM Committee Minutes dated 10/20/22 d) 2023 Compliance Program Description e) 2023 Code of Conduct f) 2023 Anti-Fraud Plan g) 2023 Privacy and Security Plan Action J. Neves, MD, Co-Chair	All consent items were presented and accepted as read. The 2023 Privacy & Security Plan was pulled for discussion to report on revisions located on pages 4, 10 and 11. The revisions include bringing the Plan into compliance as it pertains to AB 1184. AB 1184 amended the Confidentiality of Medical Information Act and requires plans to take extra steps to protect an enrollee's medical information. Specifically, these steps include not requiring a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services, or to submit a claim for sensitive services if the protected individual has the right to consent to care. It also requires the plan to direct all communications regarding a protected individual's receipt of sensitive services directly to the protected individual's designated alternate address/email/telephone. Additionally, the Privacy & Security Plan incorporated definitions for a Protected Individual and Sensitive Services.	***Motion**: Consent Agenda was approved.* *13 – 0 – 0 – 4* *(Neves / Rogers)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#5 Closed Session **1) Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility.**	Jason Epperson, General Counsel, reported out of closed session. The Commission discussed in closed session the item agendized for closed session discussion, direction was given to staff. The Commission took no other reportable action. Closed Session concluded at 1:57 pm.	
#6 Annual Administration Information D. Hodge, MD, Chair	Dr. Hodge reminded the Commission the Form 700 is due on an annual basis, due this year on 4/3/23. Commissioners will receive notification from the Commission Clerk via email. Anyone due for an updated Ethics Certification will be notified.	***No Motion***
#7 Community Support Program Ad-Hoc Committee Selection Action D. Hodge, MD, Chair	A new ad-hoc committee is needed for the Community Support Program. Dr. Hodge polled Commissioners for volunteers to sit on the Committee. Members that volunteered are: Rose Mary Rahn, Paulo Soares, Dr. Naz, and Dr. Hodge.	***No Motion - Committee members selected***
#8 2022 Annual QI Work Plan Evaluation • Executive Summary	Dr. Marabella presented the 2022 Annual Quality Improvement Work Plan Evaluation	***See #9 below for Motion***

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• Year End Evaluation Action P. Marabella, MD, CMO	Planned activities and Quality Improvement focus for 2022 were: • Access, Availability and Service: ○ Improve Access to Care: • Provider Appointment Availability Survey is the assessment tool. MY21 results reported. ○ Urgent Care scores declined compared to MY20. Non-Urgent Care scores for PCP care decreased. Specialist care also decreased significantly compared to MY20. ○ CAP Process with Targeted PPG Approach ○ Corrective Action Plans (CAPs) required for non-compliance on 1 or more metrics. 17 CAPs requested –all improvement plans received. The majority of the CAPs were closed out by 12/31/22. One CAP is still outstanding and two remains open for supporting documentation and is closely monitored. • Provider After Hours Access Survey is the tool used. Statistically significant increase noted for overall and county level scores for MY21 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. • 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. Access to care continues to be the main driver of grievances filed, especially around prior authorization delays.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Quality and Safety of Care:
	  ○ HEDIS Default Measures Rates for MY 2021 MPL:
	  ▪ Cervical Cancer Screening: three counties exceeded MPL of 59.12%
	  ▪ Childhood Immunization Combo 10: Madera exceeded MPL of 38.20%; Kings and Fresno counties fell below the MPL. The PIP ended 12/31/22.
	  ▪ Controlling High Blood Pressure: three counties exceed MPL of 5.35%.
	  ▪ Timeliness of Prenatal Care: three counties exceeded the MPL of 85.89%.
	  ○ Non-Default HEDIS MPL Rates for Measures:
	  ▪ Breast Cancer Screening: Kings and Madera counties exceeded the MPL of 53.93%; Fresno County (49.1) did not meet the MPL.
	  ▪ Child and Adolescent Well-Care Visits: Fresno and Madera counties exceeded the MPL of 45.31%. Kings (38.8) county fell below the MPL.
	  ▪ Comprehensive Diabetes Care: three counties exceeded the MPL of 43.19%.
	  ▪ Immunizations for adolescents: Madera and Fresno counties exceeded the MPL of 36.74%; Kings County (32.6) fell below the MPL.
	  ▪ Timeliness of Postpartum Care: three counties exceeded the MPL of 76.40%
	  ▪ Well-Child Visits in the first 15 months of Life: Kings and Madera counties exceeded the MPL of 54.92%; Fresno County (48.8) fell below the MPL.
	  ▪ Well-Child visits for age 15 months to 30 months: Madera County exceeded the MPL of 70.67%; Fresno (61.9) and Kings (54.4) counties fell below the MPL.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Performance Improvement Projects:
	  ○ Childhood Immunizations Under 2 years:
	  ▪ During the project 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%. 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.
	  ○ Breast Cancer Screening Disparity Project:
	  ▪ 112 of 170 (65.9%) breast cancer screenings exams scheduled 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%. Video testimonials were developed from three Southeast Asian breast cancer survivors and the videos are being shown to raise awareness of breast cancer. Health Education distributed educational materials on the importance of breast cancer.	

#9 2022 Annual UMCM Workplan Evaluation • Executive Summary • Year End Evaluation **2023 UM Program Description** Action P. Marabella, MD, CMO	Dr. Marabella presented the 2022 Annual Utilization Management Case Management Workplan Evaluation. The focus areas for 2022 consisted of: ▪ Compliance with Regulatory & Accreditation Requirements: ○ All compliance activities met objectives for this end of year evaluation with the exception of periodic audits for compliance with regulatory standards. Clear and concise letter content was not met due to use of clinical jargon. Additional training and tracking of Medical Director dictations is in progress. ▪ Monitoring the UM Process:	***Motion**: No motion taken as QIUM did not meet quorum. Will be voted on during March 2023 meeting*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Met standards except element 2.2 Timeliness of Processing Authorization Requests (TATs). Work process flow for staff was modified and implemented was modified ▪ Monitoring Utilization Metrics: ○ Objectives met except 3.1 Improve UM Acute in-Patient performance. Length of Stay for TANF met but nor for SPD and MCE populations ▪ Monitoring Coordination with Other Programs and Vendor Oversight: ○ All metrics for this section met goal. ▪ Monitoring Activities for Special Populations: ○ All monitoring activities for this section met goals. Dr. Marabella presented the 2023 Utilization Management Program Description. The highlights of changes for 2023 consist of: ▪ Updated Purpose and Mission. ▪ Changed "Medical Management" to "Population Health and Clinical Operations (PHCO)". ▪ Added Basic Prenatal Care and Biomarker Testing to Scope of Utilization Management. ▪ Changed "MHN" to "The Behavioral Health Administrator" throughout. ▪ Updated Continuity and Coordination of Care section. ▪ Updated Health Promotion Programs name and function. ▪ Added Peer Review Investigation Team and Peer Review Committee references and roles. ▪ Added Long Term Services and Supports and Waiver Programs ▪ Added CalViva Health Quality Improvement/Utilization Management Committee description. ▪ Updated HN titles and roles for certain positions.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#10 2022 Annual Compliance Evaluation Action M.L. Leone, CCO	M.L. Leone reported on the 2022 Annual Compliance Evaluation. In 2022, the Compliance Program largely focused on the following: ▪ DHCS and DMHC Medical Audits ▪ Compliance with CalAim Initiatives ▪ 2024 Operational Readiness Contract Requirements ▪ Policy & Procedure Development/Revisions There were over 220 regulatory filing made to DMHC and DHCS. State audits, corrective actions and Medi-Cal contract amendments with DHCS include: ▪ 2020 DHCS audit: CAP closed 2/11/2022. ▪ 2022 DHCS Annual Audit: final report received on 11/17/2022 and a corresponding CAP request received 11/30/2022. ▪ DHCS 2019-2020 Performance Evaluation: The Plan received the annual external quality review report and associated recommendations on 7/5/2022; the Plan submitted its response on 8/1/2022. ▪ DHCS 2020-2021 Encounter Data Validation Study: the study was completed on 5/19/2022; currently pending HSAG to share raw data. ▪ DHCS 2022 Annual Network Certification: The Plan submitted the first part of the ANC 11/2022; DHCS has postponed the second phase until 2/2023. ▪ DHCS 2021 MOT CAP: the Plan submitted a CAP response and received approval from DHCS 2/15/2022. Several Medi-Cal contract amendments were executed between DHCS and CalViva in 2022.	***Motion**: 2022 Annual Compliance Evaluation was approved* *11 – 0 – 0 – 6* *(Fields-Keene /Rogers)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	DHCS issued its 2024 Procurement Contract Operational Readiness Work Plan in June 2022. State audits and reporting with DMHC include: ▪ Measurement Year 2021 Timely Access Report submitted to DMHC in April 2022. ▪ The Plan received a final report from DMHC for the DMHC 18-month follow up audit 11/2/2021. ▪ DMHC on-site audit was conducted virtually from 9/19/22-9/21/22; pending DMHCs preliminary report. ▪ DMHC issued a CAP 3/15/22 in regards to the March 2022 DMHC Routine Financial Exam; the Plan's response to the CAP was accepted 8/11/22 and the audit was closed 8/30/22. Suspected Fraud, Waste and Abuse cases total: ▪ 1 CBAS provider ▪ 2 DME providers ▪ 1 vascular surgery provider Privacy and Security Incidents/Breaches: ▪ 31 privacy/security cases total ▪ No or low risk = 31 ▪ High risk = 0 DHCS new benefits, waivers and other programs consist of: ▪ Enhanced Care Management (ECM) and Community Supports (CS) ▪ Community Health Worker (CHW) Services ▪ Community Based Adult Services (CBAS) Emergency Remote Services (ERS) ▪ Long Term Care (LTC)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ MMCE Phase II ▪ Doula Services ▪ Cognitive Health Assessment ▪ Medical Expansion Compliance Program Activities include: ▪ Compliance Program Description (no change) ▪ Code of Conduct (no change) ▪ Compliance Committee Charter (no change) ▪ Anti-Fraud Plan (no change) ▪ Privacy and Security Plan (updated to be in compliance with the Confidentiality of Medical Information Act regarding sensitive services) ▪ Compliance Policies and Procedures (updated as needed to be compliance with DHCS/DMHC guidance) ▪ Delegation audits and CAPs of Health Net ▪ Monthly Management Oversight (MOM) meetings with Health net ▪ Review monthly/quarterly performance metrics & key indicator data ▪ Joint Workgroups with Health Net included: Access & Availability, Encounter Data Integrity, Grievances & Appeals, QI/UM/Credentialing ▪ On-going oversight of PPGs, specialty plans and vendors through report dashboards with comprehensive performance metrics accompanied by narrative reports explaining outlier data or issues ▪ 2022 CalViva Internal Audit ▪ CalViva Health staff trainings ▪ Member communications, Provider Communications, and Provider Relations Total grievances and appeals received for 2022, both expedited and standard, were 1,626; total resolved were 1,637. SPD grievances and appeals received for 2022	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	were 455; total resolved were 474. Total exempt grievances received and resolved were 2,429. For Independent Medical Reviews, there were 45 DMHC cases, and 28 DHCS State Hearings, for a total of 73 for 2022. All of which met the turn-around times at 100%. Looking ahead for 2023, the key areas of focus are Enhanced Care Management and Community Supports; 2024 Operational Readiness Contract; NCQA Accreditation; Dual-Eligible Special Needs Program; and the 2023 DHCS Audit.	
#11 Emergency Preparedness & Crisis Response Plan Action M.L. Leone, CCO	Mary Lourdes Leone provided an in-depth description of the new Emergency Preparedness & Crisis Response Plan. An overview of the Plan describes CalViva Health's contractual relationship with Health Net and highlights that Health Net, as CalViva's Plan Administrator, maintains all the systems typical of health plan operations, including those used for CalViva Health operations. The purpose of this 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. Constituents represent the various groups that may be impacted in an emergency. Constituents consist of members, providers, employees, regulators, the community, elected government officials, vendors, and the RHA Commission.	***Motion**: Disaster Preparedness Plan was approved* *11 – 0 – 0 – 6* *(Naz /Cardona)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The Emergency Preparedness Leadership Team (ERLT) consists of the CalViva Health executive officers; CEO, CFO, CMO, and CCO. Each officer maintains oversight of specific functional areas listed in the plan. The team is responsible for identifying the nature, scope and magnitude of the event's impact; mitigate and/or resolve the event's impacts; maintain during the recovery phase, fulfill required regulatory filings to the DMHC and the DHCS; and update the Plan's Emergency Preparedness and Crises Plan when needed. For each functional area impacted, 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.	
#12 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of December 31, 2022:</u> Total current assets recorded were approximately $292.3M; total current liabilities were approximately $167M. Current ratio is approximately 1.75. TNE as of the end of December 2022 was approximately $138.4M which is approximately 828% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $1.9M which is approximately $1.7M more than budgeted primarily due to rates on the Plan's money market funds being higher than projected. Premium capitation income actual recorded was	***Motion**: Standing Reports Approved* *11 – 0 – 0 – 6* *(Rogers /Fields-Keene)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Compliance** M.L. Leone, CCO	approximately $662.5M which is approximately $46M more than budgeted primarily due to rates and enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $532.2M which is approximately $41.3M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $27.3M, which is approximately $1.2M more than budgeted due to higher than budgeted enrollment. Dues and Subscriptions expense actual recorded was approximately $103K which is in line with what was budgeted; however, there is a potential future increase to this line item due to the governor's budget reinstating the MCO tax effective 1/1/2024. The Local Health Plans of California (LHPC) Board agreed that if the MCO tax is reinstated that any additional revenue should be invested back into Medi-Cal to benefit Medi-Cal enrollees. The LHPC Board agreed to assess a one-time additional membership fee for all of its member plans to support this effort. The Plan is anticipating a budget impact of approximately $65K. Recruitment expense is approximately $36K which is approximately $15K more than budgeted due to turnover and the use of staffing agencies to assist with filling vacant positions. Net income for the first six months of FY 2023 was approximately $7.3M which is approximately $5.9M more than budgeted due to rates and enrollment being higher than budgeted; interest income was approximately $1.7M more than projected; and a $3.25M MCO tax gain that was not expected. DHCS has indicated that they are likely to recoup the MCO tax gain which would likely be Q1 2023. In future financial statements there will likely be a reduction in net income by approximately $3.25M. **Compliance**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	DHCS and DMHC filings, Privacy & Security, and Fraud, Waste & Abuse were discussed during agenda item #10, the 2022 Annual Compliance Evaluation. The oversight audits currently in progress consist of Credentialing; Fraud, Waste & Abuse; and the Member Call Center. Audits that have been completed since the last Commission report are: Access & Availability; Emergency Services; and Utilization Management (CAP). New Regulations, Contractual Requirements, and DHCS Initiatives consist of: ▪ CalAim - Long-Term Care (LTC) Carve-In: effective 1/1/23 MMC Plans became responsible for authorizing and covering medically necessary SNF services. Effective 1/1/24, the remaining LTC resident receiving care from adult and pediatric subacute facilities and intermediate care facilities for the developmentally disabled will be required to enroll in managed care. ▪ The Plan began providing the 2023 Member Handbook to members on 1/1/23. ▪ 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 three phases which began on 8/12/22 for phase 1; 12/15/22 for phase 2; and 4/20/23 for phase 3. 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. The next Public Policy meeting will be held on March 1, 2023 at 11:30am in the Plan's Administrative Office.	
• **Medical Management** P. Marabella, MD, CMO	**Medical Management** <u>Appeals and Grievances Dashboard</u>	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Marabella presented the Appeals & Grievances Dashboard through December 31, 2022. • The total number of grievances remained consistent for 2022 when compared with YTD 2021. • Quality of Service Grievances remained consistent for 2022 when compared with YTD 2021. • Quality of Care Grievances increased in 2022 when compared to YTD 2021 mostly related to delay in care for PCP and Specialists secondary to staffing challenges and increased demand after pandemic. • Exempt Grievances have had a slight decrease for 2022 when compared to prior year but continued issue with Transportation access which is being addressed by CAP and more comprehensive oversight reporting. • Appeals for YTD 2022 have significantly decreased when compared to prior year, this is a result of the lower Advanced Imaging numbers and fewer Pharmacy appeal due carve-out of Medi-Cal Rx. <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through December 31, 2022. A summary was shared that provided the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through year end 2022 which shows numbers have remained steady compared to 2021. Membership continues to increase. ; Utilization has decreased for all populations except for Length of Stay for SPDs	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	Case Management results through year end 2022 have shown increased referrals and engagement and demonstrate positive outcomes in the areas of Perinatal CM, Integrated CM, Transitional CM, Behavioral CM and Palliative CM. **Executive Report** Enrollment through December 31, 2022 is 418,051 members. Enrollment continues to increase as a result of the Public Health Emergency (PHE). Medi-Cal redeterminations from the COVID-19 Public Health Emergency (PHE) and eligibility redeterminations slated to restart April 1. First actions which are adverse are anticipated July 2023. DHCS has discontinued the process of sharing monthly reports (COPS 11 Report) with requestors outside of DHCS due to the Data and Analytics De-Identification Guidelines. This impacts the data we were previously reporting to the RHA Commission around Default, County Share of Choice as %, Voluntary Disenrollment's. No changes to the default algorithm in 2023. For 2024, DHCS will be exploring changes to the default algorithm. They have shared that they are looking at changing the quality measures to align with the Bold Goals and 2024 Medi-Cal Contract Changes. All Server upgrades were completed successfully. Staff are continuing to navigate one off issues as they arise in the effort of achieving stability. Workstation and Spam Filter upgrades are in progress.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	No significant issues or concerns with regard to the Member Call Center or CVH Website. We noticed an uptick in users in Q3 2022, but also noted a decline in Q4 2022. Staff are evaluating the results. In reference to provider activities, the Plan will monitor, assess, and evaluate the provider network impact as a result of a hospital closure which occurred late December 2022. For claims processing, management is working with Administrator surrounding performance for PPG 2 and PPG 3. The management team discovered a reporting issue surrounding Acupuncture, Vision and Transportation Claims Timeliness data and has discussed issue with Administrator. For provider disputes, management is working with Administrator surrounding performance for PPG 3, PPG 5 and PPG 7. The management team discovered a reporting issue surrounding Acupuncture, Vision and Transportation Provider Disputes data and has discussed issue with Administrator. In reference to the Medi-Cal procurement, DHCS cancelled the RFP. DHCS exercised its authority to select the entities it would contract with in a particular County. Anthem Blue Cross will remain the Commercial Plan competitor to CalViva Health (the local plan), in Fresno, Kings, and Madera Counties. Kaiser will join January 1, 2024 and will be available to limited Medi-Cal beneficiaries. Operational Readiness activities have started for all MCP being awarded a contract effective January 1, 2024. Go/No Go Live Date is September 1, 2023. The Annual Report was given to all Commissioners.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#13 Final Comments from Commission Members and Staff		
#14 Announcements	David Luchini announced the Fresno County Public Health Department had an event in Helm (Fresno County), the first rural mobile event with UCSF. This will also be coordinated with Saint Agnes and Fresno State. This mobile event will not replace primary care; this is solely health screening, health literacy and connecting people to a primary care physician.	
#15 Public Comment	None.	
#16 Adjourn	The meeting was adjourned at 3:22 pm. The next Commission meeting is scheduled for March 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 11/17/22

CalViva Health
Finance
Committee Meeting Minutes

November 17, 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 September 15, 2022 Attachment 2.A Action D. Maychen, Chair	The minutes from the September 15, 2022 Finance meeting were approved as read.	Motion: *Minutes were approved 5 – 0 – 0 – 2* *(Neves / Soares)*
#3 Presentation of Fiscal Year	Rianne Suico, representative with Moss Adams, presented the results of	Motion: *Fiscal Year 2022 Audit*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2022 Audit Results Attachment 3.A Action R. Suico, Moss Adams, LLP	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. *Supervisor Rogers arrived at 11:36 am*	*Results were approved* *6 – 0 – 0 – 1* *(Nikoghosian / Soares)*
#4 Financials as of September 30, 2022 Action D. Maychen, Chair	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 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	Motion*: Financials as of September 30, 2022 were approved* *6 – 0 – 0 – 1* *(Rogers / Nikoghosian)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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.	
#5 Announcements	None.	
#6 Adjourn	Meeting was adjourned at 11:45 am	

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

Dated: February 16, 2023

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 2/16/23

Item #4

Attachment 4.C

QIUM Committee Minutes
dated 11/17/22

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

November 17th, 2022

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

Committee Members in Attendance			CalViva Health Staff in Attendance
✓	**Patrick Marabella, M.D.**, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Director of Medical Management Services
	Fenglaly Lee, M.D., Central California Faculty Medical Group	✓	**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	✓	**Norell Naoe**, Medical Management Administrative Coordinator
✓ *	**Joel Ramirez, M.D.,** Camarena Health Madera County	✓	**Patricia Gomez,** Senior Compliance Analyst
	Rajeev Verma, M.D., UCSF Fresno Medical Center	✓	**Zaman Jennaty,** Medical Management Nurse Analyst
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
	Guests/Speakers		
✓ *	**Homer Anazaldua**, Medzed, Fresno		

✓ = 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 10:32am. A quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: October 20th, 2022 - Standing Referrals Report (Q3) - California Children's Service Report (Q3) - Concurrent Review Inter-Rater Reliability Report (Q3) - MHN Performance Indicator Report for Behavioral Health Services (Q3)	The October 20th, 2022 QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. A link for Medi-Cal Rx Contract Drug List was available for reference. Dr. Ramirez arrived at 10:35am.	Motion: *Approve* Consent Agenda (Sidhu/Carmona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- County Relations Quarterly Report (Q3) - NIA/Magellan (Q3) - Appeals & Grievances Inter-Rater Reliability Report (Q3) - Appeals & Grievances Classification Audit Report (Q3) - Customer Contact Center DMHC Expedited Grievance Report (Q3) - Preventive Health Guidelines - Medical Policies Update (Q3) - Pharmacy Provider Updates (Attachments A-M) **Action** Patrick Marabella, M.D Chair		
#3 **QI Business** - Appeals & Grievances Dashboard (September) - Appeals & Grievances Executive Summary (Q3) - Appeals & Grievances Quarterly Member Report (Q3) - Quarterly A&G Member Letter Monitoring Report (Q3) (Attachments N-Q) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **Appeals & Grievances Dashboard** through September 2022. ➢ The total number of grievances through August and September 2022 has increased slightly compared to last year. ➢ Quality of Service (QOS) for Access, Administrative, and Transportation represents the majority of grievances. ➢ The volume of Quality of Care (QOC) grievances is comparable to last year. ➢ Provider Late and No Shows Grievances have increased in the Transportation category. Working with vendors to improve rates. ➢ PCP QOC has increased. Delay and Specialist Care will be monitored. ➢ The total number of grievances are up in Quarter 3, along with membership. **Appeals & Grievances Executive Summary (Q3)** through September 2022 was presented noting the following trends: ➢ Appeals & Grievances have decreased from Q3 2021 to Q3 2022.	Motion: *Approve* - Appeals & Grievances Dashboard (September) - Appeals & Grievances Executive Summary (Q3) - Appeals & Grievances Quarterly Member Report (Q3)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	➢ Transportation Grievances have increased from Q3 2021 to Q3 2022. ➢ Transportation Grievances have increased slightly for Q3. 50 formal and 87 exempt further broken down into Access and Behavior categories. Out of 23 access, 6 were missed appointments, 17 were late and 27 behavior related grievances. **Appeals & Grievances Quarterly Member Report (Q3)** through September 2022 was presented noting the following trends: ➢ Total number of Appeals decreased from last year. ➢ Total number of Grievances decreased from last year, but are trending upwards in Q2 & Q3. Will continue to monitor. ➢ Pre-Service Appeals were mainly MRI and CAT Scan with none relating to Pharmacy. ➢ Quality of Care (QOC) Grievances: Delay in referral by PCP and Specialists. **Quarterly A&G Member Letter Monitoring Report (Q3).** This report provides a summary of the results of the daily audits of Appeal and Grievance (A&G) acknowledgment and resolution letters and any related corrective actions taken. For Q3 the following actions were noting to maintain compliance in sending out member communications: o Required **bolding** od DMCH and Plan Phone numbers o Correct branding. Should be branded as CalViva Health. o Communication to members regarding decision documentation must be clear and concise (AG Letter 09). 12 Letters failed to meet these criteria. ➢ Decision criteria and rationale are determined by the Medical Reviewers and must be fully referenced to the criterion on which the appeal or decision was based. (AG Letter 10). 24 letters failed to meet these criteria. ➢ Working with Medical Directors and nurses to rectify noncompliance.	- Quarterly A&G Member Letter Monitoring Report (Q3) (Cardona/Sidhu) 5-0-0-2
#3 **QI Business** - Potential Quality Issues Report (PQI) (Q3) - Provider Preventable Conditions (PPC) (Q3) (Attachment R - S) **Action** Patrick Marabella, M.D Chair	**Potential Quality Issues (PQI) Report (Q3)** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data for Q3 was reviewed for all case types including the follow up actions taken when indicated. ➢ 3 non-member PQIs for (Q3) in Fresno County: Substandard care, surgical site infection or surgical complications. No PQIs in Kings or Madera counties. o There was one in level 0; one in level 2 and one in level 4.	Motion: *Approve* - Potential Quality Issues Report (PQI) (Q3) - Provider Preventable Conditions (PPC) (Q3) (Ayala/Ramirez)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Of the three cases closed, zero were documented as being generated from Provider Preventable Conditions (PPCs). ➢ 94 members related OQI-Total Grievances which is consistent with the previous quarters. 81 Grievances in Fresno County, 8 in Kings County and 5 in Madera County. ➢ There were 6 Peer Review cases in Fresno County, 0 in Kings County and 1 in Madera County. **Provider Preventable Conditions (PPC) (Q3)** This report provides a summary of member impacted Provider Preventable Conditions (PPC). PPCs are identified via four (4) mechanisms: 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 three (3) potential PPC Cases reviewed in Quarter 3 do not represent reportable events that occurred in Quarter 3, but rather cases ready for review in Q3 after records have been received and initial review completed. Two (2) cases were found to meet PPC criteria and were reported to DHCS via the secure online portal.	5-0-0-2
#3 **QI Business** - Initial Health Assessment Quarterly Audit Report (Attachment T) **Action** Patrick Marabella, M.D Chair	**The Initial Health Assessment (IHA) Report for Quarter 2 2022** was presented. The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA) completed within the first 120 days of enrollment. CalViva Health is required to facilitate and support members and providers through this process. The current approach to monitoring has three components: ➢ Medical Record Review (MRR) via onsite (or virtual) provider audits. ➢ Monitoring of claims and encounters data. ➢ Member outreach utilizing a three-step methodology. The Q2 2022 report shows CalViva Health's performance on IHA/IHEBA compliance monitoring from Q2 2021 through Q2 2022. ➢ Member outreach completed by the Plan resulted in a range of 56.20% – 58.39% compliance for January 2022 – March 2022 and 27.37% - 57.55% for April 2022 - June 2022. ○ Discontinued the self-mailer postcards and implementing a second phone call for the third	Motion: *Approve* - Initial Health Assessment Quarterly Audit Report (Sidhu/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	outreach attempt to members. ➢ In Q2 2022, IHA visits rates within 120 days of enrollment, with or without a completed IHEBA, range from 21.46 % (June 2022) – 24.67% (May 2022). ➢ Facility Site Review/Medical Records Review Q2 2022: o Pediatrics IHA/IHEBA shows 68% Compliant, Adult IHA/IHEBA shows 64% Compliant. o Site Reviews were not conducted during the height of Covid, nor were they required by the State at that time. ➢ Improvement Activities: o CalViva has conducted ongoing IHA/IHEBA Best Practice training. Trainings that occurred between April – June 2022. o CalViva is monitoring low performing providers and will be offering training and additional interventions to resolve barriers to IHA/IHEBA completion. o There are financial incentives for low performing providers to improve practices by using the Cozeva system to record data.	
#4 UM/CM Business - Key Indicator Report and TAT Report (September) (Attachments U) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **Key Indicator Report and TAT Report** through September 2022. ➢ Membership has steadily increased. ➢ Admission rates for Acute Care has been steady. ➢ Average Length of Stay remains steady for Acute and SPD populations and decreased for Expansion and Family/Adult populations. ➢ ER Visits have remained consistent. ➢ Integrated Case Management has seen a steady increase in the number of members referred and more members are assigned a case manager. ➢ In general, Case Management results remain strong and demonstrate positive results in all areas consistent with previous months. Behavioral Health Case Management numbers have fluctuated as more behavioral health issues have been reported.	Motion: *Approve* - Key Indicator Report and TAT Report (September) (Ramirez/Sidhu) 5-0-0-2
#4 UM/CM Business - Utilization Management Concurrent Review Report (Q3) - PA Member Letter Monitoring	The **Utilization Management Concurrent Review Report** presents inpatient data metrics and clinical concurrent review activities and interventions for Quarter 3 2022. Health Net Medical Management supports Concurrent Review (CCR) activities for CalViva Health to optimize health outcomes across the care continuum for all members. Includes Direct Network Only. ➢ All Lines of Business (TANF, SPC, MCE) met goal for bed days for Q3 2022. ➢ Utilization Admits decreased in Q3: TANF decreased by 5.21%, SPD decreased by 20.11%, and	Motion: *Approve* - Utilization Management Concurrent Review Report

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Report (Q3) (Attachment V -W) **Action** Patrick Marabella, M.D Chair	MCE decreased by 44.25%. ➢ Average Length of Stay: TANF decreased by 30.06%; the others remained roughly the same. ➢ Readmissions were variable. ➢ 2022 Inpatient utilization patterns are slowly returning to pre-pandemic levels. Hospitals in the region of the CalViva primary membership are seeing a decrease in COVID patients. ➢ Daily UM rounds continue, to discuss member needs for discharge, which include Care Management, Member connections, Public Programs and Medical Directors. **PA Member Letter Monitoring Report** Quarter 3 was presented and reviewed. This report is a summary of letter audits conducted by the Medical Management Monitoring and Reporting Team. Universe volume fluctuates due to the number of denials and deferrals audited during the Quarter. As a reminder, one letter can fail for multiple metrics. All metrics are expected to meet standard of 100% compliance. ➢ Denial/Deferral Letters did not meet the 95% standard. o There was a total of 3 decision letters that did not meet regulatory requirements and one (1) pre-auth letter that failed due to Health Net references not being removed due to Associate error. o There were one (1) deferral letters that did not have clear and concise language in training process. In follow up, Medical Management continues to monitor letters through monthly random audits and monitoring is ongoing with 100% audits for staff/physicians with multiple errors.	(Q3) - PA Member Letter Monitoring Report (Q3) (Ayala/Ramirez) 5-0-0-2
#4 UM/CM Business - Case Management and CCM Report (Q3) (Attachment X) **Action** Patrick Marabella, M.D Chair	The **Case Management and CCM Report** Q3 2022 report summarizes the case management, transitional care management, Member Connections, palliative care, and Emergency Department (ED) diversion activities for 2022 third quarter and utilization related outcomes through 6/30/22. CM continued to support member education related to COVID-19 and provided vaccine information during outreach. ➢ There was an increased in referral volume for Integrated Case Management, Transitional Care Management, Transitional Care and Palliative care from Q2 to Q3. ➢ There was a decreased in volume for Behavioral Health and Perinatal from Q2 to Q3.	Motion: *Approve* - Case Management and CCM Report (Q3) (Ayala/Sidhu) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#5 **Pharmacy Business** - Pharmacy Executive Summary (Q3) - Pharmacy Operations Metrics (Q3) - Pharmacy Top 30 Prior Authorizations (Q3) - Pharmacy Inter-Rater Reliability Results (IRR) (Q3) (Attachments Y-BB) **Action** Patrick Marabella, M.D Chair	The **Pharmacy Reports** for Q3 2022 are presented to assess for emerging operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests and compliance around PA turnaround time metrics, and to formulate potential process improvements. ➢ Pharmacy Operations Metrics o Pharmacy prior authorization (PA) metrics were within 5% of standard for Q3 2022. o Overall, TAT for Q3 2022 was 97.0%. o PA volume appears to have varied in Q3 2022 compared to Q2 2022. August had an unusually high PA request count. ➢ Top Pharmacy PA Requests o 3rd Quarter 2022 top medication were based on Medical Benefit Drug requests due to the Medi-Cal RX Transition effective 1/1/2022. o The top requests in Q3 2022 were mostly consistent when compared to Q2 2022. **Pharmacy Operation Metrics** ➢ In Q1 2022, TAT was lower than threshold in all months. The lower-than-expected results were primarily due to staffing and volume challenges with the implementation of the Medi-Cal Rx program effective 1/1/2022. ➢ In Q2 2022 PA volume stabilized and met goal, April 96.1%, May 94.6%, and June 96.1%. ➢ Q3 2022 PA volume varied with an unusually high number in August (180 total PAs), and decreased in September but were within 5% of the standard. ➢ Overall TAT was at 97% for Q3 2022. **Top 25 Prior Authorization** Q3 2022 top 25 medical benefit drug PA requests to the PA team. ➢ Top 25 PA requests in Q3 2022 were mostly consistent for July, August and September when the top 10 drugs are reviewed with a few placement variations. ➢ 92% Denial rate for Viscosupplement/Pegfilgrastim **Pharmacy Inter-Rater Reliability Results (IRR)** (Q3) Envolve Pharmacy Solutions is the delegated to review medical benefit drug prior authorization requests for the health plan. A sample of 10 prior authorizations (4 approvals and 6 denials) per month are reviewed quarterly to ensure that they meet 10 metrics. Top metrics for review are timeliness, criteria applied appropriately, clear and appropriate language, and agreed with decision consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold of 90%.	Motion: *Approve* - Pharmacy Executive Summary (Q3) - Pharmacy Operations Metrics (Q3) - Pharmacy Top 30 Prior Authorizations (Q3) - Pharmacy Inter-Rater Reliability Results (IRR) (Q3) (Ayala/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	➢ Analysis/Findings/Outcomes: o **2** cases were determined to have a questionable denial and/or were likely denied inappropriately after plan review (should clearly based on documentation.) o **1** case missed TAT o **6** cases were noted that criteria used was not applied appropriately after plan review (notes not there and clear.) Top category out of compliance at 80%. o 90% threshold met. 95% goal not met; overall score was **92.50%** ➢ Barrier Analysis: o **Criteria Application** continues to be the main issue in Q3 2022. Results will be shared with PA managers for review and feedback, and the Director will continue monitoring for improvement.	
#6 **Policy & Procedure** - UM/CM Public Health Policy Grid (Attachment CC) **Action** Patrick Marabella, M.D Chair	**The UM/CM Public Health Policies and Procedures** were presented to the committee. The majority of the policies were updated. without changes or minor changes. ➢ UM-001 Post Stabilization Inpatient Care Requested by Non-Contracted Hospitals: Added reference to APL 22-011 No Surprises Act and updated language regarding availability of health plan physician 24/7 and within 30 minutes for consultation or member transfer. ➢ UM-012 Discharge Planning: Updated Medical Necessity definition to be consistent with APL 22-006. ➢ UM-013 Provision of Enteral Nutritional Supplements/Replacements: Updated to be consistent with Medi-Cal RX, the plan is responsible for medical benefit only (not pharmacy). ➢ UM-023 Mental Health Services: Transitioned to Public Health (PH-020) and retired UM-023. Re-assigned to Public Health to be consistent with other Behavioral Health policies. ➢ UM-024 Behavioral Health Treatment Services-autism spectrum disorder: Will be updated and transitioned to Public Health (PH-025) consistent with above. ➢ UM-050 Communications and Accessibility to UM: Added statement regarding process for Call Center staff to contact UM staff when Regional Call Center is unable to respond to inquiry. ➢ UM-100 Emergency Care and Services: New policy. Emergency Rooms are open 24/7, no prior authorizations required, if care requires admission, then criteria to admit will be required. Content was part of post stabilization but has been separated out. ➢ Updated Medical Necessity definition to be in complaint with APL 22-006 for the following: o UM: 103 Continuity of Care o UM-119 Concurrent Review	Motion: *Approve* - UMCM Public Health Policy Grid (Sidhu/Carmona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ UM-120 Hospice Care Services ○ UM-121 Dental Services and IV Sedation and General Anesthesia ○ UM-210 Referrals to Non-Participating Practitioners/Providers ➢ UM-212 Transgender Services: Added Sensitive Services definition to be consistent with Assembly Bill 1184. An underage member can receive Sensitive Services without parental consent. ➢ UM-300 CBAS Authorization Process: Updated Medical Necessity definition to be compliant with APL 22-006. ➢ CMP-009 SPD Member Process to Request a Specialist as a Primary Care Provider: Transitioned to Member Services (MS-009) and retired CMP-009. ➢ CMP-015 Seniors and Persons with Disabilities (SPDs) Health Risk Stratification and Assessment: Added Attachment A: Health Information Form (CA Screening Health Risk Assessment). Added Member Services and Medical Management Sections. ➢ CMP-107 Care Coordination/Case Management Services: Added digital care option throughout. Added statement regarding identification of high-risk members using physical and BH risk scoring systems. ➢ Three (3) new policies were included in the meeting packet and reviewed with the committee: ○ UM-060 UM Decisions and Timely Access to Care ○ UM-100 Emergency Care and Services ○ CMP-050 Developmental Disability and Community Resources Linkage	
#7. **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report (Q4) - Peer Review Subcommittee Report (Q4) (Attachment DD - EE) **Action** Patrick Marabella, M.D Chair	**Credentialing Sub-Committee Quarterly Report** was presented. In Q4 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 for 2022 were reviewed for delegated entities and Q3 2022 reports were reviewed for both Health Net and MHN. **Second Quarter 2022 Credentialing/Recredentialing Totals:** ➢ Sante: 49 Initial credentialing ➢ ChildNet: 4 Initial credentialing; 44 Recredentialing ➢ MHN: 35 Initial credentialing; 18 Recredentialing ○ Overall Total: 198 Initial credentialing; 139 Recredentialing, Total 337 There was one (1) case for Q4 2022 CalViva Adverse Action Credentials Report from Health Net, covering July to September 2022. This case involved the early termination of monitoring for compliance with	Motion: *Approve* - Credentialing Subcommittee Report (Q4) - Peer Review Subcommittee Report (Q4) (Ayala/Sidhu) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	the Medical Board of California (MBOC) probation associated with a 2017 decision. The MBOC granted early termination indicating that the practitioner's probation was complete and his license fully restored. The 2023 Credentialing Sub-Committee meeting schedule was reviewed and approved. **Peer Review Sub-Committee Quarterly Report** was presented. The Peer Review Sub-Committee met on October 20, 2022. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2022 were reviewed and approved. There were no significant cases to report. The Q3 2022 Peer Count Report was presented at the meeting with a total of 7 cases reviewed. The outcomes for these cases are as follows: ➢ Three (3) cases were closed and cleared. ➢ There was one (1) case with an outstanding CAP. ➢ There were three (3) cases pended for further information. The 2023 Peer Review Sub-Committee meeting schedule was reviewed and approved.	
#8. **Compliance Update** - Compliance Regulatory Report (Attachment FF)	Maria Sanchez 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 Health. **Oversight Audits.** The following annual audits are in-progress: Credentialing, 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 10/20/22 Compliance Regulatory Report to the QIUM Committee, there have been two new MC609 cases filed. One case involved a participating group practice specializing in vascular surgery that was an outlier for billing a higher number of a particular HCPC code compared to peers. Another was filed due to SIU receiving a referral from the health plan stating a member's father received a bill for DME products that were not received or needed. Note: There was an MC609 case filed in June 2022 that was inadvertently left off the 9/15/22 and 10/20/22 Compliance Regulatory Reports. This case involved a member complaint about billing they received from a DME provider when they had not seen the provider since 2018. We will continue to work with SIU on these cases.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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 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 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). On 10/19/22, the Plan provided responses to these draft findings. DHCS' Final Report is pending. **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. Preliminary report still pending. **New Regulations / Contractual Requirements/DHCS Initiatives.** ➢ **California Advancing and Innovating Medi-Cal (CalAIM)** Enhanced Care Management & Community Supports: On 10/25/22, the Plan submitted updated MOC documents to ensure the Plan' and its subcontractors' policy and procedures related to ECM/CS authorizations are aligned to minimize administrative burden on the ECM/CS providers. Response pending. Long-Term Care (LTC) Carve-In: On 10/14/22, the Plan received written confirmation from DHCS that the Plan was compliant with the SNF network readiness requirements. Population Health Management: On 10/28/22, the Plan filed its PHM Program Deliverable with DHCS. Approval is pending. CVH will continue to supply any necessary documents to receive NCQA Accreditation. **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: o Phase 1: August 12, 2022 – December 8, 2022 o Phase 2: December 15, 2022 - March 31, 2023 o Phase 3: April 20, 2023 - July 31, 2023 The Plan has completed the 9/12/22 filing of documents and some have come back with errors. CVH has responded to the errors and a response from DHCS is pending. CVH is in the process to complete the 12/19/22 required filing.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Public Policy Committee. The next meeting will be held on December 7, 2022 at 11:30am in the Plan's Administrative Office.	
#10 **Old Business**	None.	
#11 **Announcements**	➢ Dr. Marabella introduced new staff, Zaman Jennaty, Medical Management Nurse Analyst, and Norell Naoe, Medical Management Administrative Coordinator. ➢ Conference room AV equipment will be remodeled during the break. ➢ Next meeting February 16th, 2023	
#12 **Public Comment**	None. Homer Anzaldua from MedZed introduced himself.	
#13 **Adjourn**	Meeting was adjourned at 11:42 AM	

NEXT MEETING: February 16th, 2023

Submitted this Day: 2/23/2023

Submitted by: _____

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

_____

Patrick Marabella, MD Committee Chair

Item #4

Attachment 4.D

Public Policy Committee Minutes
Dated 9/7/22

Public Policy Committee
Meeting Minutes
September 7, 2022

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

Committee Members		Community Base Organizations (Alternates)	
✓	Joe Neves, Chairman	✓	Jeff Garner, KCAO
✓	David Phillips, Provider Representative		Roberto Garcia, Self Help
	Vacant, Kings County Representative		**Staff Members**
✓	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Director Community Relations
✓	Kristi Hernandez, At-Large Representative	✓	Cheryl Hurley, Commission Clerk / Director, HR /Office
	Kevin Dat Vu, Fresno County Representative	✓	Mary Lourdes Leone, Chief Compliance Officer
	Norma Mendoza, At-Large Representative	✓	Steven Si, Senior Compliance & Privacy/Security Specialist
		✓	Maria Sanchez, Compliance Manager
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:36 am. A quorum was present.	A roll call was taken.
#2 Meeting Minutes from March 2, 2022 **Action** Joe Neves, Chair	The March 2, 2022 meeting minutes were reviewed.	**Motion:** Approve March 2, 2022 Minutes 5-0-0-3 (D. Phillips / K. Hernandez) A roll call was taken.

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#3 Meeting Minutes from June 1, 2022 **Action** Joe Neves, Chair	The June 1, 2022 meeting minutes were reviewed.	**Motion:** Approve June 1, 2022 Minutes 5-0-0-3 (D. Phillips / S. Garcia) A roll call was taken.
#4 Proposed 2023 PPC Meeting Calendar **Action** Joe Neves, Chair	The 2023 proposed meeting calendar was presented to the PPC. No conflicts were noted.	**Motion:** Approve Proposed 2023 Calendar to move to Commission for final approval 5-0-0-3 (J. Garner / D. Phillips) A roll call was taken.
#5 Annual Public Policy Committee Charter Review **Action** Joe Neves, Chair	The PPC Committee reviewed the Charter and approved to move forward to Commission for approval with no revisions.	**Motion:** Approved PPC Charter to move to Commission for full approval 5-0-0-3 (J. Garner / D. Phillips) A roll call was taken.

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#6 Enrollment Dashboard **Information** Maria Sanchez, Compliance Manager	Maria Sanchez presented the enrollment dashboard through June 2022. Membership as of June 30, 2022 was 407,069. CalViva Health maintains a 68.58% market share.	**No Motion**
#7 Health Education **Information** Steven Si, Senior Compliance Privacy/Security Specialist	Steven Si presented the Health Education Member Incentive Programs Semi Annual Report for Q1 and Q2 2022. There were six Health Education programs in Q1 & Q2 with 596 award recipients. Of the award recipients: 96% were from Fresno County; 2% from Madera County; and 2% from Kings County. $20,125 in gift cards and $2,380 in digital scales was given to CVH members. That is an increase of 522 when compared to Q3 & Q4 2021. There were six program award recipients compared to Q3 and Q4, 2021. Those programs consist of: Breast Cancer Screening; Cervical Cancer Screening; Childhood Immunization (CIS-10); Diabetes Prevention Program; Comprehensive Diabetes Care; and COVID-19. Barriers consisted of: • Point of Care (POC) incentive included in Performance Improvement Projects (PIP): Incentives were not the primary intervention for the PIP projects. Incentives were implemented as a second intervention in Q1-Q2, 2022. • Cervical Cancer Screening (CCS): Provider priorities following COVID-19 pandemic. • Comprehensive Diabetes Care (CDC): A portion of members could not be reached by phone after three unsuccessful attempts. Low engagement, members declining to schedule any in-person dietician classes. Multiple challenges such as transportation issues, short notice, family/job commitments, inconvenient time of day, etc. • COVID-19: Inability to access the internet (limited access to website and email); some members did not have an email address (e-gift card could not be sent electronically).	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Next steps consist of: Breast Cancer Screening (BSC) PIP: • Planned member incentive distribution at point of care in collaboration with selected providers. Additional mobile mammography events are being planned throughout 2022, including members to receive a $25.00 VISA gift card upon completion of the BCS exam. Details are being discussed and finalized. • Video testimonials by three breast cancer survivors will be displayed in medical office waiting rooms, YouTube, local Hmong television channel, the local southeast Asian cultural center, and community events to raise awareness of breast cancer and to persuade and encourage members to complete their breast exams. • Plans to distribute a $25 Visa Gift card upon completion of the BCS-Fresno County. CIS-10 PIP: • Continue with the text messaging campaign. • Implement two additional "Hero's for Health IZ" Re-occurring Events in the Fall; one in October and the second one in November, (approximately 3 weeks after the event in October), with emphasis on the influenza immunizations. • Plans to distribute a $25 Visa Gift card upon completion of one of the targeted CIS-10 immunizations-Fresno County. • Continue to collaborate with the providers to discuss potential new interventions for improving CIS-10 completion rates. • Continue to offer health education materials to members, and help parents understand the importance of childhood immunizations. COVID-19: • Continue with member outreach including the information on how to receive the e-gift card. Child and Adolescent Well Care Visits (WCV):	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• Planned member incentive distribution at point of care in collaboration with selected providers. Diabetes Prevention Program: • Complete another member outreach mailing.	
#8 Health Education **Information** Steven Si, Senior Compliance Privacy/Security Specialist	Steven Si presented the Health Education Population Needs Assessment Report update. Based on measurement year 2020 (MY2020) data, all CalViva counties demonstrated various HEDIS® measures below the 50th percentile minimum performance level (MPL). The COVID-19 pandemic impacted heath care access, resulting in lower performance for some HEDIS® measures. Fresno County had the most measures below the MPL, while Madera had the least. • Pediatric Health: o Madera County performed most favorably, noting three measures under the MPL out of the nine captured for review. Fresno County had eight (89%) of their measures below the MPL. o Across all counties, three measures were consistently below the MPL: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Well-Child Visits in the First 30 Months of Life – 0 to 15 Months (W30-15), and Child and Adolescent Well-Care Visits (WCV). • Women's Health: o Kings and Madera Counties had the best performance across all CalViva counties, with only one measure each, Breast Cancer Screening (BCS) and Chlamydia (CHL) respectively below the MPL. o Fresno County had at least three of five measures below the MPL. In the majority of CalViva counties, BCS and CHL were consistently below the benchmark. o All three CalViva counties met the MPL for timeliness of prenatal and postpartum visit HEDIS® measures.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN

	• Adult and Chronic Health:
	  o Kings and Madera Counties met the MPL for three of the six measures.
	  o Fresno County missed the MPL on four measures. Antidepressant Medication Management – Effective Acute Phase Treatment and Effective Continuation Phase Treatment are the most recurring measures in CalViva counties below the 50th percentile.
	
	Progress made toward the 2021-2022 objective and strategies include:
	• By June 30, 2022, Health Education Department will increase member utilization of myStrength program by 20% from 119 to 143 members (baseline: 65).
	• By December 31, 2022, increase the percentage of the BCS rate among Hmong, Laotian, and Khmer speaking females ages 50-74 years assigned to the Greater Fresno Health Organization in Fresno County from a baseline rate of 38.4% to a goal rate of 47.8%.
	• By June 30, 2022, Health Equity Department will increase the utilization of a new Video Remote Interpreting (VRI) Services from 0 to 75 appointments to support member language needs.
	
	New Action Plan for 2022-2023 consists of:
	• Health Education: continue improving myStrength participation.
	• Quality Improvement: address disparity for breast cancer screening among Southeast Asian speaking females in Fresno County.
	• Health Equity: increase Language Assistance Program (LAP) utilization with a new VRI service.	

#9 Appeals, Grievances and Complaints **Information**	For Q2 2022 there were 4 Coverage Disputes (Appeals), 105 Disputes Involving Medical Necessity (Appeals), 92 Quality of Care, 86 Access to Care, and 110 Quality of Service, for a total of 397 appeals and grievances. The majority of which are from Fresno County. The turn-around time compliance for appeal and grievance cases was as follows:	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Maria Sanchez, Compliance Manager	• Standard Grievances: 100% • Expedited Grievances: 100% • Standard Appeals: 100% • Expedited Appeals: 100% There was a total of 471 Exempt Grievances received in Q2 2022. Of the total grievances and appeals received in Q2, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 90 • Appeals: 27 • Exempt: 14 The majority of appeals and grievances were from members in Fresno County (largest CalViva Health enrollment). The majority of quality of service (QOS) grievance cases resolved were categorized as Access-Spec, Access-Other, and Other. The majority of quality of care (QOC) grievance cases were categorized as PCP Delay, Specialist Care and PCP Care. The top categories of appeal cases were related to Advanced Imaging, Pharmacy RX-Medical Benefit, and DME. The top categories for exempt grievances were Health Plan Material-ID Cards Not Received, PCP Assignment/Transfer Health Plan Assignment Change Request, and PCP-HCO Assignment - Change Request.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#10 – Audit Updates • **2021 DMHC Audit** • **2020 DHCS Audit** • **2022 DHCS Audit** • **2022 DMHC Audit** **Information** Mary Lourdes Leone, Chief Compliance Officer	Mary Lourdes Leone provided updates on the following audits: • **2021 DMHC Audit**: CVH has yet to receive the final determination due to DMHC currently re-evaluating one of the findings from that audit. • **2020 DHCS Audit**: CVH has not yet closed out the finding from that audit due to it being rolled over into this year's **2022 DHCS Audit** which was completed in April 2022. DHCS indicated they would provide CVH with the final report in July; however, CVH has yet to receive the report. • **2022 DMHC Audit**: CVH has completed all the initial filings of the required documents in June 2022. Since then, DMHC has requested additional information, which the Plan has complied with. September 19th the DMHC audit interviews will begin.	**No Motion**
#11 Final Comments from Committee Members and Staff	D. Phillips shared that United Health Centers opened three new centers in the last couple of months; one in Hanford, one in Kingsburg, and one in southeast Fresno. Grand openings will take place at each location. UHC's gold tournament is October 14th in Dinuba. J. Garner, with KCAO, announced they will be launching a "groceries-to-go" program in Kettleman City in partnership with CalViva Health and Central California Food Bank. In addition, they have purchased property in Armona to establish a new food bank in Kings County. Jeff Garner also announced that KCAO is a part of the National Community Action Network which has an annual convention to honor individuals as well as organizations that have made an impact on communities. KCAO nominated CalViva Health for the National Corporate Partner award and CVH was selected as the Corporate Partner of the Year. Jeff Nkansah, CVH CEO, and Courtney Shapiro, Director of Community Relations and Marketing with CVH, traveled to New	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	York to participate in the convention and receive the National Corporate Partner award on behalf of CalViva Health. Courtney Shapiro shared recent CVH events. This included the 2nd Annual Teacher Library Book event; UHC Golf Tournament; and Back to School Night at the Fresno Grizzlies game. CVH has purchased CalViva Health Cares banners for partners that receive CVH funding.	
#12 Announcements	Anthem Blue Cross will retain the commercial Medi-Cal plan in the central valley.	
#13 Public Comment	Isabel Rivera introduced new team member Elizabeth Campos, Program Manager Community Engagement. In addition, Isabel Rivera shared updates on the CalAim program.	
#14 Adjourn	Meeting adjourned at 12:56 pm.	

NEXT MEETING **December 7, 2022 in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: December 7, 2022

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

Approval Date: December 7, 2022

Approved By: Joe Neves
Joe Neves, Chairman

Item #4

Attachment 4.E

Public Policy Committee Minutes
Dated 12/7/22

Public Policy Committee
Meeting Minutes
December 7, 2022

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

	Committee Members		Community Base Organizations (Alternates)
✓	Joe Neves, Chairman	✓	Jeff Garner, KCAO
✓	David Phillips, Provider Representative		Roberto Garcia, Self Help
	Vacant, Kings County Representative		**Staff Members**
✓	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Director Community Relations
✓	Kristi Hernandez, At-Large Representative	✓	Cheryl Hurley, Commission Clerk / Director, HR /Office
	Vacant, Fresno County Representative	✓	Mary Lourdes Leone, Chief Compliance Officer
✓	Norma Mendoza, At-Large Representative	✓	Steven Si, Senior Compliance & Privacy/Security Specialist
		✓	Maria Sanchez, Compliance Manager
		✓	Patrick Marabella, MD, CMO
		✓	Amy Schneider, RN, Director, Medical Management
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:31 am. A quorum was present.	A roll call was taken.
#2 Meeting Minutes from September 7, 2022 **Action** Joe Neves, Chair	The September 7, 2022, meeting minutes were reviewed.	**Motion:** Approve September 7, 2022, Minutes 6-0-0-1 (J. Garner / D. Phillips)

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#3 Enrollment Dashboard **Information** Maria Sanchez, Compliance Manager	Maria Sanchez presented the enrollment dashboard through September 2022. Membership as of September 30, 2022 was 413,576. CalViva Health maintains a 68.38% market share.	**No Motion**
#4 Health Education **Information** Steven Si, Senior Compliance Privacy/Security Specialist	Steven Si presented the Health Education 2022 Executive Summary and Work Plan Mid-Year Evaluation. The 2022 Health Education Work Plan Mid-Year Evaluation report documents the progress of 15 initiatives with 34 performance objectives. Within each initiative, there are multiple objectives: • Of the 15 initiatives, 12 initiatives with 24 objectives have met or are on track to meet the year-end goal. • The remaining 3 initiatives with 3 out of 10 objectives are off-track. They consist of Fit Families for Life and HHHP, Tobacco Cessation, and Compliance Oversight & Reporting. • Of those 3 initiatives, one was impacted based on an assessment of resources; one was impacted by a protracted length of time in DHCS completing its review and providing contract approval; and one is postponed until further direction from DHCS (SHA). Accomplishments consist of: • 74 members enrolled in the Central California Asthma Collaborative in-home visitation program. • 91 members enrolled in the Diabetes Prevention Program. • 90 charlas with a 66%-member participation rate (950/1,380). ▪ Promotores Health Network conducted in-person and virtual classes on bailoterapia (physical activity), walking club, literacy club, and health education in collaboration with community partners.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• 309 members enrolled in my-Strength. • 10,591 screening claims for ACEs (Adverse Childhood Experiences) screening. • Rebranded/updated 18-member health education materials: ▪ Topics included exercise, heart health, diabetes, weight management, pain control, and health education programs & services.	
#5 Health Equity **Information** Steven Si, Senior Compliance Privacy/Security Specialist	Steven Si presented the Health Equity 2022 Executive Summary and Work Plan Mid-Yar Evaluation, and the 2022 Summary and Language Assistance Program Mid-Year Report. As of June 30, all activities are on target to be completed by the end of the year with some already completed. Language Assistance Services: • 5 contracts amended to include encryption languages to alternate format serving vendors. • 1 new OPI and VRI vendor added to language service: Language Line. • 27 staff completed their bilingual assessment/re-assessment. • 26 translation reviews completed. • Population Needs Assessment completed in collaboration with HE & QI. Compliance Monitoring: • 27 grievances received with 2 interventions identified. • Health Equity Policy & Procedures reviewed and updated. Communication, Training, and Education: • 2 trainings completed for new hires and current A&G staff. • 4-part implicit bias, Cultural Competency, and Health Literacy training are on track to be completed in Q3 & Q4.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Health Literacy, Cultural Competency, and Health Equity: • 19 English materials reviewed. • 2 Readability and EMR Database trainings completed. • Co-led internal workgroup and CAG meetings for BCS PIP project. • Attended meetings and supported CIS-10 PIP project. • Attended meetings and supported HbA1c and CCS PDSA projects.	
#6 Medical Management **Information** Dr. Marabella, CMO	Dr. Marabella presented the Quality Improvement & HEDIS® Update for Measurement Year (MY) 2021. Dr. Marabella reported that Madera County met the 50th percentile benchmark for all required measures; 100% met goal. Kings County achieved the 50th percentile goal for 73% of measures with Childhood Immunizations, Immunizations for Adolescents, and Well-Child & Adolescent Visits coming in under the benchmark. Fresno County also achieved the 50th percentile goal for 73% of measures with Breast Cancer Screening, Childhood Immunizations, and Well-Child & Adolescent Visits coming in under the benchmark. 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 • Follow-Up after ED Visit for Substance Abuse – 30 Days The two PDSA Projects were: • Cervical Cancer Screening • Comprehensive Diabetes Care The two Performance Improvement Projects (PIPs) are: • Childhood Immunizations – Under 2 years (CIS-10) • Breast Cancer Screening Disparity Project (BCS)	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN

	Projects going forward:
	• Continue the two PIPs through December 31, 2022: final analysis due April 2023.
	• New Guidance from DHCS:
	  o SWOMT for Well Child & Immunizations
	  o NEW PIPs in the fall:
	  ▪ Follow up after ED Visit for Mental Illness or Substance Abuse
	  ▪ Well Child Visits	

#7 Quarterly Appeals and Grievance Report **Information** Maria Sanchez, Compliance Manager	For Q3 2022 there were 7 Coverage Disputes (Appeals), 134 Disputes Involving Medical Necessity (Appeals), 95 Quality of Care, 94 Access to Care, and 141 Quality of Service, for a total of 471 appeals and grievances. The majority of which are from Fresno County. The turn-around time compliance for appeal and grievance cases was as follows: • Standard Grievances: 100% • Expedited Grievances: 100% • Standard Appeals: 100% • Expedited Appeals: 100% There was a total of 558 Exempt Grievances received in Q3 2022. Of the total grievances and appeals received in Q3, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 110 • Appeals: 28 • Exempt: 131 The majority of appeals and grievances were from members in Fresno County (largest CalViva Health enrollment).	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	The majority of quality of service (QOS) grievance cases resolved were categorized as Administrative, Access-Other, and Interpersonal. The majority of quality of care (QOC) grievance cases were categorized as PCP Delay, Specialist Care and PCP Care. The top categories of appeal cases were related to Advanced Imaging, Surgery, and DME. The top categories for exempt grievances were Health Plan Material-ID Cards Not Received, PCP Assignment/Transfer Health Plan Assignment Change Request, and PCP-HCO Assignment - Change Request.	
#8 2021 DHCS Audit – CAP Update **Information** **Information** Maria Sanchez, Compliance Manager	The Plan submitted the CAP response in July 2020 and currently still pending a response. Inquiry into a response from DHCS will be made once the current audit ends.	**No Motion**
#9 2022 DHCS Audit – Final Report **Information** Maria Sanchez, Compliance Manager	A final report was received on November 21, 2022; the CAP was received on November 30, 2022. There were findings in two different categories; one related to Blood Lead Screening, and the second was related to Transportation. The initial CAP response is due to DHCS by December 30, 2022.	**No Motion**
#10 2020 DMHC 18-Month Audit - Update **Information**	No update available for this audit. Inquiry with DMHC will be made once the current audit ends.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Maria Sanchez, Compliance Manager		
#11 2022 DMHC Audit **Information** Maria Sanchez, Compliance Manager	Post audit requests are still being received; the Plan is responding as needed. The last submission was made Monday, December 5, 2022.	**No Motion**
#12 Enhanced Care Management (ECM) & Community Supports - Update **Information** Mary Lourdes Leone, Chief Compliance Officer	Mary Lourdes Leone gave a brief update on the background and current status of the Enhanced Care Management (ECM) and Community Supports programs. The ECM benefits went live in Kings County for specific populations as of January 1, 2022. Fresno and Madera counties went live with ECM for specific populations in July 2022. An additional timeline was shared for 2023 and 2024 for when ECM will be rolled out to additional populations in the Plan's service area.	
#13 Final Comments from Committee Members and Staff	Rusty Robinson, Supervisor Elect for Kings County, was introduced as the alternate for Supervisor Neves. Courtney Shapiro shared the CalViva Health Cares page on the Plan's website. Jeffrey Nkansah, CVH CEO, reported on the Public Health Emergency coming to an end and potentially 18 million beneficiaries losing coverage. The Plan is working with Community partners and Provider partners in efforts to notify beneficiaries to be cognizant of any requests they may receive in the mail regarding their coverage and to ensure they respond as requested. Jeff Garner, KCAO, shared updates for Kings County. CVH made a donation to update their Domestic Violence shelter and they will be breaking ground in the upcoming weeks. A new project was launched with the help of CVH, called Groceries to Go located in Kettleman City.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	KCAO is also kicking off services regarding rental assistance for seniors and veterans, tax assistance, and assistance with paying water bills. Norman Mendoza shared attendance numbers in the promotores for the month of November. David Phillips shared United Health Centers has a change in leadership. The new President is Justin Preas. UHC is opening a new site in January located in Visalia. In addition, a new site in Fresno will open on Ashlan Avenue. There are two vacancies on the Public Policy Committee: one for Kings County and one for Fresno County. Steven Si shared there is a new CalViva Health branded YouTube channel, which can be accessed through the website or Google, and is focused on health education.	
#14 Announcements	None	
#15 Public Comment	None	
#16 Adjourn	Meeting adjourned at 1:30 pm.	

NEXT MEETING **March 1, 2023, in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: March 1, 2023,

Submitted By: C Shapiro
Courtney Shapiro, Director Community Relations & Marketing

Approval Date: March 1, 2023

Approved By: Joe Neves
Joe Neves, Chairman

Item #4

Attachment 4.F

Compliance Report

Regulatory Filings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022 YTD Total
# of DHCS Filings													
Administrative /Operational	22	19	7										48
Member Materials Filed for Approval;	2	3											5
Provider Materials Reviewed & Distributed	15	12	5										32
# of DMHC Filings	11	8	1										20

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

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	0	4	0										4
High-Risk	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	0	0	2										2
# of Cases Open for Investigation (Active Number)	10	12	12										

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 2/16/23 Compliance Regulatory Report to the Commission, there has been two MC609 cases filed. One case was regarding a participating PCP who is routinely billing high-level Evaluation and Management (E/M) services at a rate that is significantly higher than peers. The other case was referred to the Plan by the California DOJ regarding a DME provider of pulmonary equipment.

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. No oversight audits have been completed since the last Commission report.
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") 2023 Medical Audit	On 1/3/23, the Plan received DHCS' written notice scheduling the Department's medical audit of the Plan for the week of April 17, 2023. The 2023 audit will also include two additional "focus audits", one related to Behavioral Health and the other to Transportation. The Plan submitted all Pre-Audit document requests on 3/3/23, and is currently responding to DHCS' requests for specific sample case files used in the Department's audit verification process.
Department of Health Care Services ("DHCS") 2022 Medical Audit	The Plan received the DHCS' 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). Based on the Plan's monthly submission of its CAP activities, the DHCS has accepted as completed the two associated with the blood lead screening. The Plan will continue to file a monthly report on the transportation finding until the DHCS accepts the Plans actions as having been satisfactorily completed.

Department of Managed Health Care ("DMHC") 2022 Medical Audit	The Plan is awaiting DMHC's Preliminary Report.
New Regulations / Contractual Requirements/DHCS Initiatives	**Status**
California Advancing and Innovating Medi-Cal (CalAIM)	On 2/15/23, the Plan submitted an updated Model of Care (MOC) to DHCS in preparation for the new ECM population of focus (POF) that goes live 7/1/23, specifically Children and Youth which include: • Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness; • Children and Youth At Risk for Avoidable Hospital or Emergency Department (ED) Utilization; • Children and Youth with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; • Children and Youth Enrolled in California Children's Services (CCS) with Additional Needs Beyond the CCS Condition; • Children and Youth Involved in Child Welfare; • Children and Youth with Intellectual or Developmental Disabilities (I/DD); • Pregnant or Postpartum Youth. The Plan is awaiting DHCS approval of the MOC. .
Member Handbook/Evidence of Coverage	On 3/3/23, the Plan received DHCS' 2023 EOC Errata A which includes the following updates: • Language regarding the California Cancer Equity Act • The removal of the word "brief" under Cognitive health assessments The Plan is required to provide the Errata A to members electronically or by mail by May 1, 2023 and post a copy on its website no later than May 1, 2023
Plan Administration	
DHCS 2024 Operational Readiness Work Plan & Contract	The Plan has completed the monthly filings to DHCS of the various policies and other required documents through January 2023, and has received approvals on most but is still responding to additional DHCS information requests for some of the items. The Plan is on schedule to continue the required monthly filings through August 2023.
Committee Report	

Public Policy Committee	The Public Policy Committee met on March 1, 2023 at 11:30am in the Plan's Administrative Office with a quorum present. The Minutes to the December 7, 2022 PPC were approved. The following informational reports were presented: 2022 Health Education Executive Summary and Work Plan Mid-Year Evaluation; 2022 Health Equity Executive Summary and Work Plan Mid-Year Evaluation; 2022 Summary and Language Assistance Program Mid-Year Evaluation; the Quality Improvement and HEDIS Update MY 2021; and the Q3 Quarterly Grievance Report. There were no recommendations for referral to the Commission. The next PPC meeting will be held on June 7, 2023 at 11:30 in the CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711

Item #4

Attachment 4.G

2022 QI EOY Executive Summary

REPORT SUMMARY TO COMMITTEE

TO:	QI/UM Committee Members Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Amy Wittig, Quality Improvement Department
COMMITTEE DATE:	February 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. 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. 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.

Item #4

Attachment 4.H

2022 QI Work Plan EOY Evaluation

CalViva Health Quality Improvement Year-End Work Plan Evaluation 2022

02/16/2023

CalViva Health 2022 Quality Improvement Year-End Work Plan Evaluation

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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

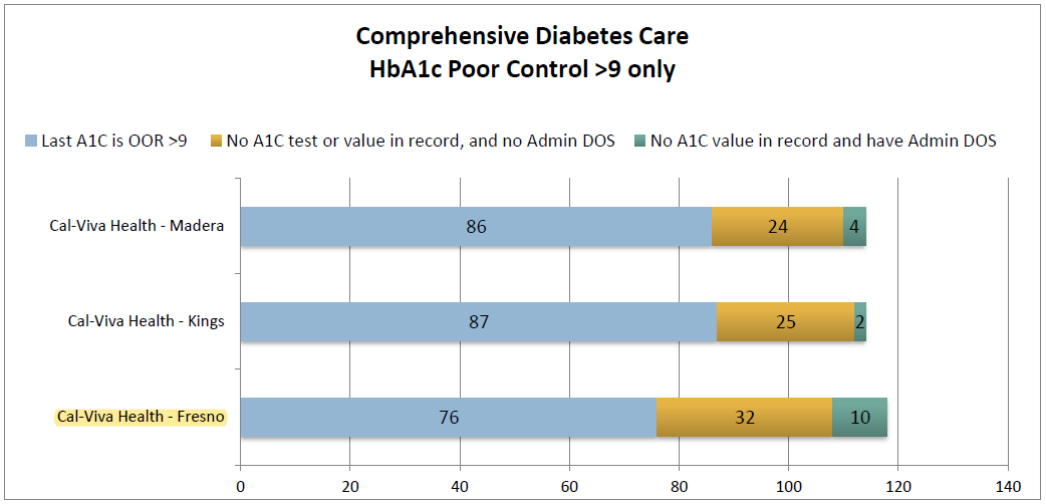
Comprehensive Diabetes Care (CDC) HbA1C Poor Control >9

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 #4

Attachment 4.I

2022 UMCM WP EOY Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Jennifer Lloyd, Vice President Medical Management
COMMITTEE DATE:	February 23, 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.

Item #4

Attachment 4.J

2022 UMCM Work Plan EOY Evaluation

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

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Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

1. Compliance with Regulatory & Accreditation Requirements

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
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<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 #4

Attachment 4.K

2023 UM Program Description

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 #4

Attachment 4.L

2023 UMCM Work Plan

Attachment V

CalViva Health 2023 Utilization Management (UM)/ Case Management (CM) Annual Work Plan

Last updated: January 31, 2023

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Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 4 clinical continuing education opportunities to staff. Conduct Population Health and Clinical Operations (PHCO) 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				
Annual Evaluation ☐ MET OBJECTIVES ☐ CONTINUE ACTIVITY IN 2024				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 PHCO processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

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

Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 January 2023, April 2023, July 2023, October 2023

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 2023. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 as needed and 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 PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2023 UM and CM Program Descriptions. Write and receive CalViva approval of 2022 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2023 UMCM Work Plan. Write and receive CalViva approval of 2023 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 2023 Q 1 2023 Q 1 2023 Q 3 2023 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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. Increase staff to prepare for the long-term care benefit carve in and ensure continuity of care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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.	PHCO Learning and Development annually administers Change Healthcare InterQual® IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews The minimum passing score is 90% on each InterQual® IRR test	Provide training to leadership focused on IRR testing CAP documentation and monitoring. Administer the Change HealthCare InterQual IRR test in Q3-Q4 2023 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews.	Q1-2023 Q3-4 2023

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 PHCO 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	Establish 2023 utilization goals once 2022 outcomes are available. 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. Leverage Member Connections to support on-site bed side enrollment of members into programs such as MedZed, CalAim, Complex Care Management and Community Supports. Explore areas for on-site support (clinical or non).	Q1-2023 Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. 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 2023 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

5. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.1 Care 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. Member connections team to collaborate with care management by providing in home visits to support appropriate interventions and improve member outcomes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program. Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high-risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFTs, 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**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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. Submit Disease/Chronic Condition Management redesign proposal for approval Q1 2023.	Ongoing 12/31/2023 3/30/2023

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2023 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**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 the behavioral health administrator 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 the behavioral health administrator provides.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
5.1 Monitor 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: Identify 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, member appeals 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. Collaborate with Public Programs and Coordination of Care Team to facilitate transition of Independent Care Facility CCS membership (begins July 1st 2023). Continue to monitor Aging-out membership, identified 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2023 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, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Item #4

Attachment 4.M

2023 Case Management Program Description

Health Net Community Solutions and CalViva Health Care Management Program Description 2023

Table of Contents

PURPOSE

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

The primary care provider (PCP) is the cornerstone of the Plan's service delivery model serving as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost-effective care and better health outcomes. The PCP is expected to manage and coordinate the holistic care needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while always ensuring patient safety.

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

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

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

SCOPE

Definition of Care Management

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

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

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

Levels of care management include:

- **Basic Population Health Management (BPHM)**
  - **Care Coordination** – appropriate for members with primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources of assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of care management is used for continuity of care transitions and supplemental support for members managed by the county.
  - **Care Management** – appropriate for members needing a higher level of service, with clinical needs. Members in care management may have a complex condition or multiple co-morbidities that are generally well managed. Members in care management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services included at this level of care management include the level of coordination along with identification of member agreed upon goals and progress towards meeting those goals.
- **Complex Care Management (CCM)** – CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. CCM is a level of care management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex care management is performed by Health Net for members who need additional support to avoid adverse outcomes, and/or those who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of complex care management include all coordination and care management services from above, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence. Care Managers will also evaluate members for referral to Enhanced Care Management (ECM) services as appropriate.

Goals and Objectives

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

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.

- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

The Goals of the Care Management Program are:

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

Care Management Functions:

Care Management functions include:

- Early identification of members who have special needs.
- Assessment of member's risk factors.
- Development of an individualized plan of care in concert with the member and/or member's family, primary care provider (PCP), and managing providers.
- Identification of barriers to meeting goals included in the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Referrals and assistance to ensure timely access to providers.
- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/care management activities.

- Addressing the member's right to decline participation in the care management program or disenroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all care management procedures in compliance with HIPAA and state law.

Program Segments

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

Complex Care Management Criteria
The Plan uses the Population Health Management (PHM) report to identify members for Complex Care Management. The PHM report combines data from multiple sources to use in its population and program eligibility process. Data elements from multiple sources are stored in corporate-wide data warehouses. Data from the warehouse is extracted into a predictive modeling tool, Impact Pro. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information. Members are stratified into one of ten Population Health Categories in Impact Pro: Level 01: Healthy to Level 10: End of Life. In addition to Impact Pro, a web-based customizable report generating system, Micro Strategies, is used to produce adjunctive analytical reports for related PHM programs including Complex Care Management. Members stratified as described below are identified as complex and are referred to care management. Members stratified into one of the PHM report categories below: 08b High Priority Homeless/SUD 07b High Priority PH CM 07a high Priority BH CM 05d Chronic Highly Complex 05c Chronic High Risk - With Care Gap (under Clinical Analytics Population Grouping) 05b Chronic Moderate Risk AND have: ER likelihood: highly or most likely Members referred from other sources may also be managed as a complex care based on the member's need.

Care Management Criteria
Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to: • HIV/AIDS • Cancer • Asthma, with associated inpatient admission • Sickle cell • Diabetes • Congestive Heart Failure • Children with special health care needs • Other State-mandated criteria such as members under 21 years of age receiving private duty nursing services • Members otherwise meeting criteria for Complex Care Management but do not have an additional parameter such as 30% inpatient probability score • Members who reach a designated score based on responses to the Screening HRA and or who requested an ICP or individualized care team may be referred to Care Management.
Care Coordination Criteria
• Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing health care services related to continuity of care • Participation in county program requiring supplemental Plan support

INFRASTRUCTURE AND TOOLS

Organizational Structure

Vice President Medical Affairs

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

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

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

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

Behavioral Health Practitioner

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

Sr. Vice President of Population Health & Clinical Operations (SVP PHCO)

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

Vice President of Population Health & Clinical Operations (VP PHCO)

The VP PHCO is a registered nurse with experience in care management activities. The VP PHCO is responsible for overseeing the operational activities of the Plan's Care Management Program. The VP PHCO reports to the Sr. Vice President of Population Health & Clinical Operations and assists with the development and oversight of the strategy, policy, and operational planning and execution of work processes for the Care Management program.

Care Management Director/ Manager

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

Supervisor, Program Coordinator (PC)

The Supervisor PC is highly skilled high school graduates or equivalent with 5 or more years of prior authorization, physician's office, customer service, claims processing or provider relations experience preferably in a managed care setting. The Supervisor PC oversees day to day operations and supervision of the Program Coordinators in CM and performs collaborative

duties related to coordinated care programs. The Supervisor PC provides support to the Program Coordinators to promote quality and continuity of services delivered to members and providers. The Supervisor PC reports to the Director of CM.

Care Team (CT) Staffing Model

Care Coordination/Care Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers work closely with the concurrent review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Care Manager's average active case load may be up to 73 cases. The Integrated Care Team roles and responsibilities include care managers, social workers, other licensed clinical staff, program specialists, program coordinators, care coordinators, and Connection Representatives.

Medical Director

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

Care Manager (CM)

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

Social Workers/Program Specialists (SW/PS)

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

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

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

Program Coordinator (PC) I

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

Member Connections Representative (MCR)

- Health outreach workers typically hired from within the communities served to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.
- Works both in the office and in the community, sometimes with face-to-face member interaction.
- Performs member outreach, education, and home safety assessments.
- May assist with community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, Reading Events, etc.
- Member Connections Representatives report to the Manager of Member Connections.

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

Information System

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

The clinical documentation system contains additional clinical information, e.g., inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters

sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location.

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

MEMBER IDENTIFICATION AND ACCESS TO CARE MANAGEMENT

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

Data Sources

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

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

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

Referral Sources

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

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Care Management Program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.

- Nurse Advice Line staff –has policies and procedures in place for referring members to the Health Plan for care management screening. This may be accomplished via a "triage summary report" that is sent to the Plan electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at the Plan.
- Disease Management (DM) Program staff –work closely with the care management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as care management rounds, are held between the care team and DM staff.
- Hospital staff, e.g., hospital discharge planning and emergency department staff - facility staff is notified of the Plan's Care Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform Plan UM staff if they feel a member may benefit from care management services; UM staff then facilitate the referral.
- Health Plan Staff - UM staff work closely with care management staff on a daily basis and can initiate a referral for care management verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - Health Plan MemberConnections® Program - Connections Representatives (CRs) are trained in all departments within the Health Plan and have a full understanding of all staff functions. CRs work closely with the care team, referring members who may benefit from care management services.
    - Health Plan Member Services - Member Services staff is also trained in all departments within the Plan and have a full understanding of all staff functions, including the role and function of the care team.
    - Other intradepartmental referrals e.g., Provider Specialists, Plan Advocates, and QI Department.
- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - members are educated about care management services in the Member Handbook, received upon enrollment and available on the Plan website, member newsletters, and through contact with Member Services and/or other Plan staff.
- Community/social service agencies – community agency staff are informed of the Care Management Program during interactions with the Plan care team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential care management needs to Plan staff (California Children's Services (CCS), Local Health Department (LHD), Local Mental Health Plan (MHP) etc.).
- Delegated entity staff (e.g., vision, dental, DME/home health, etc., as applicable) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for care management. The Plan also regularly communicates with delegates through oversight meetings, care management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- State agency/state enrollment center.

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

SCREENING AND ASSESSMENT

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

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

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

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

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

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care

Coordination. Members with complex medical conditions where the condition is mostly stable, and the member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are assigned to a care team who confirms the findings of the screening assessment and may complete a more thorough assessment with the member. Outreach to members is initiated within 7 calendar days and completed within 21 calendar days of identification/referral.
A Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history. Stratification as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Care Management, or Complex Care Management may be revised at this time or following further assessment.

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

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

Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital care managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities

and needs. The role and function of the Care Manager is also explained to the member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

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

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

Behavioral Health Services

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

Continuity and Coordination of Care between Medical and Behavioral Health Care

When staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify the Plan Care Manager of the member. If the member's primary diagnosis is a behavioral health condition, the case is referred to a Behavioral Health Care manager, who serves as the lead Care Manager, working in tandem with the medical care team. Whether the member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health Care Manager will serve as the lead Care Manager. The medical

and behavioral health Care Managers confer with each other to confirm which Care Manager will serve as the lead or secondary Care Manager. If the Care Managers cannot agree, a supervisor is consulted for a decision.

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

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

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

Coordination with External Programs

The Plan will refer identified members to external agencies offering appropriate services and programs to complement those provided by the Plan. Programs and services may include, but are not limited to: Public Health Departments, Severe Mental Health Services, California Children's Services (CCS), Regional Center for the developmentally disabled, Home and Community-Based Services (HCBS) Waiver program administered by the State Department of Developmental Services (DDS), Regional Center or local governmental health program as appropriate for the provision of TCM services. The Plan shall continue to provide all Medically Necessary Covered Services per the Memorandum of Understanding for all eligible members that are not authorized or covered by external agencies. The Plan shall ensure the coordination of services and joint care management between its Primary Care Providers, specialty providers, and the local programs or agencies.

ONGOING MANAGEMENT

Plan of Care Development

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

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

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

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

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

Monitoring and Evaluation

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

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

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

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

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

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

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

The Care Manager implements necessary changes to the care team care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, or other members of the health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The care team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in

the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved are in agreement with changes to the care plan to ensure ongoing success. The care team also monitors the case on an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement Department.

Discharge from Care Management

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

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

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

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

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

PROGRAM ASSESSMENT AND IMPACT MEASUREMENT *Population Health*

Assessment

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

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

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

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

Member Experience with Care Management

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

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

Outcomes

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

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

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

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

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

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

The evaluation covers all aspects of the Care Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Utilization Management Committee for review, action and follow-up. The final document is then submitted to the Board of Directors/governing body through the Quality Improvement Committee for approval.

Condition Specific CM and Chronic Condition Management Programs

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

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

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

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

- Asthma
- Diabetes
- Heart Failure

SPECIAL PROGRAMS

CalAIM

Is a multi-year 5+ framework program developed by the Department of Health Care services (DHCS) encompassing a broad-based delivery system, program, and payment reform across Medi-Cal. The focus is to address the complex challenges facing the plan's most vulnerable members. It also provides for non-clinical interventions focused on the whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities. Enhanced Care Management (ECM) and Community Support (formally ILOS) in Lieu of Services are the first two programs that launched on January 01, 2022. Population of focus in 2022 was those members that were previously in (WPC) or (HHP), Adults and Their Families Experiencing Homelessness; Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization; Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; Individuals Transitioning from Incarceration (some WPC counties); Adults with Intellectual or Developmental Disabilities (I/DD); Adults who are Pregnant or Postpartum. On January 1, 2023 an additional population of focus set to launch for Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; Adult Nursing Facility Residents Transitioning to the Community. In July 2023 another ECM population of focus will launch for Adults without Dependent Children/Youth Living with Them Experiencing Homelessness; Children & Youth Populations of Focus.

- **Enhanced Care Management (ECM**)
- is a plan benefit that provides a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need members through systematic coordination of services and it is community-based, interdisciplinary, high- touch, and person-centered.
- **Community Supports (formally ILOS)** are designed to be used to provide health related services as an alternative to covered Medi-Cal benefits. It will integrate care management for members at high levels of risk and intended to address SDoH. Support services that may be available will be Asthma Remediation; Community Transition Services/Nursing Facility Transition Services to a Home; Day Habilitation Programs; Environmental Accessibility Adaptation (Home Modification); Housing Deposit; Housing Tenancy and Sustaining Services; Housing Transition Navigation; Medically Tailored Meals; Nursing Facility Transition/Diversion to Assisted Living Facilities; Personal Care Services and Homemaker Services; Recuperative Care; Respite Services; Short-Term Post-Hospitalization Housing; Sobering Centers.

Members inquiring about or are active in the plan's current care management program can self-refer to (ECM) and assigned CM staff will then make outreach to determine if they fall within the population of focus and then will send notification to the assigned (ECM) provider to make outreach to determine eligibility for their program. Per DHCS policy members accepted into (ECM) cannot be in the plan's complex care management program due to duplication of services but can still be referred to Community Support services, Condition Specific CM/ DM Programs, Palliative Care and Transitional Care Management.

Transitional Care Management Program

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

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

The program includes:

- Conducting an initial outreach call within 3 to 10 calendar days from discharge to review post hospital instructions and conduct medication reconciliation with the member
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond
- Preparation for discussions with other health care professionals and use of a personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care
- Supporting the patient's self-management role
- Educating the member to follow up with the PCP/and or specialist within 7-10 days of discharge if not listed on the post discharge instructions

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

First Year of Life

This is a new program that is available for children from birth to 15months old. The purpose of the First Year of Life (FYOL) Program is to increase HEDIS rates for well-child visits and immunizations, reduce inappropriate emergency room visits, and provide parent/caregiver support. The program will consist of Care Managers and Program Specialists with pediatric nursing and/or post-partum outreach experience. Telephonic outreach is completed at 2, 4, 6, 9, 12 & 15 months. Calls are completed 2 weeks prior to each scheduled well child visit. Program staff will help with establishing Pediatrician care for the members. The plan staff also complete age-appropriate assessment and education.

Palliative Care Program

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

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

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

REFERENCES: NCQA 2020 Health Plan Standards and Guidelines

ATTACHMENTS:

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	Program Segments: Complex Case Management Criteria section updated to reflect new Population Health Categories in ImpactPro. Program Assessment and Impact Measurement: updated to reflect Plan's overall population assessment - not limited to CM. Member Experience with Case Management deleted or 60 days after >45 days. Condition Specific CM and DM Programs deleted DM programs not offered. Attachments: removed reference to Complex CM Program Description as information is consolidated into one document. Other minor grammatical and formatting changes made throughout.	11/28/18

Annual Review	Screening and Assessment: changed reference to outreach by priority to calendar days for all for consistency.	2/13/19
Annual Review	1. Goals of CM Program added outcome measure for pre-term delivery and clarified goal percentage is percentage difference for the OB measures. 2. Infrastructure and Tools, Organizational Structure changed Chief Medical Director to VP Medical Affairs, updated VPCM to Sr. VPMM. 3. Care Team Staffing, changed average caseload of 40-50 to average active caseload of 62. 4. Screening and Assessment, paragraph 1, changed outreach initiated within 30 calendar days to 7 calendar days. Paragraph 5 changed to outreach is initiated within 7 calendar days and completed within 14 calendar days. 5. Discharge from Case Management, bullet 4, deleted WIC. 6. Outcomes, added pre-term delivery as an outcome measure for OB program. Condition Specific CM and DM Programs, plan program list changed Post Hospitalization Follow-up Care to Transitional Care Management.	1/13/20
Annual Review	1. Levels of Case Management added header for Non-complex CM 2. Goals of CM Program updated time frame for postpartum visit and clarified goal percentage for pre-term delivery. 3. Updated criteria for Complex CM, and Case Management. 4. Integrated care team meetings updated frequency and added weekly huddles. 5. Infrastructure and Tools, Organizational Structure added description for VPMM and updated reporting for Director CM. 6. Care Team Staffing, changed average active caseload to up to 70. 7. Members Experience with Case Management updated methods used to complete survey and related criteria. 8. Added Special Program section including subsections for TCM and Palliative Care References – updated NCQA standards to 2020.	1/21/21
Annual Review	1. Changed Dept to Care Management	1/4/22

	2. Updated criteria for Complex CM, and Case Management. 3. Care Team Staffing, changed average active caseload to up to 73. 4. Members Experience with Case Management updated methods used to complete survey and related criteria. 5. Updated what the TCM program includes 6. Updated template 7. Added CalAIM to special programs 8. Changed Disease Management Program to Chronic Condition Management	
Annual Review	1. Updated Dept to PHCO 2.Added information about medical home/PCP expectations in Purpose section. 3. Updated job titles for VP and SVP. 4. Updated levels of CM section to include Basic Pop Health management. 5. Added FYOL program in special programs. 6. Updated CalAIM info. 7. Updated DM and NurseWise teams to reflect change from EPC to Corporate. 8. updated all program references from Case Management to Care Management	1/9/23

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POLICY APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature

POLICY AND PROCEDURE APPROVAL

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

Item #6

Attachment 6.A

2023 Quality Improvement
Program Description

CalViva Health
Quality Improvement (QI) Program Description

~~2022~~2023

Table of Contents

I.

Introduction and Background

A. *Health Plan Products and Membership*

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

CalViva recognizes the challenges posed by the diverse ethnic, cultural and health needs of Medi-Cal beneficiaries in the Fresno-Kings-Madera Region. CalViva, in conjunction with HNCS, has the network, staff, knowledge, systems, infrastructure and cultural and linguistic competence to serve members in the Fresno-Kings-Madera Region and meet those challenges. CalViva's collaborative health plan partner, HNCS, has over 20 years' experience in Fresno County since 1997 when the Two-Plan model was implemented. As such, CalViva is well prepared to serve Medi-Cal beneficiaries in Fresno, Kings and Madera Counties with quality care through evidence-based practices that emphasizes preventive care and encourages self-management for healthy behaviors.

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

The CalViva Quality Improvement Program (QI Program) provides members with access to network-wide safe clinical practices and services and assures they are given the information they need to make better decisions about their healthcare choices. The QI Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QI Program employs an organizational structure that reports to the QI/UM Committee and RHA Commission and is led by committed decision-makers. The QI Program functions in collaboration with multiple departments that have QI-related functions. CalViva also collaborates externally with network physicians, other provider types and community partners for effective QI integration process. This includes collaborative activities with participating provider groups (PPGs) and provider clinics to complete performance improvement projects (PIPs) and Plan, Do, Study, Act (PDSA) projects to close care gaps and improve provider performance and quality of care for members. Quarterly reports of these activities and outcomes are presented to the QI Work Group and subsequently at the QIUM Committee.

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

B. *Provider Network*

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

C. *Information Systems and Analysis*

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

- Accounts Receivable
- Claims and Encounters
- Benefits
- Grievance and Appeals
- Billing
- ~~Medical Management~~Population Health and Clinical Operations
- Membership
- Credentialing
- Member Complaints
- Provider Network Management
- Remittance
- Customer Call Centers

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

II.

Purpose and Goals

A. *Mission*

The CalViva mission is:

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

The mission of the CalViva QI Program is:

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

The vision of CalViva QI Program is to:

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

B. *Purpose*

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

C. *Goals*

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

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

III.

Scope

A. *Scope of QI Program*

The CalViva QI Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. CalViva's Population Health Management (PHM) strategy provides a unifying framework to support the QI Program in delivering a whole-person approach to caring for members. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social determinants of health (SdoH) needs at all stages of life.

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

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

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

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

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

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

B. *Preventive Health Screening Guidelines (PSGs)*

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

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

C. *Health Promotion Programs*

CalViva provides health education programs, services and resources to Medi-Cal members 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. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers may obtain more information by contacting the toll-free Health Education Information Line at (800) 804-6074. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website based services are available 24/7. The Plan sends member informing health education materials to members in their preferred threshold language or alternative format.

- Weight Management Programs –Members have access to three program options under Fit Families for Life-Be In Charge!SM:

    - The Fit Families for Life-Home Edition is a five-week self-paced home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. Materials include a program booklet, cookbook, and exercise stretch band. Exercise videos are available online. Providers may complete and fax or email a copy of the Fit Families for Life – ~~–~~ *Be In Charge!SM* Program Referral Form to the CalViva Health Education Department to refer members to the Home Edition program.
    - The Healthy Habits for Healthy People weight management educational resource is for older adults and seniors. Program materials also include a program booklet, cookbook, and exercise stretch band. Exercise videos are available online.
    - Fit Families for Life and Healthy Habits for Healthy People Community Classes/Webinars – ~~–~~ classes and/or webinars that teach basic nutrition and physical activity information. The community classes and/or webinars are free to all CalViva members and the community.

- CalViva Pregnancy Program – The pregnancy program incorporates the concepts of c~~a~~rse management, care coordination, chronic condition~~s~~ management, and health promotion, teaching ~~in an effort to teach pregnant~~ members how to have a healthy pregnancy and first year of life for babies. In addition, ~~The~~l program supports the following:

    - Information about pregnancy and newborn care.
    - Community resources to assist parents in getting the things they need during pregnancy and after the baby's birth. These services include food, cribs, housing, and clothing.
    - Breastfeeding support and resources.
    - Professional medical staff who work with doctors and nurses to support members with a more difficult pregnancy.
    - Resources for members who feel down during or after their pregnancy.
    - Methods to help pregnant members quit smoking, alcohol, or drug use.

    The program ~~-~~also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and

infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for the baby. High-risk pregnancies receive additional casre management services.

- Kick It California – Formerly known as the California Smokers' Helpline, Kick It California 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.
- Diabetes Prevention Program – Eligible members 18 years old and older at risk of developing type 2 diabetes can participate in a yearlong evidence-based, lifestyle change program that promotes and focuses on emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes. ~~An all-mobile app program is available for Medi-Cal members.~~
- Healthy Hearts, Healthy Lives – Members have access to a comprehensive heart health toolkit to maintain a healthy heart.
- Digital Health Education -Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and seek preventive health care services.
- myStrength Program – Members have access to an evidence-based, self-help resource that is available on-line or in a mobile app. myStrength offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic condition~~s~~, pain management and many other conditions.

The following resources are also available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, weight control, diabetes, immunizations, dental care, breastfeeding, breast cancer, cervical cancer, exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at www.calvivahealth.org.
- Health Education Programs and Services Flyer — This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages. They are mailed to new members and are also available on www.CalvivaHealth.org. These are available in English, Spanish and Hmong.
- Member Newsletter – CalViva News is mailed to members once a year and covers various health topics and the most up-to-date information on health education interventions.

MemberConnections® Program

MemberConnections is an educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of

member engagement and care management efforts by making telephonic and home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan and providers and members.

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the Health Risk Screening and social determinate of health needs.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect and reconnect members to carse management and chronic conditions management to better manage their chronic and/or complex health conditions.
- Identify and address SDoH needs by linking members to county and community based organizations.
- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.
- Support various outreach programs from the Health Plan. These include multiple Plan, Do, Study, Act and Performance Improvement Projects.
- Schedule and complete home visits for noncompliance members. These visits include benefit information, Emergency Department and Readmission diversion, as well as other high-risk issues.Having "eyes on the member" to do visual assessments while in the member's home.
- Follow-up and monitor the status of high-risk member referrals.
- Help with utilizing telehealth services.
- Completing emergency outreach during natural disasters.
- Engage members based on Population Health Prioritization Reporting, to refer into CaseCare Management.

D. *Clinical Practice Guidelines*

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

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

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

E. *Health Management Programs*

Population Health Management (PHM)
Annually, through the PHM Program, CalViva evaluates the needs of its enrolled population and uses that information to assess whether current programs need modification to better address the needs of its membership. CalViva's PHM Program examines data through population risk stratification using a predictive modeling tool that utilizes data from various sources including medical and behavioral claims and encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records (EHRs), data from health plan UM and/or CM programs, and advanced data sources such as all-payer claims databases or regional health information. The data are used for:

- Evaluation of the characteristics and needs of the member population including an analysis of the impact of relevant social determinants of health.
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: birth to age 18, age 19 to 64 and ages 65 and over.
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of member with severe and persistent mental illness.

Data combined with SDOH and QI data (e.g.,, HEDIS care gaps), are reported to facilitate an understanding of similarities and differences in health needs and status. When the data analyses are complete, they are used to determine if changes are required to population health management (PHM) programs or resources. In addition, there is an evaluation of the extent to which population health management programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

The PHM operations team is a cross-unit operations team composed of talent from multiple departments and is led by a core team of a Medical Director and a Pharmacist. The team is accountable to the QI/UM Committee.

Chronic Condition~~s~~ Management
CalViva's chronic condition~~s~~ management programs increase awareness of self-care strategies and empower participants to better manage their disease. The program targets high-risk members identified with chronic conditions such as asthma, diabetes and heart failure ~~conditions~~ and encourages them to participate in the ~~chronic conditions management~~ program. This program includes a population-based identification process, interventions based on clinical need, patient self-management and~~,~~ disease education~~, and process and outcome measurement~~. Multi-disciplinary teams are involved in the development of these efforts. Additional r~~R~~eferrals to chronic condition~~s~~ management programs are multichannel and come through provider, Ca~~s~~re Management and member self-referrals.

Nurse Advice Line

The nurse advice line provides ~~appropriate and~~ timely triage for health-related problems through ~~experienced trained~~ CA-licensed Registered Nurses (RNs) ~~and~~ using physician-approved guidelines and protocols. The service is offered 24 hours a day, seven days a week, 365 days a year, in English and Spanish with translation services available for other languages.

Using nationally recognized algorithms and world-class clinical triage guidelines, the nurse advice line Registered Nurses accurately identify member needs and ensure they are directed to the appropriate level of care for their situation whether it be providing self-care guidance or recommending a visit to Urgent Care or the ER.

Adult Weight Management

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

Raising Well - Pediatric Weight Management

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

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

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

Audio Library

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

F. *Transitional Care ~~Management Program~~Services*

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

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

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

~~1. Introducing the CTI to the member at the time of hospitalization~~
~~2. Use of other tools to transfer skills to patients and family members on how to communicate care needs effectively during direct encounters with their health care team~~
~~3.~~1. Conducting a post-acute follow-up call within 24~~-~~72 hours of discharge that actively engages the member in medication reconciliation, how to respond to medication discrepancies, and how to utilize a personal health record (PHR)~~.~~, and
~~4.~~2. Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.

A minimum of two f~~F~~ollow-up calls ~~with~~ are made to the member ~~are conducted~~ within ~~30~~ 15 days of ~~post-~~discharge~~,~~ which focus~~es interventions~~ on:

- Reviewing progress toward established goals
- Discussing encounters with other health care professionals
- Reinforcement of the importance of maintaining and sharing the PHR
- Supporting the member's self-management role
- Medication reconciliation with access to pharmacist, and
- Educating the member to follow up with the PCP, ~~/~~and/~~-~~or specialist within ~~7~~ 30 days of discharge

After the post discharge period, the TCS staff perform a warm hand off for continued care management needs as necessary. All assessment documents are transferred to the assuming care manager along with outstanding and/or in process issues that need additional care management intervention.
~~During the post discharge period, the nurse evaluates the member for case care management, palliative care and other programs that may best support the member in managing their continued~~

~~needs. A referral to these programs is conducted as applicable to ensure continuity of addressing outstanding member needs/goals.~~

Member Impact of ~~TCM~~TCS

The ~~TCM~~ TCS ~~Program~~ process has a positive impact on participating members, including outcomes such as:

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

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

G. ~~Case~~ Care Management (CM) Program

CalViva partners with HNCS to provide ~~Case~~ Care Management (CM) services. The program targets members identified as being at high risk for hospitalizations or poor outcomes and who have barriers to their care. The program utilizes an evidence-based approach, which is member focused and goal directed in developing, implementing and monitoring an individualized care plan. Trained nurse care managers, in collaboration with a multi-disciplinary team, provide coordination, education and support to the member (family and caregiver) in achieving optimal health, enhancing quality of life and accessing appropriate services.

The goals of the CM program are:

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

This program seeks to identify and intervene with members:

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

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

- Health information forms
- Any of the chronic condition~~s~~ management programs
- The concurrent review and discharge planning process

- A member/caregiver request for ~~case~~ care management
- A practitioner request for ca~~s~~re management

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

Once members are identified for potential inclusion in the ~~case~~ care management program, outreach to the member is completed to assess the care need. The member is then invited to participate in ~~case~~ care management if they meet established screening criteria. If the member agrees, the member is assigned to the appropriate program and acuity level to address their care needs. Acuity levels vary from complex to low. Members are also afforded the opportunity to decline participation in the program.

The ~~Case~~ Care Management Program includes an initial assessment, the use of evidence-based care plans and algorithms, documentation of member preferences, resources, barriers, goals, progress and ongoing evaluation of members needs with adjustments of interventions as needed.

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

H. *Behavioral Health Services*

CalViva delivers covered mental health services to the majority of its members through ~~a contract~~ Health Net. Health Net's behavioral health administrator ~~holds with its affiliate MHN Services ("MHN"). MHN~~ contracts directly with psychiatrists as well as non-MD behavioral health specialists and is delegated to perform certain functions (e.g., credentialing, claims, utilization management, etc.).

CalViva, HNCS and the behavioral health administrator ~~and MHN~~ are taking a collaborative approach to educate providers and members on the importance of:

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

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

- Member survey to assess satisfaction with and access to covered mental health services
- Provider survey to assess satisfaction with the timeliness and usefulness of information from behavioral health practitioners, along with their experience with coordination of care
- Network availability and adequacy of behavioral health providers
- Member quality of care and service complaints investigation
- Evaluation of behavioral health HEDIS measures and other QI behavioral health initiatives~~.~~

I. *Palliative Care (Care Connections) Program*

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

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

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

A. General Eligibility Criteria

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

B. Disease- Specific Eligibility Criteria

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

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

C. Pediatric Palliative Care Eligibility Criteria

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

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

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

Palliative care services shall include the following services:

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

Referrals can come from multiple sources. This may include:

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

J. *Credentialing / Recredentialing*

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

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

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

K. *Continuity and Coordination of Care*

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

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

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

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

For all members with identified complex health needs, CalViva supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. Nurse advice line also addresses member triage needs 24 hours a day, seven days a week. Provider groups also support members through their coordination of care programs.

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

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

L. *Delegation*

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

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

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

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

CalViva assesses the capability of each delegated entity by performing a capability assessment prior to delegation specifically with regard to technical expertise and review of budgetary resources. As part of the delegation audit, HNCS and other delegated entities must demonstrate they have adequate clinical staffing to provide timely determinations.

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

data to ensure issues involving inappropriate denial of emergency claims or inappropriate billing of members are addressed in a timely and complete manner to prevent future similar occurrences.

M. *Safety*

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

- Informing and educating health care professionals on safety issues
- Identifying and evaluating strategies for reducing errors and improving member safety
- Promoting the dissemination of effective strategies and best practices throughout the health care industry
- Making performance data publicly available for members and practitioners
- Current member safety activities include but are not limited to: Conducting PCP facility site/medical record reviews and physical accessibility reviews of PCP and other high-volume provider sites
- Conducting a rigorous credentialing and recredentialing process to ensure only qualified practitioners and organizational providers provide care in the network
- Monitoring quality of care indicators on a quarterly basis to identify patterns and/or trends
- Working with contracted pharmacies to assure a system is in place for classifying drug-drug interactions and/or notifying dispensing providers of specific interactions when they meet CalViva's severity threshold
- Monitoring narcotic prescribing carefully and ensuring a narcotic contract is in place for any member on narcotic medication in excess of Department of Health Care Services (DHCS) determined or nationally recommended quantity limit
- Analysis of member quality of care complaints, potential quality of care, and provider preventable conditions cases to identify patterns and trends
- Care coordination for high risk patients
- Member education
- Assuring that affected members and providers are notified of FDA and voluntary drug safety alerts and recalls
- Nurse advice and triage line available 24 hours a day, 7 days a week, every day of the year

Mechanisms for communication include:

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

N. *Health Plan Performance*

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

CalViva maintains a broad range of key performance metrics to monitor clinical and service quality in ~~Medical Management,~~ Appeals & Grievances, ~~Care Management, Chronic Conditions Management,~~ Customer Service, Population Health Management, and Population Health & Clinical Operations (PHCO) which includes ~~Utilization Management,~~ Care Management, ~~Appeals & Grievances,~~ Chronic Conditions Management, and Utilization Management (Prior Authorization, Concurrent Review, and the Medical Review Unit). CalViva's QI Program also monitors key performance metrics for Pharmacy and ~~MHN~~ behavioral health ~~S~~services ~~(MHNS)~~.

O. *Satisfaction*

CalViva continuously monitors member experience throughout the year using the Access Survey results and monitoring member pain points (member appeals and grievances). Access survey results are integrated into DHCS Medi-Cal Managed Care Quality Improvement Reports. Results from the bi-annual CAHPS survey conducted by DHCS are also reviewed to track member experience improvement and include in the Population Needs Assessment Report.

Improvement activities are focused on educating CAHPS stakeholders and measure owners, partnering with operational areas to implement initiatives and leading quarterly CAHPS Steering Committees. The CAHPS Program Managers meet with several business areas including Population Health & Clinical Operations~~Medical Management~~, Customer Contact Center, Appeals and Grievances, Pharmacy, Provider Network Management, Provider Relations, Delegation Oversight, Sales, Marketing, and the behavioral health administrator~~MHNS~~.

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

P. *Access and Availability*

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

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

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

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

- Member Satisfaction Surveys: HEDIS CAHPS (DHCS administered), SWBHC (Satisfaction With Behavioral Health Care), and the annual Access Survey.
- Provider After-Hours Access Survey (PAHAS): Annual provider telephone survey assessing after-hours ER information and physician after-hours access.
- Provider Appointment Availability Survey (PAAS): Annual provider appointment survey to assess member access to care and service. Specific elements include preventive care, routine care, and urgent care for medical and behavioral care.
- Provider Satisfaction Survey (PSS): Annual provider survey to assess provider perspective and concerns regarding compliance with the access standards and to evaluate satisfaction with the time-elapsed standards.
- Telephone Access Survey: Annual provider telephone survey to assess how long it takes a provider's office to answer the phone and return calls to members.
- Member Grievances: Grievance data related to access is tracked and trended to identify issues with access.
- Geo Access Analysis: Geographic distribution of PCPs, SCPs, high volume SCPs, hospitals, emergency services, ambulatory clinics and ancillary (laboratory, radiology) providers.
- Hospital Bed Capacity: Ratio of members per hospital beds in the contracted hospital network.
- Ratio of Members to Practitioner/Provider: Assessment of the ratio of members to PCPs, SCPs, and high volume SCPs.
- Network Open Access Report: Presents the percentage of PCPs accepting new members by line of business.

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

Q. *Member Rights and Responsibilities*

CalViva has established a list of member rights and responsibilities that ensure members are treated with dignity and have full access to information about their care and benefits. These rights and responsibilities are reviewed and approved annually by the appropriate CalViva staff. Members are informed of their rights and responsibilities through the member Evidence of Coverage (EOC) and other member communications.

Member rights include the right to:

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

Member responsibilities include:

- Acting courteously and respectfully toward doctors and staff and being on time for visits
- Providing up-to-date, accurate and complete information
- Following the doctor's advice and participating in the treatment plan
- Using the Emergency Room only in an emergency
- Reporting health care fraud or ~~wrong doing~~wrongdoing

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

R. *Medical Records*

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

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

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

CalViva monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits. This occurs during the HEDIS process, Department of Managed Health Care (DMHC) and CMS surveys, during routine DHCS audits, and as part of the Managed Care Quality and Monitoring Division of DHCS PCP Full Scope Facility Site and Medical Record Review process.

Annually, the data ~~is~~ are aggregated and analyzed to evaluate effectiveness of interventions and identify opportunities for improvement. Actions are taken when compliance issues are identified and interventions are implemented based on compliance rates established for each standard. Interventions may include sending Medical Record review Corrective Action Plans, Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, creating template medical record forms, and face to face instructions with a QI Compliance Nurse. Follow up may be conducted to evaluate the effectiveness of corrective actions implemented.

S. *Health Equity and Cultural and Linguistic Needs*

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

The Health Equity Department, on behalf of CalViva, provides resources, materials, trainings, and in-services on a wide range of health equity and cultural and linguistic (C&L) topics that impact health and health care. The cultural competency training program adheres and implements HHS guidelines for Section 1557 of the ACA for C&L services and requirement for non-discrimination based on sex, race, color, national origin, creed, ancestry, religion, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, gender, gender identity, or sexual orientation, marital status and health status. Services offered include cultural and language information for providers and their staff, as well as for Plan staff; trainings on language assistance requirements imposed by state and federal regulatory agencies; interpreter support for members and providers; culturally appropriate translation and review of member materials; and culturally responsive education. Health Equity also analyses the needs of its membership by reviewing various sources of data which may include membership demographic data, call center data, appeals and grievance information, and geo-access analysis of provider network language capabilities.

~~Health Net~~HNCS is aware of the diverse culture of California and is fully compliant with the contract requirements related to California's Department of Health Care Services (DHCS) regulatory agency Medi-Cal Managed Care Division (MMCD) Policy Letters and DMHC regulations for language assistance services and federal rules that require the provision of language assistance services. Additionally, it will ensure processes to meet contractual and regulatory cultural and linguistic requirements identified by Centers for Medicare and Medicaid Services (CMS) and other regulatory and oversight entities.

At least annually, the Health Equity Department, on behalf of CalViva, informs CalViva members, practitioners, and providers of the availability of the Language Assistance Program (LAP), which offers language assistance services at no cost to members, including how to access the services and their rights to file grievances, in compliance with legal, contractual, regulatory agency, and oversight agency guidelines. Semi-annually, the LAP is monitored; this report includes trend analysis of grievances, and summary of language preference for all product lines. CalViva quality committees approve the appropriate quality benchmarks, review language preference results, and make recommendations for incorporating language preference into QI programs, follow-up actions or corrective action plans as needed.

A Geo Access assessment is conducted using member zip code data and correlated with member language preference every two years. The language capabilities of the practitioner and provider network are compared to the language needs of CalViva members. The availability of linguistic services by contracted providers for limited English proficient members is analyzed and recommendations are made to further enhance the promotion of available language services in support of members, practitioner and provider network. Contracted practitioners and providers are informed of the cultural and linguistic services available via Provider Updates and the provider operations manuals. Culturally informative materials, trainings and in-services are provided to network practitioners and internal department associates periodically. Cultural competency training

addresses the delivery of services in a culturally competent manner to all members, including prohibiting discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

The Health Equity and Health Education Departments complete a CalViva Population Needs Assessment every three years to determine member demographics, health risks and health care needs. Assessment findings are used to develop appropriate health education, cultural and linguistic, and quality improvement interventions to meet members' needs.

Health Net ~~employees~~staff can be involved in Centene's national employee inclusion groups (EIG) for veterans, military families, women, LGBTQ+ community, multicultural network, and people with disabilities. The EIGs have community engagement subcommittees that may indirectly impact health equity efforts and support employees in addressing health disparities within their communities.

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

To ensure compliance with applicable Medi-Cal contractual requirements, state and federal rules and regulations and other requirements of the DHCS and DMHC, the Health Equity Services Department:

- Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services
- Utilizes and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities
- Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities
- Collects, analyzes and reports membership language, race and ethnicity data in reports such as the Population Needs Assessment (PNA)
- Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually
- Maintains information links with the community through Public Policy Committee (PPC) meetings, Population Needs Assessment (PNA) and other methods
- Informs contracted providers annually of the C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources
- Engage community-based organizations, coalitions, and collaborative in counties where CalViva members reside and be a resource for them on C&L issues
- Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (HICE) and America's Health Insurance Plans (AHIP)
- Provide health equity and C&L services that support member satisfaction, retention, and growth

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

- Provide C&L information and support for HNCS and CalViva staff in their efforts to provide excellent customer relations and services
- Collaborate with other departments, where appropriate, to further the mutual attainment of culturally and linguistically appropriate healthcare services received by members, e.g., work with the Appeals and Grievance department on culture and language related grievances
- Support efforts of contracted providers to deliver culturally and linguistically appropriate health care services by providing informative materials, cultural competency workshops, and in-services
- Promote effective communication by staff and contracted providers with LEP members by providing them with easy access to culturally and linguistically appropriate materials, high quality translations of member-informing materials, high quality interpreter services, and culturally responsive staff and health care providers
- Deliberately address health equity through collaborating to identify, develop and implement interventions at the member, community and provider levels to improve health disparities
- Sustain efforts to address health literacy in support of CalViva members
- Assess bilingual capabilities of bilingual staff and provide ongoing education and support
- Increase cultural awareness of pPlan staff through trainings, newsletter articles, annual "Heritage/CLAS Month" activities, and other venues

T. *Telehealth Services*

Member to Provider
Hazel Health provides on-demand telehealth care in schools and supports school nurses when a child has an urgent need. Via a computer, a child is connected to a health care professional for physical or mental health care. If a primary care physician's information is provided on the new patient questionnaire, Hazel will send follow-up records to the child's provider, improving the continuity of care. For kids needing behavioral health services, Hazel Heath can email or fax a referral form to the behavioral health administrator~~MHN~~, Health Net's behavioral health administrator. ~~MHN~~The behavioral health administrator will refer members who require care management to the appropriate Health Net care management team for follow up, as needed. Hazel Health is currently available at approximately 180 participating schools with further expansion to more sites in the coming year.

Bright Heart Health (BHH) provides virtual programs, enabling live interaction between patients and the BHH care team through face-to-face sessions online for the following services:

- Alcohol and Substance Use
- Mental Health
- Chronic Pain Management
- Eating Disorder Treatment

Treatment plans include:

- Individual and Group Therapy
- Tele-psych appointments over the phone or video conferencing
- Medication management

BHH provides individualized treatment tailored to the patient. The BHH virtual clinic is available for patient enrollment 24/7, 365 days a year. Patients can access services through their smart device (including phone, computer, or tablet) to complete intake, assessments, and engage in treatment. All communication is secure and HIPAA compliant.

Benefits of BHH services are:

- No trips to the ER or waiting rooms
- Treatment delivered through video visits
- Proven treatment from a team of experts
- Allows for confidential care from the comfort of your home

Electronic Consultation Services – Provider to Specialist
Electronic Consultation a concurrent exchange between a primary care physician (PCP) and a specialist. A PCP can consult with a specialist through a secure electronic message to initiate care for a non-urgent, non-procedural patient needs. A digital referral, along with clinical information, images, lab results, and other content from the medical record, is sent directly to a specialist. In 70%–75% of cases, an eConsult will result in PCP management which helps prevent unnecessary/low value diagnostic testing and in-person appointments with specialists. Most eConsults reviewed by the specialist and responded to within 72-hours, which improves timely access for patients and removes potential geographic or language barriers that may occur during in person visits.

IV.

QI Process

A. *Confidentiality / Conflict of Interest*

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

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

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

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

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

B. *QI Process*

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

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

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

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

Selection of topics takes into account:

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

Data collected to support the CalViva QI process include:

- Claims and encounter data
- Membership and Medical Benefit Pharmacy data
- Reports of key indicators and sentinel events
- Demographic factors generally associated with risk such as age and sex or special health care needs status
- Cultural and linguistic makeup of membership
- Federal and state-reported quality and administrative data
- Clinical quality data collected by the plan, including recognized quality indicators such as HEDIS and HEDIS-like measures
- Annual Access Survey
- CAHPS Survey (bi-annual survey administered by DHCS)
- SWBHC
- Medical Record Review
- Member & Practitioner Complaint & Inquiry Reports
- Appeals Reports

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

V.

Program Structure and Resources

A. *QI Committees*

Governing Body/RHA Commission

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

RHA Commission functions:

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

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

The CalViva QI/UM Committee is chaired by CalViva's Chief Medical Officer and meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its delegated and non-delegated, and collaborative quality improvement activities. Quality of care and service is defined as medical care and service which is accessible, meets CalViva standards of performance, is provided in the most timely and appropriate setting, and results in a high level of member satisfaction and improved health outcomes. This Committee identifies opportunities for improvement, recommends and oversees policy decisions and changes, evaluates the results of delegated and non-delegated, and collaborative QI activities, institutes needed actions, and ensures follow up as appropriate. The Committee also ensures external providers, who are representative of specialties in the network (i.e.; behavioral health, SPD and members with chronic conditions), participate in the planning, design, implementation and review of the CalViva QI Program, and are included as members of the Committee. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis. Representatives from CalViva and HNCS who report up to the QI/UM Committee include the Quality Improvement Department, Health Equity and CAHPS teams, HNCS' behavioral health administrator, Pharmacy Department, Provider Network Management, Delegation Oversight, Customer Service Center, Credentialing, Peer Review, Appeals and Grievances, and Population Health & Clinical Operations (PHCO) which includes Utilization Management and Care Management.Membership of the CalViva QI/UM Committees includes practicing practitioners. Refer to the CalViva QI/UM Charter for more information on committee members, roles and functions.

CalViva QI/UM Committee has the following subcommittees:

Credentialing and Peer Review Subc-Committees

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

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

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

Peer Review Subcommittee

The RHA Commission and the QI/UM Committee provides oversight of the Peer Review Subcommittee, through annual approval of the Peer Review Program and quarterly reports supplied by the Peer Review Subcommittee. The chairperson of the Peer Review Subcommittee, the CalViva Chief Medical Director, is responsible for the Peer Review Subcommittee operations, including, but not limited to, communicating committee decisions to network practitioners and providers, maintaining committee protocol, and signing and enacting Peer Review policies. The CalViva QI/UM Committee provides program oversight through annual review and approval of the Peer Review Program and quarterly reports supplied by the Peer Review Subcommittee. Membership of the Peer Review Subcommittee includes participatingpracticing practitioners.

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

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

B. *QI Workgroups*

QI/UM Operational Workgroup

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

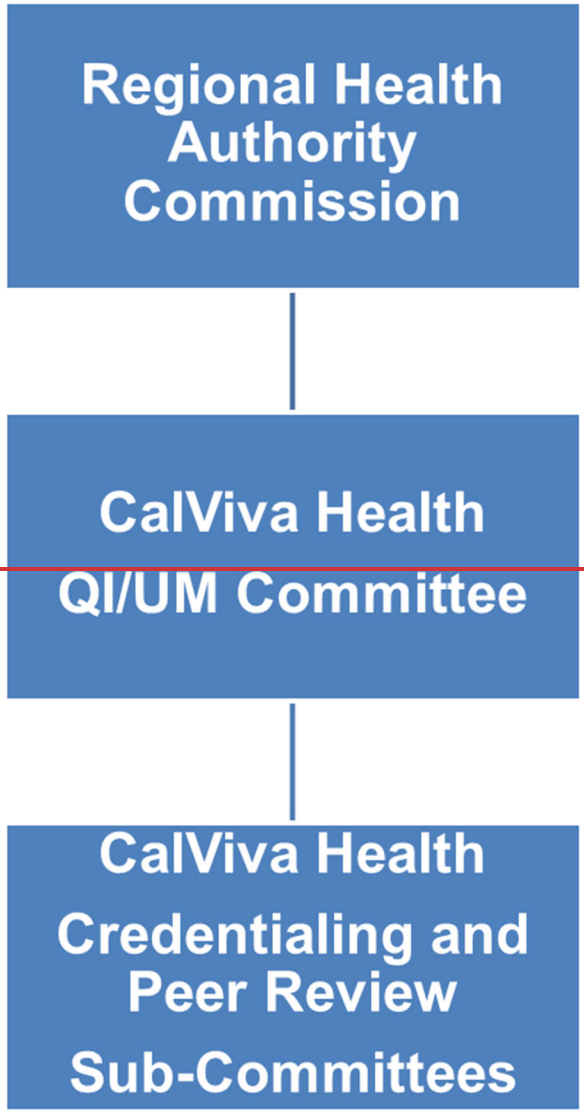
Access Workgroup

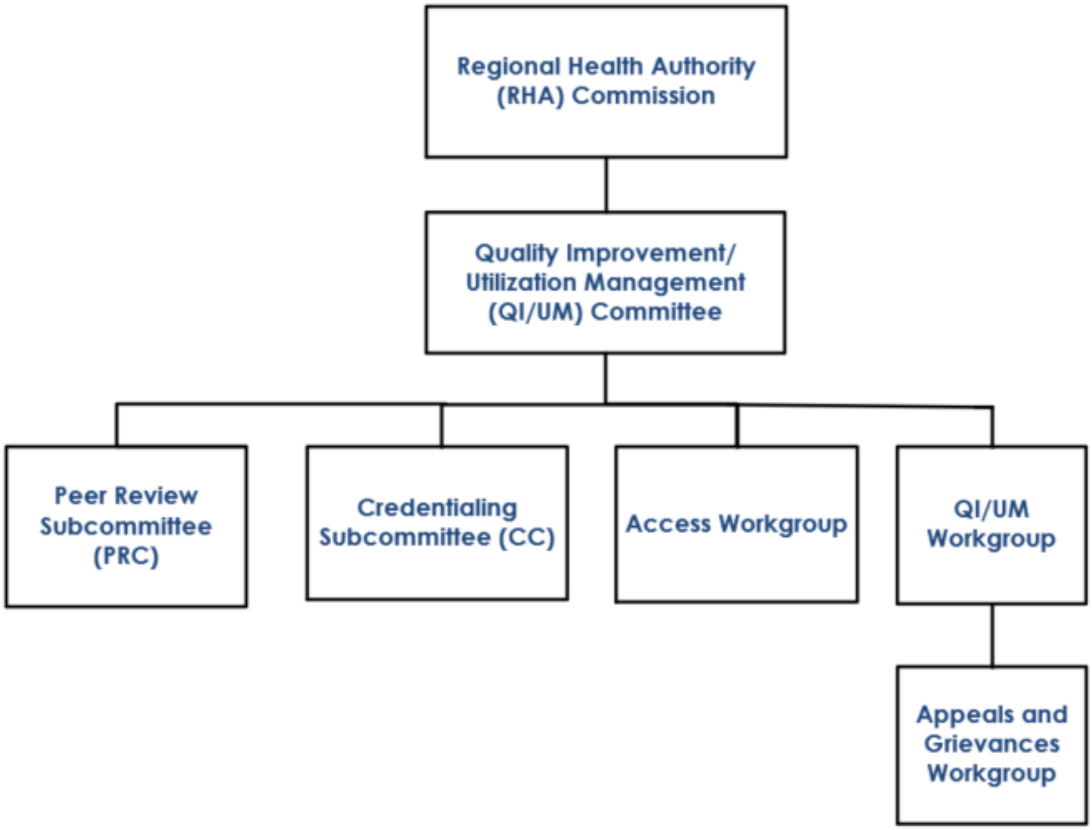
The CalViva Access Workgroup brings together representatives from CalViva and multiple HNCS departments that have access and network adequacy related functions. The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and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

Appeals and Grievances Workgroup

CalViva has an Appeals and Grievances Workgroup which processes, tracks and trends member grievances and appeals at the practitioner and plan level. CalViva identifies patterns and/or trends of potential risk exposures via the Potential Quality Incident Referral Form. The Appeals and Grievances Workgroup will submit reports to the CalViva QI/UM ~~Committee~~ Work Group and as indicated its Peer Review Subcommittee to ensure and allow CalViva the ability to review, act, and follow-up on identified clinical and/or service events or trends that are significant at the practitioner or plan level.

Committee Organizational Chart




Regional Health Authority (RHA) Commission
Quality Improvement/ Utilization Management (QI/UM) Committee
Peer Review Subcommittee (PRC)
Credentialing Subcommittee (CC)
Access Workgroup
QI/UM Workgroup
Appeals and Grievances Workgroup

C. *Staff Resources and Accountability*

CalViva Chief Medical Officer

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

Regional Medical Director

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

Behavioral Health Medical Director

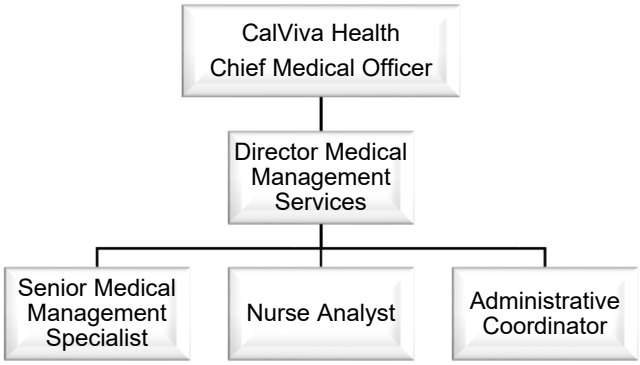
The Behavioral Health Medical Directors are board certified psychiatrists from MHN who are involved with the delegated behavioral health care aspects of the QI clinical program for CalViva members, including reviewing all potential quality concerns. They are responsible for ensuring delegated behavioral health clinical services for members are administered in a manner consistent with accepted standards of care and provides direction and oversight for clinical quality improvement activities. Results are reported to CVH's QI/UM Committee.

Department Resources

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

QI Team

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



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

CalViva delegates DHCS's required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per APL 22-017, PL ~~Medi-Cal Managed Care Division (MMCD) Policy Letters 14-004,~~ 12-006, APL 15-023~~, and 21-011,~~ HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records. PARS are conducted for PCPs and high volume specialists (including behavioral health), ancillary providers, CBAS providers and hospitals. Collaboration with other Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process.

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

Health Education

CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services. Health education services include individual, group and community-level education, and support by trained health educators. Under the oversight of CalViva, the Health Education Department (HED), in coordination with Health Equity and Quality Improvement Departments, conduct a population needs assessment annually. Assessment results are used to develop health education, culturally and linguistic, and quality improvement priorities and annual work plans.

Pharmacy Services

CalViva is responsible for managing the pharmaceutical benefits of CalViva. HNCS will assist CalViva in the establishment and maintenance of the Pharmacy Medical Drug Benefit. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service,

pre-authorized urgent and prior authorization of medical benefit drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CalViva members. Pharmaceutical services reports shall be made to the CalViva QI/UM Committee on a quarterly basis.

~~*Grievances and Appeals*~~

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

Credentialing/Recredentialing

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

Utilization Management/Population Health & Clinical Operations (PHCO)~~Medical Management~~

CalViva's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and ~~medical management~~PHCO programs. A systematic approach is used by CalViva, with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS ~~Healthcare Services~~ Medical Affairs~~Department~~ and PHCO~~medical management~~ Departments ~~team~~ partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CalViva's members. ~~Utilization/Medical Management~~PHCO staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CalViva members. HNCS UM Department prepares and presents reports to the CalViva QI/UM committee at each meeting and presents a semi-annual and annual report on the UM Workplan. HNCS seeks input from the CalViva QI/UM committee and RHA Commission prior to preparing the annual Work Plan.

Customer Contact Centers

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

Provider Network Management

CalViva delegates provider network management to HNCS. HNCS Provider Network management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CalViva Medi-Cal members. The Provider Network

Management staff liaison also collaborates with the hospitals, practitioners and other providers for the resolution of contractual, operational, service and medical issues and conducts training sessions to provide contracted practitioners and providers with current CalViva policies and operational and product changes.

Delegation Oversight

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

HEDIS Management and Clinical Reporting

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

VI.

Program Evaluation and Work Plan

A. *Review and Oversight*

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

B. *Annual QI Evaluation*

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

C. *Annual QI Work Plan*

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

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

- Follow-up action plan, including continuation status (close, continue, or continue with modifications)

VII.

Approval

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

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

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

Date

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

Date

Item #6

Attachment 6.B

2023 Quality Improvement Work Plan

CalViva Health
Quality Improvement
Work Plan 2023

03/01/2023

TABLE OF CONTENTS

Submitted by:

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

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.

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. BEHAVIORAL HEALTH

1.1 Behavioral Health	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Linda Ciotoli, Program Manager III, Quality Improvement Rhonda Dick, Sr. QI Specialist
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL (FUA-30 and FUM-30). **Rationale:** According to the National Committee on Quality Assurance, HEDIS Volume 1 Narrative, substance use disorders are a prevalent and serious public health issue and, if left untreated, can lead to damaging effects on an individual's health, finances and overall well-being. Individuals who are seen in the Emergency Department (ED) due to substance misuse are at high-risk of subsequent adverse events, especially within the year following their ED visit. This measure focuses on ensuring care coordination for members who are discharged from the ED following high-risk substance use events, since those individuals may be particularly vulnerable to losing contact with the health care system.

	Additionally, many individuals are affected by a serious mental illness (SMI). Although ED visits are common among patients suffering from mental illness, many may be avoidable. In 2007, approximately 12 million ED visits were related to mental health or substance abuse—1 out of 8 (12.5%) of all ED visits. More than 7.6 million were related to mental health conditions only. Two million (28.9%) of mental health-related ED visits listed a mental health disorder as the primary diagnosis.
Program Objectives	Meet directional improvement of 1-5% from prior year or exceed DHCS MPLs Quality Compass (QC) 50th percentile benchmarks for DHCS required metric (Non-Clinical PIP): • FUA-30 • FUM-30 **Prior rate (%, ratio):** • FUA-30: 0% (0/3) • FUM-30: 0% (0/3) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)*

Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)	☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

II. CHRONIC CONDITIONS

2.1 Respiratory Health	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Alicia Bednar, Program Manager III, Medicare QI
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL. • AMR **Rationale:** Treating asthma early may prevent long-term lung damage and help keep the condition from getting worse over time. Asthma medications are long-term controllers used to achieve and maintain control and quick-reliever medications used to treat acute symptoms and exacerbations. Appropriate ratios for these medications improve symptomatic control.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: • AMR

	Prior rate (%, ratio): 100% (3/3) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

2.2 Heart Health/ Blood Pressure	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Gigi Mathew Program Manager III, Medicare, QI
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL. • CBP **Rationale:** High blood pressure affects more than half of people over age 50 and more than 75% of those older than 65. Findings have shown that both high systolic and high diastolic pressure can predict the risk of heart attack or stroke. Focusing on initiatives for prevention of age-related increase in blood pressure in addition to managing existing hypertension is imperative to reducing the large burden of blood-pressure related cardiovascular disease and microvascular complications.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: • CBP

	Prior rate (% , ratio): 100% (3/3) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

2.3 Diabetes	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Gigi Mathew, Program Manager III, Quality Improvement
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance of measures included in the DHCS MCAS measures held to MPL. • CDC >9 **Rationale:** Diabetes is a chronic disease that places high demands on the health system, both regarding the care processes and associated expenditures. Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities. Social factors such as income, education, race, ethnicity, and built environment play a crucial role in determining the incidence and severity of diabetes and need to work to eliminate the disparities they cause. Diabetes control is achieved through effective comprehensive diabetes care and management, and clinical preventive care.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure:

	• CDC >9 **Prior rate (%, ratio):** 100% (3/3) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged*

	☐ *Continue Initiative with Modifications*

III. MATERNAL/WOMEN'S HEALTH

3.1 Perinatal Care	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Juli Coulthurst, Program Manager III, Quality Improvement
Program/Indicator Performance Goal	**Goal(s):** Improve maternal health by ensuring all pregnant members have timely prenatal care and postpartum care. **Rationale:** To align activities with DHCS MCAS measures.
Program Objectives	• Make directional improvement in the number of reporting units that meet the 75th percentile for Medi-Cal MCAS perinatal measures: PPC-pre and PPC-post. • Reduce disparities in African-American (A-A) members in timely prenatal care and postpartum care. Target rate to reduce disparity by 50% ○ PPC-pre: 84%

	○ PPC-post: 70% **Prior rate (%, ratio):** MY 2021 • MCAS rates: 66.67% (4/6) • PPC-pre A-A: 82% • PPC-post A-A: 64% **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*

Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

IV. MEMBER ENGAGEMENT AND EXPERIENCE

4.1 Initial Health Appointments (IHA)	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☒ Member Experience ☐ Other:
Responsible Person	Miriam Rosales, Program Manager III, QI Tanya Demirjian, Manager, QI
Program/Indicator Performance Goal	**Goal(s):** Increase number of members who receive their IHA within 120 days of enrolling as a new member and increase the compliance of outreaching new members 3 times within 120 days of enrolling as a new member. **Rationale:** To meet DHCS APL 22-030 requirements.
Program Objectives	Meet year over year performance improvement of (1-5%) for MY 2023 rates. **Prior rate (%, ratio):** N/A **Mid-year rate (%, ratio):** **Final rate (%, ratio):**

	Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

4.2 CAHPS Improvement	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☐ Quality of Care ☒ Quality of Service ☐ Safety ☒ Member Experience ☐ Other:
Responsible Person	Ashley Kaye Alfonso, Program Manager III, CAHPS Team
Program/Indicator Performance Goal	**Goal(s):** Implement initiatives and partner with operational stakeholders to improve CAHPS survey results and overall member experience. **Rationale:** The Regulatory CAHPS Survey will launch to CalViva members in Q1 2023. The CAHPS survey captures member experience on various topics including: • Access to Care • Customer Service • Doctor Communication • Care Coordination • Overall Rating Measures (Health Plan, Health Care Quality, Provider, Specialist) Survey results will help guide where improvement efforts should be focused on. Final results will be analyzed by the CAHPS Team and cascaded out to appropriate stakeholders.
Program Objectives	• Meet Performance Improvement of (1-5%) for MY 2023 rates.

	• YOY improvement on all measures. Please refer to internal CAHPS tracker. **Prior rate (%, ratio):** RY 2022 Access Survey Measures YOY Improvement: 50%, (2/4) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation	☐ *Closed*

(Populate at year end)	☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

V. Hospital Quality/ Patient Safety

5.1 Hospital Quality/ Patient Safety	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☒ Safety ☐ Member Experience ☐ Other:
Responsible Person	Barbara Wentworth, Program Manager III, Quality Improvement
Program/Indicator Performance Goal	**Goal(s):** High quality hospital networks should be designed and managed in ways that account for facility quality. Patient safety and C-section performance are the primary focus, with particular emphasis on poor performing facilities. **Rationale:** Work to ensure contracted hospitals are providing appropriate, safe care to patients that avoids preventable harm, and provide guidance to members about informed choice that accounts for quality performance when selecting a site for care.
Program Objectives	• Poor Performing Hospital engagement (across networks; includes multi-plan collaborative targets): Obtain quality updates from 75% of targeted hospitals each year. • Hospitals with reportable data: Directional improvement, based on appropriate scores (SIR=<1.0) or outliers (SIR>2) for target HAIs (CAUTI, CLABSI, C.Diff, MRSA, and SSI-Colon), if baseline is <90% (appropriate) / >5% (outlier). Otherwise, maintain =>90%/<5% status.

	• Maternity hospitals with reportable data: Directional improvement for the proportion of hospitals meeting the national standard (=<23.6%) for all-payer NTSV C-section rates. **Prior rate:** For MY 1/1/21 to 12/31/21, all network hospitals with sufficient data to produce a Scorecard: • CAUTI: ○ SIR=<1.0: 65.7% ○ SIR>2.0: 7.0% • CLABSI: ○ SIR=<1.0: 52.1% ○ SIR>2: 12.8% • C.Diff: ○ SIR=<1.0: 94.2% ○ SIR>2: 0.4% • MRSA: ○ SIR=<1.0: 59.4% ○ SIR>2: 14.7% • SSI-Colon: ○ SIR=<1.0: 68.3% ○ SIR>2: 2.2% • NTSV C-sections (MY '21): ○ Rate of =<23.6%: 47.6% **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023

Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

VI. PEDIATRIC

6.1 Performance Improvement Project – Infant Well-Child Visits (W30-6+)	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Tanya Demirjian, Manager, QI; Rhonda Dick, Sr. QI Specialist
Program/Indicator Performance Goal	**Goal(s):** Improve pediatric health by ensuring all infants under 15 months of age complete timely well-child visits and all appropriate immunizations and screenings. **Rationale:** To align activities with DHCS required PIP.
Program Objectives	Meet or exceed DHCS MPLs at QC 50th percentile benchmarks for DHCS required W30 -6+ measure. (PIP) **Prior rate (%, ratio):** MY 2021: 33% (1/3) **Mid-year rate (%, ratio):** **Final rate (%, ratio):**

	Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

6.2 Pediatric SWOT: CIS-10 and W30	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Tanya Demirjian, Manager, QI; Rhonda Dick, Sr. QI Specialist
Program/Indicator Performance Goal	**Goal(s):** Improve pediatric health by ensuring all infants under 2 years of age complete timely well-child visits and all appropriate immunizations and screenings. **Rationale:** To align activities with DHCS required SWOT.
Program Objectives	Meet or exceed DHCS MPLs at QC 50th percentile benchmarks for DHCS required W30/CIS-10 measure. (SWOT). **Prior rate (%, ratio):** MY 2021: 33% (2/6) **Mid-year rate (%, ratio):** **Final rate (%, ratio):**

	Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

VII. PREVENTIVE HEALTH

7.1 Cancer Screenings	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Ravneet Gill, Program Manager III, Quality Improvement
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL (BCS, CCS, CHL). **Rationale:** It is important for members to stay up to date on the recommended screening schedules to stay healthy and detect diseases early when they are easier to treat.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measures: • BCS • CCS • CHL **Prior rate (%, ratio):**

	MY 2021: • BCS: 33.3% (1/3) • CCS: 66.7% (2/3) • CHL: 33.3% (1/3) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation	☐ *Closed*

(Populate at year end)	☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

7.2 Childhood Blood Lead Screenings	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☒ Member Experience ☐ Other:
Responsible Person	Tanya Demirjian, Manager, QI Rosa Calva-Songco, Manager QI Shekinah Wright, Manager, QI Amy Wittig, Director, QI Pam Carpenter, Director, QI
Program/Indicator Performance Goal	**Goal(s):** Increase overall rates of childhood blood lead screening and anticipatory guidance year over year for Medi-Cal. **Rationale:** To meet DHCS APL-18-017 AND APL 20-016 requirements.

Program Objectives	• Conduct quarterly monitoring of HEDIS Lead Screening for Children administrative rate and anticipatory guidance. • Update member education materials including lead screening flyer and preventative service guidelines (PSGs). • Update provider training and education materials including the Medi-Cal operations manual and HEDIS provider tools on Lead Screening for Children. • Conduct Medical Records Reviews for lead screening during Facility Site Reviews and report to DHCS twice a year. **Prior rate (%, ratio):** N/A **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Refer to Quality Improvement Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)*	*Completed at (ratio; % range):*

Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)	
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

VIII. PROVIDER ENGAGEMENT

8.1 Quality Evaluating Data to Generate Excellence (EDGE)	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Suvas Patel, Program Manager III, Quality Improvement Amy Wittig, Director, QI Tanya Demirjian, Manager, QI
Program/Indicator Performance Goal	**Goal(s):** Have a 10% increase in performance (MCAS measures achieving MPL) from previous year's workplan outcomes (% objectives met in year-end 2022) for CalViva priority providers. **Rationale:** Through continued EDGE process refinement and implementation, incremental improvement in provider QI performance should positively impact % of MCAS metrics achieving MPL (% objectives met) for CalViva in MY2023.
Program Objectives	Program objective: Incrementally improve Quality metric performance (MCAS) among key providers in CalViva through implementation of Quality EDGE.

	Prior rate (%, ratio): MY 2022: 47% (7/15) **Mid-year rate (%, ratio):** **Final rate (%, ratio):** Insert Quality EDGE Dashboard activities log: N/A until mid-year.
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged*

	☐ *Continue Initiative with Modifications*

8.2 Provider Access, Availability, and Service	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☒ Other: Provider Experience
Responsible Person	Paul Fuentes, Provider Relations Specialist II
Program/Indicator Performance Goal	**Goal(s):** Improve Access to Care: Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After-Hours Access. **Rationale:** Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. The Provider Appointment Access Survey (PAAS) and Provider After-Hours Availability Survey (PAHAS) assess practitioner compliance with access standards and surveying members allows the identification of areas for improvement. • Timely Appointment Access for primary care physicians and specialists are monitored using the DMHC PAAS Tool and the CVH PAAS Tool. • Timely Appointment Access for ancillary providers is monitored using the DMHC PAAS Tool. • After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey (PAHAS).

Program Objectives	To meet performance goal for Provider Appointment Access Survey (PAAS) at 70%. To meet performance goal for Provider After-Hours Access Survey (PAHAS) at 90%. **Prior rate (%, ratio):** MY 2021 PAAS: • PCP Urgent: 50.9% • PCP Non-Urgent: 71.4% • Specialists (All) Urgent: 40.2% • Specialists (All) Non-Urgent: 64.8% • Ancillary Non-Urgent: 94.1% PAHAS: • Appropriate Emergency Instructions: 100.0% • Ability to Contact On-Call Physicians: 82.0% **Mid-year rate (%, ratio):** **Final rate (%, ratio):**
	Supporting activities: • 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. • Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability. • Develop and distribute Provider Updates, as applicable, informing providers of upcoming training webinars, surveys, survey results, and educational information for improvement. • Conduct provider training webinars related to timely access standards and surveys. • Conduct Telephone Access surveys annually to monitor provider office answer time and member callback times.

	• Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval. • 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. • Complete a CAP as necessary when CalViva Health providers are below standard, including additional interventions for providers not meeting standards for two consecutive years. • Annual review, update and distribution of "Improve Health Outcomes - A Guide for Providers Toolkit," After-Hours Script and Timely Appointment Access flyer.
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio; %): *(Populate at mid-year, if available)*	
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio; % range):*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation	☐ *Closed*

(Populate at year end)	☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

IX. ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Completion Date	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. Gill, Program Manager III, Quality Improvement	Ongoing. December 2023		☐		
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	CalViva Health/HN J. Serratore Director, Clinical Programs	Ongoing. December 2023		☐		
3. Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	C. Patnuade, Director, Care Management	Ongoing. December 2023		☐		
4. Promote Kick It California (formerly known as CA Smokers' Helpline) to smokers.	J. Felix, Sr. Health Education Specialist	Ongoing. December 2023		☐		
5. Promote Diabetes Prevention Program to members at risk of developing type 2 diabetes; identify new DPP provider(s) for 2023.	R. CalVa- Songco, Manager, Health Education	Ongoing. December 2023		☐		
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	Ongoing. December 2023		☐		
CONTINUITY OF CARE						
1. Monitor opportunities and interventions for QI 3 & QI 4	L. Ciotoli/ M. Rosales Program Manager III, Quality Improvement	Ongoing. December 2023		☐		
DISEASE/CHRONIC CONDITIONS MANAGEMENT						
1. Monitor Chronic Conditions Management Program for appropriate member outreach.	M. Nuno, Clinical Accounts Manager; C. Jornado, Manager;	Ongoing. December 2023		☐		

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
	Chronic Conditions Management					
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE						
1. C&L Report: Analyze and report on Cultural and Linguistics.	D. Fang, Manager, Health Equity	Q2, Q3 2023.		☐		
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	P. Fuentes, PR Specialist, Access & Availability	Ongoing. December 2023		☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date.	P. Fuentes, PR Specialist, Access & Availability	March 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	Ongoing. December 2023		☐		
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	P. Fuentes, PR Specialist, Access & Availability	Q1, Q2, Q3, Q4 2023.		☐		
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	P. Fuentes, PR Specialist, Access & Availability	Q1, Q2, Q3, Q4 2023.		☐		
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	Q1, Q2, Q3, Q4 2023.		☐		
8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	D. Saldarriaga; Manager, A&G	Ongoing. December 2023.		☐		
9. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement.	D. Fang, Manager, Health Equity	Q3 2023.		☐		

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
Analyze and inform Provider Network Management of areas needing increased contracting with a particular provider to improve availability.						
10. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	T. Demirjian, Manager, Quality Improvement	Ongoing. December 2023.		☐		
12. Engage with CVH provider offices to complete MY 2022 MCAS training focused on best practices for closing care gaps.	A. Wittig, Director, Quality Improvement	Ongoing. December 2023.		☐		
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. December 2023.		☐		
QUALITY AND SAFETY OF CARE						
1. Integrated Care Management (ICM) • Implement PHM pyramid 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 ○ ED utilization ○ Overall health care costs ○ Member Satisfaction	C. Patnaude, Director, Care Management	PHM pyramid: 01/09/2023 ICM: Q1, Q2, Q3, Q4 2023.		☐		
CREDENTIALING / RECREDENTIALING						
1. Credentialing/Recredentialing Practitioners/Providers: Achieve and	M. Catello, Manager, Credentialing	Ongoing. December 2023.		☐		

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
maintain a 100% timely compliance and 100% accuracy score.						
2. PPG Delegates Credentialing/Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	M Catello, Manager Credentialing; K. Bowling, Sr. Manager Delegation Oversight	Ongoing. December 2023.		☐		
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	Ongoing. December 2023.		☐		
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	Ongoing. December 2023.		☐		
2. Complete all potential quality issues (PQIs) received within 90day TAT to maintain compliance with regulatory requirements.	P. Carpenter, Director, Quality Improvement	Ongoing. December 2023.		☐		
3. Evaluation of the QI program of the previous year. Complete QI Work Plan evaluation annually.	A. Wittig, Director; T. Demirjian, Manager; Quality Improvement	Q1 2023.		☐		

Item #7

Attachment 7.A

Financials as of January 31, 2023

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of January 31, 2023

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	141,716,349.64
5	Total Bank Accounts	$ **141,716,349.64**
6	Accounts Receivable	
7	Accounts Receivable	98,914,607.90
8	Total Accounts Receivable	$ **98,914,607.90**
9	Other Current Assets	
10	Interest Receivable	427,323.48
11	Investments - CDs	0.00
12	Prepaid Expenses	758,823.09
13	Security Deposit	85,207.55
14	Total Other Current Assets	$ **1,271,354.12**
15	Total Current Assets	$ **241,902,311.66**
16	Fixed Assets	
17	Buildings	6,104,897.52
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	63,081.05
21	Total Fixed Assets	$ **9,329,397.67**
22	Other Assets	
23	Investment -Restricted	300,850.18
24	Lease Receivable	3,454,054.92
25	Total Other Assets	$ **3,754,905.10**
26	TOTAL ASSETS	$ **254,986,614.43**
27	LIABILITIES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	152,091.50
32	Accrued Admin Service Fee	4,623,553.00
33	Capitation Payable	92,987,486.45
34	Claims Payable	29,612.98
35	Directed Payment Payable	1,509,230.45
36	Total Accounts Payable	$ **99,301,974.38**
37	Other Current Liabilities	
38	Accrued Expenses	1,218,424.23
39	Accrued Payroll	71,005.11
40	Accrued Vacation Pay	303,768.99
41	Amt Due to DHCS	11,722,648.57
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	0.00
47	Total Other Current Liabilities	$ **19,451,051.79**
48	Total Current Liabilities	$ **118,753,026.17**
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	$ **118,778,932.96**
54	Deferred Inflow of Resources	3,072,127.99
55	Equity	
56	Retained Earnings	127,950,997.92
57	Net Income	5,184,555.56
58	Total Equity	$ **133,135,553.48**
59	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ **254,986,614.43**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2022 - January 2023

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	Interest Income	2,417,943.27	198,331.00	2,219,612.27
3	Premium/Capitation Income	755,455,418.03	707,283,830.00	48,171,588.03
4	**Total Income**	**757,873,361.30**	**707,482,161.00**	**50,391,200.30**
5	**Cost of Medical Care**			
6	Capitation - Medical Costs	621,567,337.91	575,478,470.00	46,088,867.91
7	Medical Claim Costs	781,264.06	630,000.00	151,264.06
8	**Total Cost of Medical Care**	**622,348,601.97**	**576,108,470.00**	**46,240,131.97**
9	**Gross Margin**	**135,524,759.33**	**131,373,691.00**	**4,151,068.33**
10	**Expenses**			
11	Admin Service Agreement Fees	31,940,194.00	30,347,900.00	1,592,294.00
12	Bank Charges	0.00	4,200.00	(4,200.00)
13	Computer/IT Services	117,614.96	136,192.00	(18,577.04)
14	Consulting Fees	14,675.00	175,000.00	(160,325.00)
15	Depreciation Expense	168,857.89	189,175.00	(20,317.11)
16	Dues & Subscriptions	120,758.63	119,700.00	1,058.63
17	Grants	3,224,090.92	3,224,090.92	0.00
18	Insurance	112,313.26	113,043.00	(729.74)
19	Labor	1,873,438.43	2,069,095.00	(195,656.57)
20	Legal & Professional Fees	53,675.66	111,300.00	(57,624.34)
21	License Expense	685,721.54	684,810.00	911.54
22	Marketing	761,424.10	980,000.00	(218,575.90)
23	Meals and Entertainment	15,247.89	18,800.00	(3,552.11)
24	Office Expenses	52,882.34	53,000.00	(117.66)
25	Parking	184.39	910.00	(725.61)
26	Postage & Delivery	2,281.52	2,380.00	(98.48)
27	Printing & Reproduction	1,275.20	2,800.00	(1,524.80)
28	Recruitment Expense	36,668.73	24,000.00	12,668.73
29	Rent	0.00	7,000.00	(7,000.00)
30	Seminars and Training	5,700.10	15,400.00	(9,699.90)
31	Supplies	5,840.92	6,650.00	(809.08)
32	Taxes	91,437,096.77	91,437,500.00	(403.23)
33	Telephone	17,459.38	23,275.00	(5,815.62)
34	Travel	11,130.71	14,900.00	(3,769.29)
35	**Total Expenses**	**130,658,532.34**	**129,761,120.92**	**897,411.42**
36	**Net Operating Income/ (Loss)**	**4,866,226.99**	**1,612,570.08**	**3,253,656.91**
37	**Other Income**			
38	Other Income	318,328.57	385,000.00	(66,671.43)
39	**Total Other Income**	**318,328.57**	**385,000.00**	**(66,671.43)**
40	**Net Other Income**	**318,328.57**	**385,000.00**	**(66,671.43)**
41	**Net Income/ (Loss)**	**5,184,555.56**	**1,997,570.08**	**3,186,985.48**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2023 vs FY 2022

		Total	
		July 2022 - January 2023 (FY 2023)	July 2021 - January 2022 (FY 2022)
1	Income		
2	Interest Income	2,417,943.27	159,726.61
3	Premium/Capitation Income	755,455,418.03	802,335,573.06
4	Total Income	$ 757,873,361.30	$ 802,495,299.67
5	Cost of Medical Care		
6	Capitation - Medical Costs	621,567,337.91	662,927,418.55
7	Medical Claim Costs	781,264.06	591,522.76
8	Total Cost of Medical Care	$ 622,348,601.97	$ 663,518,941.31
9	Gross Margin	$ 135,524,759.33	$ 138,976,358.36
10	Expenses		
11	Admin Service Agreement Fees	31,940,194.00	30,109,046.00
12	Bank Charges	0.00	8.22
13	Computer/IT Services	117,614.96	101,507.66
14	Consulting Fees	14,675.00	0.00
15	Depreciation Expense	168,857.89	167,038.56
16	Dues & Subscriptions	120,758.63	98,215.15
17	Grants	3,224,090.92	2,568,181.84
18	Insurance	112,313.26	106,515.75
19	Labor	1,873,438.43	2,319,130.09
20	Legal & Professional Fees	53,675.66	46,228.69
21	License Expense	685,721.54	464,960.51
22	Marketing	761,424.10	820,997.59
23	Meals and Entertainment	15,247.89	14,860.81
24	Office Expenses	52,882.34	34,189.01
25	Parking	184.39	262.95
26	Postage & Delivery	2,281.52	2,054.00
27	Printing & Reproduction	1,275.20	2,024.32
28	Recruitment Expense	36,668.73	1,698.65
29	Rent	0.00	0.00
30	Seminars and Training	5,700.10	9,448.88
31	Supplies	5,840.92	5,736.13
32	Taxes	91,437,096.77	96,979,166.67
33	Telephone	17,459.38	20,187.62
34	Travel	11,130.71	9,285.64
35	Total Expenses	$ 130,658,532.34	$ 133,880,744.74
36	Net Operating Income/ (Loss)	$ 4,866,226.99	$ 5,095,613.62
37	Other Income		
38	Other Income	318,328.57	147,885.76
39	Total Other Income	$ 318,328.57	$ 147,885.76
40	Net Other Income	$ 318,328.57	$ 147,885.76
41	Net Income/ (Loss)	$ 5,184,555.56	$ 5,243,499.38

Item #7

Attachment 7.B

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2023

Current as of End of the Month: January
Revised Date: 1/31/2023

CalViva Health Appeals and Grievances Dashboard 2023

CalViva - 2022																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022 YTD**
Expedited Grievances Received	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	74
Standard Grievances Received	93	0	0	93	0	0	0	0	0	0	0	0	0	0	0	0	93	1109
Total Grievances Received	**101**	**0**	**0**	**101**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**101**	**1183**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.5%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	74
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	93	0	0	93	0	0	0	0	0	0	0	0	0	0	0	0	93	1105
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.9%**
Total Grievances Resolved	**100**	**0**	**0**	**100**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**100**	**1180**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**65**	**0**	**0**	**65**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**65**	**826**
Access - Other - DMHC	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13	176
Access - PCP - DHCS	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	85
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	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	57
Administrative	10	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	10	119
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	102
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	101
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Transportation - Access	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	81
Transportation - Behaviour	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	66
Transportation - Other	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	30
Quality Of Care Grievances	**35**	**0**	**0**	**35**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**	**354**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
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	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	43
PCP Care	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	93
PCP Delay	12	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	12	104
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	66
Specialist Delay	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	33
Exempt Grievances Received	144	0	0	**144**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**144**	2429
Access - Avail of Appt w/ PCP	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	53
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Wait Time - wait too long on telephone	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	25
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	10
Access - Panel Disruption	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	25
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
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**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	6
Attitude/Service - Provider	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	198
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	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	15
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	14
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Eligibility Issue - Member not eligible per Provider	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	44
Health Plan Materials - ID Cards-Not Received	14	0	0	**14**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**14**	243
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	7
Health Plan Materials - Other	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	6
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Health Plan Assignment - Change Request	53	0	0	**53**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**53**	629
PCP Assignment/Transfer - HCO Assignment - Change Request	35	0	0	**35**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**35**	533
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	20

CalViva Health Appeals and Grievances Dashboard 2023

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	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	32
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	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
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**	0
Transportation - Access - Provider No Show	8	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**8**	133
Transportation - Access - Provider Late	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	77
Transportation - Behaviour	13	0	0	**13**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**13**	139
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	12
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	7
Claims Complaint - Balance Billing from Provider	8	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**8**	173

CalViva Health Appeals and Grievances Dashboard 2023

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	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	42
Standard Appeals Received	29	0	0	29	0	0	0	0	0	0	0	0	0	0	0	0	29	396
Total Appeals Received	**29**	**0**	**0**	**29**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	29	**438**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	1	3
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**96.55%**	**99.2%**
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	42
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%**	**#DIV/0!**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Resolved Compliant	21	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	21	414
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.8%**
Total Appeals Resolved	**21**	**0**	**0**	**21**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**21**	**457**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**21**	**0**	**0**	**21**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**21**	454
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	7
DME	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	49
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	2
Advanced Imaging	10	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	10	244
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	33
Pharmacy/RX Medical Benefit	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	58
Surgery	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	61
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**	3
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	1
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	2
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	6	0	0	**6**	0	0	0	0	0	0	0	0	0	0	0	0	6	196
Uphold Rate	**28.6%**	**0.0%**	**0.0%**	**28.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**28.6%**	**42.9%**
Overturns - Full	15	0	0	**15**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	15	244
Overturn Rate - Full	**71.4%**	**0.0%**	**0.0%**	**71.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**71.4%**	**53.4%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	9
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%**	**0.00%**	**0.0%**	**2.0%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**0**	8
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%**	**1.8%**
Membership	421,006	-	-		-	-	-		-	-	-		-	-	-			417,000
Appeals - PTMPM	0.05	-	-	0.05	-	-	-	-	-	-	-	-	-	-	-	-	0.05	0.09
Grievances - PTMPM	0.24	-	-	0.24	-	-	-	-	-	-	-	-	-	-	-	-	0.24	0.24

CalViva Health Appeals and Grievances Dashboard 2023 (Fresno County)

Fresno County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022 YTD
Expedited Grievances Received	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	59
Standard Grievances Received	81	0	0	81	0	0	0	0	0	0	0	0	0	0	0	0	81	929
Total Grievances Received	**89**	**0**	**0**	**89**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**89**	**988**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.57%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	59
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	71	0	0	71	0	0	0	0	0	0	0	0	0	0	0	0	71	932
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.9%**
Total Grievances Resolved	**78**	**0**	**0**	**78**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**78**	**992**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**51**	**0**	**0**	**51**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**51**	**686**
Access - Other - DMHC	12	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	12	139
Access - PCP - DHCS	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	72
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	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	47
Administrative	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	97
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	90
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	83
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Transportation - Access	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	65
Transportation - Behaviour	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	61
Transportation - Other	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	26
Quality Of Care Grievances	**27**	**0**	**0**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**27**	**306**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
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	3
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	35
PCP Care	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	76
PCP Delay	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	94
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	59
Specialist Delay	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	27

CalViva Health Appeals and Grievances Dashboard 2023 (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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	33
Standard Appeals Received	23	0	0	23	0	0	0	0	0	0	0	0	0	0	0	0	23	320
Total Appeals Received	**23**	**0**	**0**	**23**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	23	**353**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**95.7%**	**99.7%**
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	33
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	1
Standard Appeals Resolved Compliant	19	0	0	19	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	19	336
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.7%**
Total Appeals Resolved	**19**	**0**	**0**	**19**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**370**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**19**	**0**	**0**	**19**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**368**
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	7
DME	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	40
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	2
Advanced Imaging	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	199
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	29
Pharmacy/RX Medical Benefit	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	44
Surgery	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	47
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pharmacy/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	0	0	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	164
Uphold Rate	**26.3%**	**0.0%**	**0.0%**	**26.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**26.3%**	**44.3%**
Overturns - Full	14	0	0	**14**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	14	189
Overturn Rate - Full	**73.7%**	**0.0%**	**0.0%**	**73.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**73.7%**	**51.1%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	9
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%**	**2.4%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	8
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%**	**2.2%**
Membership	338,835																	**335572**
Appeals - PTMPM	0.06	-	-	0.06	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.01	0.07
Grievances - PTMPM	0.23	-	-	0.23	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.06	0.18

Kings County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022 YTD
Expedited Grievances Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Standard Grievances Received	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	76
Total Grievances Received	**4**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**79**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Expedited Grievance 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 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	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	75
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**9**	**0**	**0**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	9	**78**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**4**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**57**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
Access - PCP - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
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	7
Administrative	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	4
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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	8
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Transportation - Access	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Quality Of Care Grievances	**5**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**21**
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	0	0	0	0	0	0	0	1	4
PCP Care	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	4
PCP Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	6
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	0	0	0	0	0	0	0	0	6
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

CalViva Health Appeals and Grievances Dashboard 2023 (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	0
Standard Appeals Received	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	16
Total Appeals Received	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	1	**16**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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%**	**0.0%**
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	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	14
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**14**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**14**
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	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Surgery	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	5
Uphold Rate	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**35.7%**
Overturns - Full	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	9
Overturn Rate - Full	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**64.3%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
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%**	**0.0%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Membership	36,388																	**314148**
Appeals - PTMPM	0.05	-	-	0.05	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.01	0.03
Grievances - PTMPM	0.25	-	-	0.25	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.06	0.18

Madera County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022 YTD
Expedited Grievances Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
Standard Grievances Received	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	104
Total Grievances Received	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**116**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
Expedited Grievance 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 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	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13	98
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**13**	**0**	**0**	**13**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13**	**110**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**10**	**0**	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**10**	**83**
Access - Other - DMHC	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	22
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Administrative	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	18
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	8
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	10
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Transportation - Access	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	11
Transportation - Behaviour	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	1
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Quality Of Care Grievances	**3**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	**27**
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	1
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	0	0	0	0	0	0	0	1	4
PCP Care	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	13
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	3
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2

CalViva Health Appeals and Grievances Dashboard 2023 (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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Standard Appeals Received	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	60
Total Appeals Received	**5**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	5	**69**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	64
Standard 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%**
Total Appeals Resolved	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**73**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**72**
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	0	0	0	0	0	0	0	0	0	0	0	0	8
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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	40
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/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	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	27
Uphold 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%**	**37.0%**
Overturns - Full	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	46
Overturn Rate - Full	**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%**	**0.00%**	**0.0%**	**63.0%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
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%**	**0.0%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Membership	45,783																	**45377**
Appeals - PTMPM	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.14
Grievances - PTMPM	0.28	-	-	0.28	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.07	0.21

CalViva SPD only

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022 YTD
Expedited Grievances Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	25
Standard Grievances Received	30	0	0	30	0	0	0	0	0	0	0	0	0	0	0	0	30	342
Total Grievances Received	**32**	**0**	**0**	32	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**	**367**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.71%**
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	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	25
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	24	0	0	24	0	0	0	0	0	0	0	0	0	0	0	0	24	356
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**26**	**0**	**0**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	26	**381**
Grievance Descriptions - Resolved Cases	**26**	**0**	**0**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	26	**381**
Access to primary care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	51
Access to specialists	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	72
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	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	89
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	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	41
QOS Non Access	10	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	10	118
Exempt Grievances Received	10	0	0	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	180
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
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**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Provider	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	15
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	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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	0	**0**	**0**	1
Health Plan Materials - ID Cards-Not Received	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	26
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Health Plan Materials - Other	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Health Plan Assignment - Change Request	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	58
PCP Assignment/Transfer - HCO Assignment - Change Request	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	50
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	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**	0
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**	0
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	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	13

CalViva Health Appeals and Grievances Dashboard 2023 (SPD)

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	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	76
Total Appeals Received	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	8	**80**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**87.5%**	**98.7%**
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	11
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	7	0	0	7	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	7	89
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**7**	**0**	**0**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**93**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**7**	**0**	**0**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**96**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26
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	1
Advanced Imaging	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	43
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Pharmacy/RX Medical Benefit	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
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	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	31
Uphold Rate	**42.9%**	**0.0%**	**0.0%**	**42.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.9%**	**33.3%**
Overturns - Full	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	4	65
Overturn Rate - Full	**57.1%**	**0.0%**	**0.0%**	**57.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**57.1%**	**69.89%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
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%**	**3.2%**
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	38,875																	**109421**
Appeals - PTMPM	0.18	-	-	0.00	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.10
Grievances - PTMPM	0.67	-	-	0.00	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.51

Item #7

Attachment 7.C

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 1/01/2023 to 1/31/2023
Report created 2/27/2023

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.con
Authorization Metrics	John Gonzalez

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2023 to 1/31/2023
Report created 2/27/2023

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	2023-01	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
MEMBERSHIP																Quarterly Averages					Annual Averages		
Expansion Mbr Months	106,100	106,761	107,711	108,318	109,074	109,963	111,924	112,978	113,991	114,769	115,686	116,370		116,424		106,857	109,118	112,964	115,608		111,137	116,424	
Family/Adult/Other Mbr Mos	163,860	168,390	174,577	181,704	189,521	199,445	207,745	215,922	225,286	235,338	245,651	255,294		266,305		168,942	190,223	216,318	245,428		205,228	266,305	
SPD Mbr Months	30,244	30,627	31,126	31,640	32,172	32,784	33,371	33,977	34,619	35,248	35,878	36,568		39,224		30,666	32,199	33,989	35,898		33,188	39,224	
COUNTS																							
Admits - Count	2,202	1,894	2,237	2,073	2,214	2,135	2,235	2,274	2,340	2,243	2,269	2,147		2,163		2,111	2,141	2,283	2,220		2,189	2,163	
Expansion	704	590	733	680	761	728	771	732	748	710	664	607		644		676	723	750	660		702	644	
Family/Adult/Other	1,006	881	1,039	910	953	945	986	1,073	1,093	1,110	1,160	1,104		972		975	936	1,051	1,125		1,022	972	
SPD	485	420	456	481	499	459	475	467	491	421	439	432		543		454	480	478	431		460	543	
Admits Acute - Count	1,596	1,361	1,590	1,522	1,611	1,513	1,558	1,543	1,639	1,553	1,647	1,486		1,526		1,516	1,549	1,580	1,562		1,552	1,526	
Expansion	584	495	609	562	638	594	627	592	614	588	546	488		514		563	598	611	541		578	514	
Family/Adult/Other	553	470	563	514	512	490	486	514	574	573	684	587		542		529	505	525	615		543	542	
SPD	458	394	417	445	461	429	445	437	450	392	415	410		469		423	445	444	406		429	469	
Readmit 30 Day - Count	225	208	207	189	212	205	235	222	220	229	188	190		235		213	202	226	202		211	235	
Expansion	94	98	92	77	95	85	104	97	97	95	73	63		91		95	86	99	77		89	91	
Family/Adult/Other	44	40	36	30	45	34	36	37	47	50	46	31		43		40	36	40	42		40	43	
SPD	87	69	79	82	72	86	95	88	76	84	69	95		101		78	80	86	83		82	101	
**ER Visits - Count	14,092	11,242	14,108	13,754	16,631	15,068	14,268	14,106	14,032	14,380	14,914	12,864		4,590		13,147	15,151	14,135	14,053		14,122	4,590	
Expansion	3,862	2,962	3,691	3,559	4,158	4,022	4,116	3,968	3,618	3,617	3,489	3,110		1,040		3,505	3,913	3,901	3,405		3,681	1,040	
Family/Adult/Other	4,901	4,046	5,364	5,429	6,925	6,464	6,044	6,319	7,025	7,517	8,461	7,525		3,083		4,770	6,273	6,463	7,834		6,335	3,083	
SPD	1,079	898	1,156	1,250	1,453	1,395	1,448	1,443	1,429	1,532	1,598	1,344		316		1,044	1,366	1,440	1,491		1,335	316	
PER/K																							
Admits Acute - PTMPY	46.7	39.7	46.2	44.0	46.4	43.4	44.3	43.7	46.2	43.7	46.0	41.4		42.3		44.2	44.6	44.7	43.7		44.3	42.3	
Expansion	66.1	55.6	67.8	62.3	70.2	64.8	67.2	62.9	64.6	61.5	56.6	50.3		53.0		63.2	65.8	64.9	56.1		62.4	53.0	
Family/Adult/Other	40.5	33.5	38.7	33.9	32.4	29.5	28.1	28.6	30.6	29.2	33.4	27.6		24.4		37.6	31.9	29.1	30.1		31.8	24.4	
SPD	181.7	154.4	160.8	168.8	172.0	157.0	160.0	154.3	156.0	133.5	138.8	134.5		143.5		165.5	165.8	156.8	135.6		155.3	143.5	
Bed Days Acute - PTMPY	264.4	216.3	224.8	225.7	242.0	224.0	225.6	215.7	232.2	221.3	241.2	223.1		218.5		235.2	230.6	224.5	228.5		229.6	218.5	
Expansion	359.8	330.3	386.6	345.9	380.4	335.9	365.5	318.8	374.3	370.2	349.8	333.8		318.7		359.0	354.0	352.9	351.2		354.2	318.7	
Family/Adult/Other	171.6	134.6	133.6	119.6	135.2	119.7	98.6	96.9	105.6	96.9	124.2	104.6		86.5		146.2	124.8	100.4	108.7		118.0	86.5	
SPD	1,395.8	1,010.9	896.4	1,087.4	1,049.6	1,005.5	1,012.6	1,014.7	933.5	826.9	905.1	833.8		880.2		1,098.7	1,047.0	986.4	855.3		991.6	880.2	
ALOS Acute	5.7	5.4	4.9	5.1	5.2	5.2	5.1	4.9	5.0	5.1	5.2	5.4		5.2		5.3	5.2	5.0	5.2		5.2	5.2	
Expansion	5.4	5.9	5.7	5.6	5.4	5.2	5.4	5.1	5.8	6.0	6.2	6.6		6.0		5.7	5.4	5.4	6.3		5.7	6.0	
Family/Adult/Other	4.2	4.0	3.5	3.5	4.2	4.1	3.5	3.4	3.5	3.3	3.7	3.8		3.5		3.9	3.9	3.5	3.6		3.7	3.5	
SPD	7.7	6.5	5.6	6.4	6.1	6.4	6.3	6.6	6.0	6.2	6.5	6.2		6.1		6.6	6.3	6.3	6.3		6.4	6.1	
Readmit % 30 Day	10.2%	11.0%	9.3%	9.1%	9.6%	9.6%	10.5%	9.8%	9.4%	10.2%	8.3%	8.8%		10.9%		10.1%	9.4%	9.9%	9.1%		9.6%	10.9%	
Expansion	13.4%	16.6%	12.6%	11.3%	12.5%	11.7%	13.5%	13.3%	13.0%	13.4%	11.0%	10.4%		14.1%		14.0%	11.8%	13.2%	11.7%		12.7%	14.1%	
Family/Adult/Other	4.4%	4.5%	3.5%	3.3%	4.7%	3.6%	3.7%	3.4%	4.3%	4.5%	4.0%	2.8%		4.4%		4.1%	3.9%	3.8%	3.8%		3.9%	4.4%	
SPD	17.9%	16.4%	17.3%	17.0%	14.4%	18.7%	20.0%	18.8%	15.5%	20.0%	15.7%	22.0%		18.6%		17.3%	16.7%	18.1%	19.2%		17.8%	18.6%	
**ER Visits - PTMPY	412.1	328.1	409.8	397.9	478.7	431.9	405.8	399.4	395.8	404.3	416.9	358.6		127.1		383.3	436.2	400.3	393.2		403.2	127.1	
Expansion	436.8	332.9	411.2	394.3	457.5	438.9	441.3	421.5	380.9	378.2	361.9	320.7		107.2		393.6	430.3	414.4	353.5		397.5	107.2	
Family/Adult/Other	358.9	288.3	368.7	358.5	438.5	388.9	349.1	351.2	374.2	383.3	413.3	353.7		138.9		338.8	395.7	358.5	383.1		370.4	138.9	
SPD	428.1	351.8	445.7	474.1	542.0	510.6	520.7	509.6	495.3	521.6	534.5	441.0		96.7		408.7	509.1	508.4	498.5		482.9	96.7	
Services	TAT Compliance Goal: 100%													T Compliance Goal: 10		TAT Compliance Goal: 100%					TAT Compliance Goal: 100%		
Preservice Routine	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	84.0%	82.0%	98.0%	98.0%	96.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%				
Preservice Urgent	96.0%	100.0%	98.0%	98.0%	100.0%	100.0%	100.0%	96.0%	100.0%	98.0%	98.0%	100.0%		100.0%		99.3%	99.1%	99.1%	100.0%				
Postservice	98.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	94.0%	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		100.0%		100.0%	99.1%	100.0%	100.0%				
Deferrals - Routine	100.0%	95.4%	100.0%	100.0%	100.0%	100.0%	83.3%	78.6%	95.2%	95.2%	100.0%	100.0%		100.0%		100.0%	91.5%	98.8%	96.0%				
Deferrals - Urgent	100.0%	Null	100.0%	null	50.0%	100.0%	N/A	100.0%	100.0%	N/A	100.0%	N/A		N/A		100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	null	null	null	NA	NA	NA	NA	NA	NA	NA	NA	NA		null		null	null	null	null				
	CCS ID RATE													CCS ID RATI		CCS ID RATE					CCS ID RATE		
CCS %	8.17%	8.29%	8.25%	8.21%	8.17%	8.33%	8.36%	8.37%	8.37%	8.37%	8.48%	8.33%		8.50%		8.69%	8.72%	8.31%	8.44%		8.54%	8.50%	
	Perinatal Case Management													rinatal Case Managem		Perinatal Case Management					Perinatal Case Management		
Total Number Of Referrals	136	154	259	173	128	97	145	162	106	118	158	174		145		472	598	476	386		1,932	145	
Pending	0	0	0	0	0	0	0	0	2	2	3	2		8		0	2	1	21		24	8	
Ineligible	7	9	22	23	6	3	2	2	3	8	4	7		6		18	32	10	19		79	6	
Total Outreached	129	145	237	150	122	94	143	160	101	108	151	165		131		454	564	465	346		1,829	131	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2023 to 1/31/2023
Report created 2/27/2023

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	2023-01	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
Engaged	32	40	47	36	34	29	42	40	20	24	29	18		63		157	224	183	137		701	63	
Engagement Rate	25%	28%	20%	24%	28%	31%	29%	25%	20%	22%	19%	11%		48%		35%	40%	39%	40%		38%	48%	
New Cases Opened	32	40	47	36	34	29	42	40	20	24	29	18		63		157	224	183	137		701	63	
Total Cases Managed	257	251	281	286	274	263	278	291	274	262	251	237		291		344	432	496	410		887	291	
Total Cases Closed	46	17	32	46	36	32	30	39	35	38	33	47		39		136	154	182	180		652	39	
Cases Remained Open	212	215	225	217	158	115	193	160	166	188	204	180		242		199	263	263	224		224	242	
						Integrated Case Management								egrated Case Manager			Integrated Case Management					Integrated Case Management	
Total Number Of Referrals	121	116	115	91	81	133	104	136	132	121	86	77		210		288	503	622	529		1,942	210	
Pending	0	0	0	0	0	0	0	0	2	2	4	6		16		1	1	0	23		25	16	
Ineligible	17	9	9	7	7	3	6	10	10	8	9	12		48		16	26	42	32		116	48	
Total Outreached	104	107	106	84	74	130	98	126	120	111	73	59		146		271	476	580	474		1,801	146	
Engaged	74	76	74	55	51	86	55	77	73	83	48	38		91		185	341	445	328		1,299	91	
Engagement Rate	71%	71%	70%	65%	69%	66%	56%	61%	61%	75%	66%	64%		62%		68%	72%	77%	69%		72%	62%	
Total Screened and Refused/Decline	8	9	11	8	9	17	12	15	12	12	11	3		35		19	46	54	60		179	35	
Unable to Reach	22	22	21	21	14	27	31	34	35	16	14	18		20		67	89	81	86		323	20	
New Cases Opened	74	76	74	55	51	86	55	77	73	83	48	38		91		185	341	445	328		1,299	91	
Total Cases Closed	60	60	51	48	51	85	57	84	81	82	78	78		111		181	238	333	395		1,147	111	
Cases Remained Open	310	322	330	327	253	166	271	230	224	292	301	258		382		267	368	471	411		411	382	
Total Cases Managed	378	394	406	408	409	445	416	435	432	431	395	354		507		458	622	900	818		1579	507	
Critical-Complex Acuity	60	58	60	58	50	56	56	57	48	46	44	40		40		44	60	73	70		120	40	
High/Moderate/Low Acuity	318	336	346	350	359	389	360	378	384	385	351	314		467		414	562	827	748		1459	467	
						Transitional Case Management								sitional Case Manager			Transitional Case Management					Transitional Case Management	
Total Number Of Referrals	143	201	229	250	212	201	115	138	101	94	105	80		77		252	326	436	363		1,377	77	
Pending	0	0	0	0	0	0	0	0	0	0	0	5		0		0	0	0	5		5	0	
Ineligible	23	21	26	40	23	21	21	10	10	7	13	8		8		21	24	21	18		84	8	
Total Outreached	120	180	203	210	189	180	94	128	91	87	92	67		69		231	302	415	340		1,288	69	
Engaged	57	102	116	128	132	148	73	97	66	63	70	45		56		158	213	375	264		1,010	56	
Engagement Rate	48%	57%	57%	61%	70%	82%	78%	76%	73%	72%	76%	67%		81%		68%	71%	90%	78%		78%	81%	
Total Screened and Refused/Decline	13	24	15	10	10	6	4	6	1	4	3	1		1		4	12	18	25		59	1	
Unable to Reach	50	54	72	72	47	26	17	25	24	20	19	21		12		69	77	22	51		219	12	
New Cases Opened	57	102	116	128	132	148	73	97	66	63	70	45		56		158	213	375	264		1,010	56	
Total Cases Closed	89	49	109	120	122	145	132	74	109	48	65	73		70		138	220	338	301		997	70	
Cases Remained Open	76	61	92	103	92	60	64	67	40	50	62	50		30		71	56	87	45		45	30	
Total Cases Managed	148	161	228	251	263	295	218	182	174	125	147	126		113		214	297	579	372		1127	113	
High/Moderate/Low Acuity	148	161	228	251	263	295	218	182	174	125	147	126		113		214	297	579	372		1127	113	
						Palliative Care								alliative Ca				Palliative Care				Palliative Care	
Total Number Of Referrals	13	12	17	14	10	18	13	9	12	10	15	12		13		24	32	51	39		146	13	
Pending	0	0	0	0	0	0	0	0	0	0	0	3		3		0	0	0	3		3	3	
Ineligible	6	4	4	5	4	3	2	3	5	6	7	5		6		11	7	17	11		46	6	
Total Outreached	7	8	13	9	6	15	11	6	7	4	8	4		4		13	25	34	25		97	4	
Engaged	5	8	7	4	5	11	9	5	6	2	7	3		4		9	19	23	19		70	4	
Engagement Rate	71%	100%	54%	44%	83%	73%	82%	83%	86%	50%	88%	75%		100%		69%	76%	68%	76%		72%	100%	
Total Screened and Refused/Decline	2	0	4	2	1	3	2	1	0	2	1	0		0		2	2	5	4		13	0	
Unable to Reach	0	0	2	3	0	1	0	0	1	0	0	1		0		2	4	6	2		14	0	
New Cases Opened	5	8	7	4	5	11	9	5	6	2	7	3		4		9	19	23	19		70	4	
Total Cases Closed	5	2	8	2	8	9	9	5	6	14	4	3		7		23	12	15	19		69	7	
Cases Remained Open	92	91	91	94	68	46	79	66	71	76	84	83		88		73	82	92	92		92	88	
Total Cases Managed	102	103	107	104	108	108	110	104	105	101	94	93		98		99	97	114	111		167	98	
						Behavioral Health Case Management								oral Health Case Mana			Behavioral Health Case Management					ehavioral Health Case Managemen	
Total Number Of Referrals	73	92	86	87	93	82	91	90	111	120	103	82		78		295	318	270	214		1,097	78	
Pending	0	0	0	0	0	0	0	0	0	0	1	13		5		0	0	0	8		8	5	
Ineligible	6	3	3	1	2	4	2	6	5	3	5	4		2		25	18	13	6		62	2	
Total Outreached	67	89	83	86	91	78	89	84	106	117	97	65		71		270	300	257	200		1,027	71	
Engaged	29	47	39	40	42	40	41	53	57	63	51	35		49		164	203	175	140		682	49	
Engagement Rate	43%	53%	47%	47%	46%	51%	46%	63%	54%	54%	53%	54%		69.0%		61%	68%	68%	70%		66%	69%	
Total Screened and Refused/Decline	0	2	3	0	1	0	1	0	0	0	1	1		1		11	12	13	9		45	1	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
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Report created 2/27/2023

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	2023-01	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
Unable to Reach	38	40	41	46	48	38	47	31	49	54	45	29		21		95	85	69	51		300	21	
New Cases Opened	29	47	39	40	42	40	41	53	57	63	51	35		49		164	203	175	140		682	49	
Total Cases Closed	52	28	25	33	34	40	50	45	53	53	51	51		42		134	142	217	148		641	42	
Cases Remained Open	75	92	101	104	80	80	90	84	91	116	128	116		167		149	212	171	160		160	167	
Total Cases Managed	133	129	140	154	161	163	170	173	182	192	191	176		215		293	359	444	316		809	215	
Critical-Complex Acuity	7	6	6	9	9	8	9	7	9	12	10	11		7		18	15	17	12		30	7	
High/Moderate/Low Acuity	126	123	134	145	152	155	161	166	173	180	181	165		208		275	344	427	304		779	208	

Item #7

Attachment 7.D

Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: March 16th, 2023

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2023

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st. Quarter 2023 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 23rd, 2023. At the February 23rd meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the third quarter for 2022 were reviewed for delegated entities and fourth quarter for Health Net and MHN. A summary of the third quarter data is included in the table below.

III. Table 1. Third Quarter 2022 Credentialing/Recredentialing

	Sante	ChildNet	MHN	HN	LaSalle	ASH	Envolve	IMG	CVMP	Adventist	Totals
Initial credentialing	55	17	47	3	107	0	7	6	18	37	**297**
Recredentialing	0	75	27	22	29	0	7	20	56	14	**250**
Suspensions	0	0	0	0	0	0	0	0	0	0	0
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	0
Totals	**55**	**92**	**74**	**25**	**136**	**0**	**14**	**26**	**74**	**51**	**547**

IV. The 2023 Credentialing Sub-Committee annual policy and procedure review was completed. One policy was retired, one new policy was presented and five policies were updated with minor or no changes. The policies were revised as follows:

a. New policy CR-109 *Ongoing Monitoring of Sanctions-Complaints*. This policy was provided for committee review.
b. The *Appeals Process* policy was revised in order to added health and safety precautions statement to assure the comfort levels of all fair hearing participants.
c. Policy CR-190 *Medi-Cal Termination Appeals Process* was retired and combined into CR-140.

The policies and procedures were approved.

V. There was one Adverse Action case. A practitioner from Fresno County who has been subject to Medical Board of California disciplinary action based on pain med prescribing patterns, detailed the circumstances under which his prescribing patterns were abnormal. It was determined that he has fully complied with the terms and conditions imposed by the Board and thus would be placed on semiannual monitoring for continued compliance. The Committee approved this determination.

Item #7

Attachment 7.E

Peer Review Sub-Committee
Quarterly Report

Attachment

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	March 16th, 2023
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2023

Purpose of Activity:

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

I. The Peer Review Sub-Committee met on February 23rd, 2023. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2022 were reviewed for approval. There were no significant cases to report.

II. The 2023 Peer Review Sub-Committee Policies and Procedures were reviewed. PR-001 policy was reviewed without changes. PR-100 Peer Review Committee Policy had significant changes including a Changed "Investigations Team Data Analyst" to "Investigations Team" and "Data Analyst" to "Associate". Changed Special Handle and Low-Level reviews from quarterly to semi-annually. Updated Attachment A Peer Review Case Coding 2023. The policies were approved.

III. The Quarter 4, 2022 Peer Count Report was presented at the meeting with a total of three (3) cases reviewed. The outcomes for these cases are as follows:
- There were two (2) cases closed and cleared. There were no cases pending closure for Corrective Action Plan compliance or cases with outstanding CAPs. There was one (1) case tabled for further information.

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

Item #7

Attachment 7.F

QIUM Charter

Fresno-Kings-Madera Regional Health Authority
Quality Improvement/Utilization Management Committee Charter

I. Purpose:

A. 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, Health Equity, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.

B. 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 delegated, nondelegated, and collaborative QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

II. Authority:

A. 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.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. 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.

IV. Committee Focus:

The QI/UM Committee's responsibilities include but are not limited to the following activities.

A. Review and recommend approval to the RHA Commission of the program documents listed below:
   1. Annual QI Program Description
   2. Annual QI Work Plan
   3. Annual QI Program Evaluation
   4. Annual UM Program Description
   5. Annual CM Program Description
   ~~5.~~6. Annual CM Program Evaluation
   ~~6.~~7. Annual UM/CM Work Plan
   ~~7.~~8. Annual UM/CM Program Evaluation;
   ~~8.~~9. Annual Health Education Program Description
   ~~9.~~10. Annual Health Education Work Plan
   ~~10.~~11. Annual Health Education Program Evaluation

~~11.~~12. Annual ~~Culture and Linguistics~~Health Equity ("HE~~C&L~~") Program Description
~~12.~~13. Annual ~~Culture and Linguistics~~Health Equity Work Plan
~~—~~Annual ~~Culture and Linguistics~~ Health Equity Program Evaluation
~~13. Population Health Management Program~~

14.

B. Reviews quarterly reports of Work Plan progress for the programs listed above;
C. Monitors key clinical and service performance indicators for QI, UM, HE and Credentialing/Recredentialing activities (e.g., access & availability, over and under utilization, key UM and case management indicators, behavioral health, population health, appeals and grievances, HEDIS® and CAHPS® measure results, provider satisfaction surveys, disease management and public health programs activities, timeliness standards etc.);
D. Analyze and evaluate the results of QI and Health Equity activities;
~~C.~~E. Monitor effectiveness of the language assistance services offered to support members with limited English proficiency and address identified health disparities, social risk, social determinants of health (SDoH), and community needs and makes ongoing recommendations;
~~D.~~F. Provide oversight and review reports of delegated UM and Credentialing/ Recredentialing functions and collaborative QI functions;
~~E.~~G. Reviews summarized grievance reports for medically related issues and administrative quality concerns;
~~F.~~H. Reviews analysis of potential quality incident reports (developed from grievances/complaints, utilization management, utilization reports suggesting over or under utilization);
~~G.~~I. Oversees and monitors CalViva's participation in the Department of Health Care Services ("DHCS") required Quality Improvement Projects ("QIPs");
~~H.~~J. Approve and oversee conduct of special QI studies as warranted;
I. Brings general medically-related concerns to the attention of the Plan's Operating Administrator (Health Net);
J. Advises on the conduct of provider and member satisfaction surveys and submits its review to the Commission;
K. Reviews the results of clinical outcome studies, identifies gaps and reports findings to the Commission;
L. Forwards to the Credentialing /Peer Review Sub-Committee potential quality incidents that might involve the conduct of specific providers and should be further investigated;
M. Receives reports from the Credentialing/Peer Review Sub-Committee;
N. Provide quarterly summary reports of QI, UM, HE, and Credentialing activities to the RHA Commission.
O. Ensure that the Plan is in compliance with state, federal a~~nd~~ contractual and NCQA requirements for QI, UM, HE and Credentialing.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee.
   2. The Committee is chaired by the CalViva Chief Medical Officer ("CMO").
   3. Committee size is determined by the RHA Commission with the advice of the CMO.
   4. The QI/UM Committee will be composed of:
      4.1. Participating health care providers, including external participating physicians, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network.
      4.2. 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.
      4.3. 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.
      4.4. Participating Practitioners from other specialty areas shall be retained as necessary to provide specialty input.
      4.5. For purpose of meeting a quorum, the RHA Commission Chair may appoint an alternate member, who is also a provider member of the RHA Commission, to serve as a voting member of the committee.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Committee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
   1. All members of the Committee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the QI/UM Committee meetings will be at least quarterly.
   2. The Committee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.
   4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Notice

1. The meeting date will be determined by the Chairperson with the consensus of the Committee members.
2. Committee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
1. Minutes will be kept at every Committee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the Committee's recommendations.

VII. ~~VII.~~ Committee Support:
~~VII. Subcommittees and Reporting Committees~~

The Plan Medical Management department staff will provide Committee support, coordinate activities and perform the following as needed:

A. Regularly attend Committee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and improvement discussions,
E. Ensure a quarterly summary of Committee activity and Committee recommendations is prepared for submission to the RHA Commission.

VIII. ~~VIII.~~ Subcommittees and Work Groups reporting to QI/UM:

A. ~~A.~~ QI/UM -Committee has two ~~four~~ Ssubcommittees and three work groups:
1. ~~1.~~ Credentials Sub-Committee and Peer Review Sub Committee each with own charter
~~1.~~ ~~2.~~ QI/UM Operational Work Group consists of CalViva and Health Net staff/leadership. The QI /UM Operational Work Group has one sub group:
2.
- Appeals and Grievances Work Group consists of CalViva~~CVH~~ and Health Net~~N~~ staff -to review, track, trend appeals and grievances and reports to QI/UM Operational Work Group

~~3.~~ Access Work Group reports information reviewed by CalViva~~CVH~~ and Health Net~~N~~ staff regarding access and availability of services to QI/UM Committee

3.

~~The QI /UM Operational Work group has one subcommittee :~~

~~1. Appeals and Grievances Work Group with CVH and HN staff to review, track, trend AG and reports to QI/UM Operational WG~~

~~VIII~~ IX. Authority

A. Health & Safety Code Sections 1370, 1370.1
B. California Code of Regulations, Title 28, Rule 1300.70
C. DHCS Contract, Exhibit A, Attachments 4 and 5
D. RHA Bylaws

APPROVAL:

RHA Commission Chairperson _____ **Date:** _____

Item #7

Attachment 7.G

Executive Dashboard

	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2022	2023
Month	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**
CVH Members													
Fresno	321,656	322,473	324,116	325,345	326,706	328,315	330,629	331,857	333,152	334,058	335,572	336,359	338,835
Kings	34,008	34,122	34,280	34,457	34,780	34,935	35,216	35,453	35,619	35,804	36,051	36,208	36,388
Madera	42,804	42,838	43,033	43,263	43,528	43,819	44,285	44,542	44,805	44,997	45,377	45,484	45,783
Total	398,468	399,433	401,429	403,065	405,014	407,069	410,130	411,852	413,576	414,859	417,000	418,051	421,006
SPD	34,882	34,976	35,147	35,225	35,420	35,710	35,896	36,079	36,243	36,409	36,589	36,848	38,875
CVH Mrkt Share	68.85%	68.79%	68.74%	68.66%	68.61%	68.58%	68.41%	68.39%	68.38%	68.34%	68.29%	68.23%	68.10%
ABC Members													
Fresno	132,511	133,212	134,230	135,210	136,115	137,062	139,004	139,689	140,370	141,093	142,029	142,820	144,993
Kings	22,652	22,758	22,853	22,985	23,185	23,312	23,622	23,735	23,794	23,857	24,011	24,185	24,323
Madera	25,154	25,242	25,470	25,754	26,023	26,168	26,745	26,935	27,089	27,242	27,552	27,692	27,897
Total	180,317	181,212	182,553	183,949	185,323	186,542	189,371	190,359	191,253	192,192	193,592	194,697	197,213
Default													
Fresno	770	690	803	762	707	576	566	693	630				
Kings	158	143	136	144	186	138	133	159	144				
Madera	126	106	106	110	106	82	101	128	90				
County Share of Choice as %													
Fresno	56.40%	56.50%	59.80%	58.30%	62.40%	61.80%	65.10%	64.80%	62.60%				
Kings	54.20%	44.70%	51.50%	52.70%	57.10%	56.50%	47.90%	58.90%	55.40%				
Madera	54.40%	53.50%	56.30%	58.60%	64.00%	69.50%	61.60%	73.30%	72.40%				
Voluntary Disenrollment's													
Fresno	439	346	405	464	481	458	389	448	414				
Kings	52	44	45	36	60	35	48	46	63				
Madera	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.		

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**	**27,000**
		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 & Q4 2022 numbers were presented during February 16, 2023 Commission. The Plan's website vendor finished validating the Q4 2022 numbers. There was a revision in # of Users from 12,000 to 27,000. The Plan's website vendor discovered and fixed a reporting error. The Do You Qualify page was the top page because of the campaign the Plan is currently running.							

Provider Network & Engagement Activities	**Year**	**2022**	**2022**	**2022**	**2022**	**2022**	**2022**	**2023**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Hospitals	**11**	**11**	**11**	**11**	**11**	**11**	**10**
	Clinics	**155**	**155**	**155**	**156**	**156**	**156**	**154**
	PCP	**390**	**387**	**390**	**391**	**391**	**386**	**378**
	PCP Extender	**267**	**277**	**280**	**277**	**284**	**284**	**284**
	Specialist	**1430**	**1337**	**1332**	**1324**	**1335**	**1284**	**1194**
	Ancillary	**256**	**242**	**242**	**241**	**242**	**240**	**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**	**2023**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Providers Touched by Provider Relations	**133**	**121**	**139**	**79**	**112**	**160**	**282**
	Provider Trainings by Provider Relations	**523**	**538**	**448**	**432**	**549**	**411**	**281**
	Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
	Total Providers Touched	**2,786**	**2,552**	**1,932**	**3,354**	**1,952**	**1,530**	**282**
	Total Trainings Conducted	**762**	**808**	**1,353**	**257**	**3,376**	**5,754**	**281**
Message From the CEO	The Plan is continuing to monitor, assess, and evaluate the provider network impact as a result of the closure which the Plan discussed with the Commission on February 16, 2023.							

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	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	100% / 100% 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 were presented during February 16, 2023 Commission. Management resolved the reporting issue which occurred with Acupuncture, Vision, and Transportation Claims Timeliness data. The Q2 and Q3 for Acupuncture, Vision, and Transportation is now available.							

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	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	100%	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	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 were presented during February 16, 2023 Commission. Management resolved the reporting issue which occurred with Acupuncture, Vision, and Transportation Provider Disputes Timeliness data. The Q2 and Q3 for Acupuncture, Vision, and Transportation is now available.							