Jeff Nkansah
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DATE: September 22, 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, September 28, 2023
1:30 pm to 3:30 pm

Where to attend:

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

2) Family Health Care Network
114 W. Main Street
Visalia, CA 93291

Meeting materials have been emailed to you.

Currently, there are **10** 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
September 28, 2023
1:30pm - 3:30pm
Meeting Location:

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

2) Family Health Care Network
114 W. Main Street
Visalia, CA 93291

Item	Attachment #	Topic of Discussion	Presenter
1.		**Call to Order**	D. Hodge, MD, Chair
2.		**Roll Call**	C. Hurley, Clerk
3. Action	Attachment 3.A Attachment 3.B Attachment 3.C Attachment 3.D	**Consent Agenda:** • Commission Minutes dated 7/20/2023 • Finance Committee Minutes dated 5/18/2023 • QI/UM Committee Minutes dated 5/18/2023 • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
4.	Information	**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)** A. Conference with Legal Counsel-Existing Litigation Name of Case: Case #21CV381776	
5. Action	Attachment 5.A	**Provider Network Plan** • BL 23-008 *Action: Approve Provider Network Plan*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for item 6 - 8* ***One vote will be taken for combined items 6 - 8***	
6. Action	Attachment 6.A Attachment 6.B	**2023 Quality Improvement Work Plan Mid-Year Evaluation** • Executive Summary • Work Plan Evaluation *Action: See item 8 for Action*	P. Marabella, MD, CMO
7. Action	Attachment 7.A Attachment 7.B	**2023 Utilization Management Case Management Work Plan Mid-Year Evaluation** • Executive Summary • Work Plan Evaluation *Action: See item 8 for Action*	P. Marabella, MD, CMO

8. Action	Attachment 8.A	**Population Health Management Strategy Description** *Action: Approve 2023 Quality Improvement Work Plan Mid-Year Evaluation; 2023 Utilization Management Work Plan Mid-Year Evaluation; and Population Health Management Strategy Description*	P. Marabella, MD, CMO
9. Action		**Standing Reports**	
		Finance Report	
	Attachment 9.A	• Financial Report Fiscal Year End June 30, 2023	D. Maychen, CFO
		Medical Management	
	Attachment 9.B	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 9.C	• Key Indicator Report	
	Attachment 9.D	• Credentialing Sub-Committee Quarterly Report – Q3 2023	
	Attachment 9.E	• Peer Review Sub-Committee Quarterly Report – Q3 2023	
		Executive Report	
	Attachment 9.F	• Executive Dashboard	
	No attachment	• Operational Readiness Update	J. Nkansah, CEO
		Action: Accept Standing Reports	
10.		**Final Comments from Commission Members and Staff**	
11.		**Announcements**	
12.		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
13.		**Adjourn**	D. Hodge, MD, Chair

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

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

Next Meeting scheduled for October 19, 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

Commission Minutes
Dated 7/20/23

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
July 20, 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,** M.D., 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	✓	**Lisa Lewis**, Ph.D., 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	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / 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. Chairman, Dr. Hodge, welcome Lisa Lewis, Ph.D., to the Commission.		*A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#3 Fresno County At-Large Commission Seat Appointment Action J. Neves, Co-Chair	The Commission ratified the re-appointment of Joyce Fields-Keene for the Fresno County BOS appointed At-Large Commission seat.		***Motion**: Ratified re-appointment of Fresno County BOS appointed At-Large seat* *11 – 0 – 0 – 6* *(Neves / Rogers)*
#4 Consent Agenda • *Commission Minutes dated 5/18/23* • *Finance Committee Minutes dated 3/16/23* • *QI/UM Committee Minutes dated 3/16/23* • *Public Policy Committee Minutes dated 3/1/23* • *Finance Committee Charter* • *Credentialing Committee Charter* • *Peer Review Committee Charter* • *QIUM Committee Charter* • *Public Policy Charter* Action J. Neves, Co-Chair	All consent items were presented and accepted as read. *Michael Goldring arrived at 1:31 pm*		***Motion**: Consent Agenda was approved.* *12 – 0 – 0 – 5* *(Neves / Cardona)*
Closed Session: **A. Conference with Legal Counsel-Existing Litigation**	Jason Epperson, General Counsel, reported out of closed session. The Commission discussed in closed session the items agendized for closed session discussion, specifically item 5.A. Conference with Legal Counsel – Existing Litigation Case Number 21CV381776; and 5.B Public Employee Appointment, Employment, Evaluation, or Discipline position title Equity Officer pursuant to Government Code Section 54957(b)(1); and 5.C Public Employee Appointment,		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Name of Case: Case #21CV381776 B. **Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Equity Officer Per Government Code Section 54957(b)(1) **C. Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Executive Officer Per Government Code Section 54957(b)(1)	Employment, Evaluation, or Discipline position title Chief Executive Officer pursuant to Government Code Section 54957(b)(1). Direction was given to staff regarding each item. Regarding item 5.C, motion was made by Supervisor Neves, seconded by David Luchini to continue the CEO's current contract with the amendment of a 5% merit increase in pay effective on the anniversary date of the CEO's current contract. There was no other reportable action and the Commission adjourned Closed Session at 1:48 pm.		
#6 Review of FY End 2023 Goals Information J. Nkansah, CEO	Results for fiscal year end 2023 goals were presented to Commissioners. In regard to the 2024 Medi-Cal Contract Readiness, the Plan has successfully submitted the deliverables required and remains on track for final approval by September 2023. The Plan remains on schedule for Health plan Accreditation. The Plan is scheduled for Tuesday May 7, 2024, for NCQA Health Plan Accreditation Survey. With regards to Health Equity, the Plan has begun the initial stages of submitting a pre-application to attempt to get on schedule for a survey date.	*No questions, comments or concerns from Commissioners were expressed.*	***No Action***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#7 Goals & Objectives for FY 2024 Information J. Nkansah, CEO	The goals and objectives for FY 2024 were presented to Commissioners. A new goal for Diversity, Equity, and Inclusion was added for FY 2024. This is new goal is a requirement of NCQA Health Plan Accreditation. The Plan already had a policy, procedure and process in place for this category; however, it is important to be able to report back to the Commission on the Plan's Diversity, Equity, and Inclusion goals and objectives. All other goals and objectives remain consistent with previous years.	*Commissioner Sara Bosse questioned there should be a more active and assertive approach with regards to making sure there is access for Madera County residents for hospital services.* *CEO J. Nkansah requested Ms. Bosse send information to CalViva for follow-up. In addition, this item will be addressed separately from the FY 24 Goals & Objectives.*	***Motion**: Goals & Objectives for FY 2024 were approved.* *12 – 0 – 0 – 5* *(Neves / Rahn)*
#8 Quality Improvement HEDIS® MY 2022 Information P. Marabella, MD, CMO	The HEDIS® results for CalViva for MY 2022 have been received. Dr. Marabella provided an update noting that Fresno County fell below the target on Cervical Cancer Screening. Childhood Immunizations fell below the target for both Fresno and Kings Counties. Follow-up for Mental Health/Substance Use Disorder also fell below the target in both Fresno and Madera Counties. Lead Screening fell below target in Fresno and Kings Counties. Well-Child Visits fell below target in Fresno and Kings Counties. • Overall, 64% (29/45) of measures met or exceeded the minimum performance level (MPL). • Six (6) of 45 measures (13%) are at the high-performance level (HPL). • Sixteen (16) of 45 measures (36%) did not meet the MPL.	*Commissioner Aldo De La Torre asked if the 15 measures are the only measures, or if they are the only ones selected.* *Dr Marabella responded that the 15 measures are the ones the State has selected to hold Plans accountable for. There are approximately 15 =18 additional measures MCPs are required to report data on but failure to meet goals does not result in corrective action plans/sanctions.*	***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		Commissioner Aldo De La Torre asked if with Health Equity being a focus will there be new HEDIS measures, or will these measures be broken into different categories. *Dr. Marabella responded that the State wants everything the Plan does to go through the Health Equity lens. Health Equity is a component of all Quality Improvement projects.*	
#9 Case Management 2022 Program Evaluation & Executive Summary Action P. Marabella, MD, CMO	Dr. Marabella presented the Care Management Annual Program Evaluation for 2022. Care Management (CM) processes have been consistent, and evaluation/monitoring of CM metrics continues to be a priority. Case Management monitors the effectiveness of programs in order to better serve our members. The Plan maintained above 90% on Satisfaction Surveys and in our quality audits. The Plan increased the volume of members managed in CM programs in 2022 and outcomes showed a decrease in readmissions and ED use for members enrolled in CM., For maternal care greater adherence to Prenatal and Postpartum visits is consistently noted for women in the perinatal care management program. Goals for improvement in 2023, include supporting CalAIM activities, Regionalize the Care Management program and an emphasis on supporting member needs. The goals for 2022 were as follows:	*Commissioner Aldo De La Torre asked how many cases a Care Manager can manage per FTE.* *Dr. Marabella responded that it depends somewhat on the type of care management program but the current increase is from 70 to 75 members per Care Manager.* *Commissioner Rosemary Rahn asked in reference to Care Management, does the Plan also evaluate if high-risk pregnant women*	***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	1. Increase the number of cases managed in 2022 over 2021. The goal was met with the 2022 total average per month being 993: an increase over 2021 average of 838. 2. Manage more than 7,800 High Risk Members. The goal was met with 7,826 High Risk Members managed. Care Management Outcomes: • Claims data demonstrated a reduction in readmissions for the care managed members, 3.8% decrease (pre 42.5% vs post 38.7%) in readmission rate based on claims. There was also a reduction in ED utilization for this population by 204 ED visits and a reduction of 534 ED visits per 1,000 members per year. Comparing health care costs demonstrated a reduction in inpatient claims of 584, a decrease of 5,220 for outpatient services, and a 392 increase for pharmacy. The increase in pharmacy claims reflects improved care when members are supported by their care manager to obtain medications prescribed by their physician. • Members in the Perinatal CM program demonstrated a 3.9% percentage increase in compliance with completing the first prenatal visit in their first trimester and a 9.5% percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program. Additionally, there were 2.1% fewer pre-term deliveries for high-risk mothers managed versus high-risk mothers not managed. Satisfaction: • The goal for member satisfaction is >than 90%. All survey questions had responses scoring over 90%. • There were no grievances related to care management in 2022. The goal for member complaints/grievances < 1/10,000 members was met. • 8/9 Care Team related Questions had 100% positive response. • Q9 91.4% Care Management was always available to speak with the member at times convenient for the member. • 100% of Members Reported “Expectations were Exceeded”. Metrics Not Met:	*get any other support services beyond Care Management?* *Dr. Marabella responded that Perinatal Case Management is a multi-disciplinary team and appropriate referrals is a key responsibility of the care manager. Coordination of care encompasses synchronization of medical, social, and financial services especially with the current emphasis on CalAIM and Community Supports.* *Commissioner Aldo De La Torre inquired as to the bullet point under Barriers, “New staff not accepting complex cases.” And also if this is a Plan function or a Health Net function.* *Dr. Marabella clarified that there is an overall goal to increase the volume of cases managed by each care manager. Each care manager has a mix of complex and non-complex*	

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	• 50% of high-risk moms in Case Management ○ Actual 37.22% (Up from 33.62% in 2021) • 10% of Physical Health and Behavioral Health cases are Complex. ○ Actual 4.4 % Physical Health and 3.7% Behavioral Health • 7% of Perinatal Case Management cases are Complex. ○ Actual 5.4% Barriers: • Staff focus to increase overall caseload. • New staff not taking complex cases. • Some Case Managers not following correct process. Goals for 2023: • Support CalAIM Implementation of new Populations of Focus & Community Supports. • Manage more Members across programs. • Enhance Transition Care Management program as part of PHM Roadmap. • Regionalize the Care Management Program and staff to better support member needs.	*cases. There are a number of new staff members in care management and depending on where they are in their orientation, staff may not be ready to take on a high volume of complex cases. Therefore, they can increase overall volumes, but it is harder to increase the number of complex cases. In 2023, as CM staff become more experienced it is expected that we will see improvement in this area. n In addition, Dr. Marabella confirmed that Care Management is performed by Health Net.* *Commissioner Sara Bosse asked in terms of supporting CalAIM, because they are also onboarding venders to also do Care Managers ECM, is this different populations than the Plan's Care Management.* *Dr. Marabella confirmed that is correct. The ECM function is performed by Providers external to the*	

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		health plan, but the Plan's Care Management team are integrating with these ECM providers. ECM's are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM. They do, on occasion, cross with the same patients. Not every ECM patient has a Care Manager, and not every Care Managed patient goes to ECM.	
#10 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of May 31, 2023:</u> Total current assets recorded were approximately $323.9M; total current liabilities were approximately $194.8M. Current ratio is approximately 1.66. Total equity was approximately $139M, which is approximately 805% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $4.7M which is approximately $4.4M 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 $1.2B which is approximately $133.6M more than budgeted primarily due to rates and enrollment being higher than projected.	*Commissioner Sara Bosse asked Daniel to repeat the percentage of Total Equity, and asked if that is where the Plan normally stands.* *Daniel restated 805% and added that under the new 2024 contract, DHCS is adding language about changing the financial reserve requirements. Instead of utilizing DMHC's minimum required TNE numbers, DHCS was*	***Motion**: Standing Reports Approved* *10 – 0 – 0 – 7* *(Neves / De La Torre)*

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	Total cost of medical care expense actual recorded is approximately $1B which is approximately $127.6M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $51.3M, which is approximately $4.2M more than budgeted due to higher than budgeted enrollment. Dues and Subscriptions expense actual recorded was approximately $241.8K which is approximately $54K more than budgeted due to the Local Health Plans of California (LHPC) one-time additional assessment related to their work in renewing the MCO tax and allocating dollars to reinvest back into Medi-Cal as opposed to the State general fund. All other expense line items are below or close to what was budgeted. Net income recorded through May 2023 was approximately $11.1M, which is approximately $6.9M more than budgeted primarily due to enrollment and rates being higher than projected, and interest income being approximately $4.4M higher than budgeted.	*initially asking for two months average monthly capitation revenue, noting that the Plan gets approximately $126M in capitation revenue per month. At that rate, DHCS would want the Plan to have approximately $252M in reserves. Currently the Plan has $139M in reserves which is significantly short of the $252M amount. Plans have pushed back stating it's unreasonable to have that high of a reserve requirement. DHCS has said they are willing to use one month in arrears capitation payment to Plans to meet at least one of the two-months revenue reserve requirement. DHCS is still working through the process and a final answer has not been provided.* *Commissioner Soyla Griffin asked what the requirements are, and when a decision will be made.*	

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		Daniel responded the requirements are still the DMHC TNE. The decision could potentially be made by August 2023. DHCS stated the reason behind implementing the change is to protect DHCS if a Plan leaves the market. *Commissioner Aldo De La Torre asked if the tier status for MCO was dependent on CalViva or Health Net.* *Daniel responded that the tier status is based off CalViva's membership.* *Commissioner Goldring inquired as to what the annual hit is on the MCO tax.* *Daniel responded theoretically it is supposed to be Net Income neutral; however, the Plan has run a gain of approximately $8M from FY 2022 – FY 2023. which DHCS is looking to recoup in the future.*	

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• **Compliance Report** Mary Lourdes Leone, CCO	**Compliance Report** There were 143 Administrative & Operational regulatory filings for YTD 2023; 119 Member Materials filed for approval; 88 Provider Materials reviewed and distributed; and 56 DMHC filings. There were 13 Privacy & Security Breach Cases that were No-Risk/Low-Risk cases filed YTD 2023. There have been four (4) Fraud, Waste & Abuse MC609 cases filed with DHCS for YTD 2023, and 11 cases open for investigation. The Annual Oversight Audits of HN in-progress are Appeals & Grievances, Fraud, Waste & Abuse, Pharmacy, Privacy & Security, and Emergency Room. Audit completed since the last report is Member Call Center (CAP). The Plan is still awaiting responses for the 2021 DMHC 18-Month Follow-Up Audit CAP response. The DMHC 2022 Medical Audit was conducted 9/19/22 and 9/20/22. The Plan is currently awaiting for the preliminary report. The Plan is awaiting DHCS' CAP closure for the DHCS 2022 Medical Audit; as well as the DHCS preliminary final report for the DHCS 2023 Medical Audit. For the Populations of Focus (POFs) that went live 7/1/23 (Children and Youth), CalViva received approval of its Community Supports and ECM MOCs. The next ECM MOC submission scheduled for 9/1/23 (Justice Involved) that will go live 1/1/24. CalViva Health continues to work with Health Net as it stands up its EAE D-SNP product, "Wellcare CalViva Health Duel Align". Health Net and DHCS have recently executed the State Medicaid Agency Contract (SMAC) which is a care coordination and benefit coordination agreement.	*Commissioner Aldo De La Torre asked for clarification of what eligibility online means.* *Mary Lourdes Leone responded with the definition is the Medicare Advantage Plan and the Medi-Cal Plan are under one-owner. In CalViva's case, we are Medi-Cal only, the Plan does not have a Medicare option. Health Net handles that for CalViva. Members currently get a separate Handbook, a separate ID card, etc., one for Medicare through Health Net and one for Medi-Cal through CalViva. Currently there is no co-branding alignment. The State is now wanting more alignment so CalViva and Health are working on co-branding so that materials can be "co-branded." The Medicare Plan will determine which Medi-Cal Plan a beneficiary would have as the State wants a*	

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	CalViva is waiting to obtain from Health Net the integrated Medicare Advantage/Medi-Cal member materials (i.e., EOC and Member ID card, member notices) for CalViva's submission to DMHC. CalViva must obtain DMHC approval to co-brand with Wellcare/Health Net. On 6/29/23, DHCS released the 2024 Model EOC. Plans must review and customize the EOC by 9/1/23. For the DHCS 2024 Operational Readiness Workplan and Contract, the Plan is on schedule to continue the required monthly filings through September 2023. On 7/3/23 the DHCS issued new draft MOU agreement templates for: 1. County Behavioral Health Departments: Specialty Mental Health Services 2. County Behavioral Health Departments: Substance Use Disorder Services 3. Local Health Departments: Including, without limitation, California Children's Services (CCS), Maternal, Child, and Adolescent Health (MCAH), TB Direct Observed Therapy 4. Local Health Departments: Women, Infant, & Children (WIC) 5. Regional Centers: Behavioral Health Treatment; Intermediate Care Facility – Developmentally Disabled Services 6. Local Government Agencies: In-Home Services and Supports (IHSS) 7. County Social Services Departments: County Social Services programs and Child Welfare. 8. Local Government Agency: targeted Case Management The Public Policy Committee (PPC) was held on June 7, 2023, at 11:30am in the CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. The following informational reports were presented: 1. 2022 Health Education Work Plan Evaluation 2. 2023 Health Education Program Description 3. 2023 Health Education Work Plan 4. 2022 Health Equity Work Plan Evaluation	*"one-parent" product for the purpose on integration between the two.* *Commissioner Aldo De La Torre asked who performs the Plans oversight.* *Mary Lourdes Leone responded that the Plan manages its own oversight.* *Commissioner Sara Bosse questioned closed loop referrals being mandated. Is there a particular system the Plan is looking at? Madera County recommends advocating with DHCS to pick one system that all Plans can use.* *Mary Lourdes Leone responded she has not had any discussions yet with Health Net. The systems have yet to be developed to do cross tracking of services.*	

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• **Medical Management** P. Marabella, MD, CMO	5. 2023 Health Equity Program Description 6. 2022 Health Equity Work Plan 7. 2022 Language Assistance Program Evaluation 8. Q1 2022 Appeals & Grievance Report Additionally, a discussion of the Appeals and Grievances report with the PPC members was led by Dr. Marabella which covered how the A&G data is derived, trended, compiled, and reported in the A&G Dashboard (which is also reviewed by the QIUM Committee and the Commission). There were no recommendations for referral to the Commission. The next meeting will be held on September 6, 2023, at 11:30am in the CalViva Health Conference Room. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through May 2023. Grievances received overall for Q1 2023 increased when compared to the previous year. 1. Total count of Grievances received for May increased above recent months; most of which were quality of service. It is important to note that CalViva membership is also high at this time due to the Public Health Emergency and suspension of eligibility redetermination. The 2023 PTMPY rate is 0.29 YTD compared to 2022 PTMPY of 0.24. 2. Quality of Service Grievances increased this month; high volume categories were Administrative, Other, Prior Authorizations, Referral delays, and Access to Specialists. 3. Quality of Care Grievances remained consistent, and most were related to Delay in PCP care, and PCP delay. 4. Exempt Grievances remained consistent with recent months. "Transportation-No Show" showed improvement. Claims Complaint has increased related to Balanced Billing issues.	*No questions or comments from Commissioners for Appeals & Grievances Dashboard.*	

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	5. Appeals had a slight increase for May. Advanced Imaging remains one of the top categories. <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through May 2023. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through May 31, 2023, which demonstrates that rates have remained steady. The Expansion population had a slight increase; Other populations (TANF and SPD) have leveled out. Utilization has slightly increased through May 2023. Turn-around times remain at 100% compliance with standards this reporting month, except for preservice urgent. The issue associated with this failure has been addressed and follow up completed. Case Management (CM) results have fluctuated within the various programs; Perinatal CM remained stable, Integrated Case Management had a decrease in referrals, Transitional Case Management (Transitions of Care) noted an increase with recent modifications to the program, Palliative Care, and Behavioral Health CM remained stable. <u>QI & UMCM Quarterly Report – Q2 2023</u> Dr. Marabella provided the QI & UMCM Q2 2023 update. One QI/UMCM meeting was held in Quarter 2 on May 18, 2023. The following guiding documents were approved at the May meeting: 1. 2022 Health Equity End of Year Evaluation 2. 2023 Health Equity Program Description 3. 2023 Health Equity Work Plan 4. 2022 Health Equity Language Assistance Program Report 5. 2022 Health Education End of Year Evaluation 6. 2023 Health Education Program Description 7. 2023 Health Education Work Plan	*No questions or comments from Commissioner for the Key Indicator Report.* *No questions or comments from Commissioner for the Quarterly Summary Report, Credentialing Quarterly Report, and the Peer Review Quarterly Report.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	In addition, the following general documents were approved at this meeting: 1. Medical Policies 2. Pharmacy Provider Updates The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard & Quarterly A & G Reports, Potential Quality Issues (PQI) & Access Related Reports – Provider Office Wait Time Report. Additional Quality Improvement reports were reviewed as scheduled during Q2. The Utilization Management & Case Management reports reviewed were the Key Indicator Report & UM Concurrent Review, TurningPoint Musculoskeletal Utilization Review, PA Member Letter Monitoring Report, and other reports scheduled during Q2. HEDIS® Activity: In Q2, HEDIS® related activities focused on finalizing and preparing Measurement Year (MY)2022 full HEDIS® Data for submission to HSAG & DHCS for the Managed Care Accountability Set (MCAS) measures. Final Attestations and IDSS submission were completed by the June 15th deadline. Medi-Cal Managed Care (MCMC) health plans currently have 15 quality measures (MCAS) on which we will be evaluated this year. The Minimum Performance Level (MPL) remains at the 50th percentile. In 2023, MCPs are required to initiate two (2) new Performance Improvement Projects (PIPs) which will continue through the end of 2026. Each health plan is required to initiate one clinical PIP and one non-clinical PIP. Medical Management's current improvement projects are: 1. One clinical Disparity PIP – Well-Child Visits in the African American population in Fresno County. In Q2 our proposal was submitted and approved. Sections 1-6 of the PIP Documentation Form are due to HSAG by 09/08/2023.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	2. One Non-clinical PIP - Improve referrals to Community Support programs (Sobering Centers, Day Habilitation programs) within 7 days of visiting emergency department (ED) for members with a SUD/SMH diagnosis and seen in ED for the same diagnoses. In Q2 our proposal was submitted and approved. Sections 1-6 of the PIP Documentation Form are due to DHCS by 09/08/2023. 3. One SWOT Improvement Project - Childhood Immunizations (CIS-10) & Well-Child (WCV) SWOT in progress with three (3) strategies in the implementation phase. Our second Progress Report is due to DHCS on 07/17/2023. No significant compliance issues have been identified. Oversight and monitoring processes will continue. Credentialing Sub-Committee Quarterly Report The Credentialing Sub-Committee met on May 18, 2023. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q4 2022 were reviewed for delegated entities, and Q1 2023 for MHN and Health Net. Credentialing Adverse Actions for Q1 for CalViva from Health Net Credentialing Committee was presented. There were no cases for January or February 2023 and two cases presented in March. Both cases were pended awaiting the Medical Board's decision and actions. The 2023 Adverse Events Report is a new report for the Credentialing Sub-Committee and provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were two cases identified for Q1 2023 with adverse outcomes associated with a contracted practitioner. Both cases remain open for review in the Peer Review Process. The 2023 Credentialing Sub-committee Charter was reviewed for annual approval. The following edits to the Charter were discussed: 1) Added NCQA to the list of		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	credentialing and re-credentialing compliance activities. 2) The description of the composition of the physicians that make up the Credentialing Sub-Committee was revised to include, "external participating practitioners". The revised Charter was approved. <u>Peer Review Sub-Committee Quarterly Report</u> The Peer Review Sub-Committee met on May 18, 2023. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2022 were reviewed for approval. There were no significant cases to report. The 2023 Peer Review Sub-committee Charter was reviewed for annual approval. The following edits to the Charter were discussed: 1) Added NCQA to the list of criteria and compliance activities to comply with. 2) The description of the composition of the physicians that make up the Peer Review Sub-Committee was revised to include, "external participating practitioners". The revised Charter was approved. The 2023 Adverse Events Report is a new report for the Peer Review Sub-Committee and provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were two cases identified for Q1 2023 with adverse outcomes associated with a contracted practitioner. Both cases remain open for review in the Peer Review Process. Quarter 1, 2023 Peer Count Report was presented at the meeting with a total of twelve (12) cases reviewed. The outcomes for these cases are as follows: • There were six (6) cases closed and cleared. There was one (1) case pending closure for Corrective Action Plan compliance. There were five (5) cases tabled for further information. Ongoing monitoring and reporting will continue.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	**Executive Report** Enrollment through May 31, 2023, continues to increase; however, this does not reflect the redeterminations as previously discussed. Since the decline in Market Share, the Plan has seen for four consecutive months the Market Share trending up. This will continue to be monitored. In terms of redetermination activity, the Plan is still waiting for the finalized report for July enrollment numbers; verbally the Plan has been given information July enrollment may show a decline of approximately 3,000 members throughout the three service counties. There are no significant issues or concerns to report as it pertains to IT Communications and Systems. The organization has been successful in obtaining a Cyber Security Insurance policy. There are no significant issues or concerns to report as it pertains to the Member Call Center, or the CVH website. Q2 2023 numbers not available yet. With regard to Provider Network and Engagement Activities, the number for Specialists counts has increased as a result of a new Provider Group in the service area. There are no significant issues or concerns to report as it pertains to Claims Processing and Provider Disputes. Management is monitoring PPG2 and PPG3 for deficiency disclosures and non-compliance metrics. All other areas met goals related to Claims and Provider Disputes. On June 29, 2023 the Plan hosted a listening tour with DHCS for Fresno County specifically, related to CalAIM and redeterminations. The Plan is being provided a draft of the 2024 contract and is in the process of comparing the 2024 contract with previous years to see what's changed, what's new, and what stayed consistent. The Plan anticipates to have the final 2024 contract for signature potentially in the last quarter of 2023 for a January 1, 2024 effective date. The 2024 Medi-Cal Managed Care transitions in the three services counties, there are no exiting Plans; the local Plan is the same, the commercial Plan is the same, and Kaiser is entering the market January 1, 2024. Based on what the Plan has seen, Kaiser is only going to accept 3,000		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	members through Default Assignment for calendar year 2024 and none of those will be in Fresno, Kings or Madera counties. The MOU between Kaiser and DHCS are now publicly available on the DHCS website. *Joyce Fields-Keene left at 3:01 pm* *David Luchini left at 3:12 pm*		
#11 Final Comments from Commission Members and Staff	None.		
#12 Announcements	None.		
#13 Public Comment	None.		
#14 Adjourn	The meeting adjourned at 3:19 pm. The next Commission meeting is scheduled for September 21, 2023, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #3

Attachment 3.B

Finance Committee Minutes
Dated 5/18/23

CalViva Health
Finance
Committee Meeting Minutes

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

May 18, 2023

	Finance Committee Members in Attendance		CalViva Health Staff in Attendance
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Office Manager
✓	Jeff Nkansah, CEO		Jiaqi Liu, Director of Finance
	Paulo Soares		
✓	Joe Neves		
✓	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 11:31 am, a quorum was present.	
#2 Finance Committee Minutes dated March 16, 2023 Attachment 2.A Action, D. Maychen, Chair	The minutes from the March 16, 2023, Finance meeting were approved as read.	Motion: *Minutes were approved* *4 – 0 – 0 – 2* *(Rogers / Nkansah)*
#3 Financials as of March 31, 2023 Action	Total current assets recorded were approximately $331.1M; total current liabilities were approximately $204.3M. Current ratio is approximately 1.62.	Motion: *Financials as of March 31, 2023, were approved* *4 – 0 – 0 – 2*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
D. Maychen, Chair	Total equity was approximately $136.9M which is approximately 793% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $3.6M which is approximately $3.3M 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 $1B which is approximately $122.4M more than budgeted primarily due to rates and enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $862.9M which is approximately $117.7M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $41.6M, which is approximately $2.8M more than budgeted due to higher than budgeted enrollment. Dues and Subscriptions expense actual recorded was approximately $207K which is approximately $53K more than budgeted due to the Local Health Plans of California (LHPC) one-time additional assessment related to their work in renewing the MCO tax and allocating dollars to reinvest back into Medi-Cal as opposed to the State general fund. All other expense line items are below or close to what was budgeted. Net income recorded was approximately $8.9M, which is approximately $5.9M more than budgeted primarily due to Interest income being approximately $3.3M higher, and rates and enrollment being higher than budgeted.	*(Rogers / Neves)*
#4 Finance Committee Charter Action D. Maychen, Chair	No edits or revisions were recommended during the annual Charter review. This was approved to move to Commission for final approval.	Motion: *Finance Charter was approved to move to Commission for full approval.* *4 – 0 – 0 – 2*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
		(Rogers / Neves)
#5 Announcements	The FY 2024 budget which was approved during the March Finance meeting will be presented to the Commission today for final approval. When the Plan's budgeted MCO tax was created, it was based off the proposal that the State presented in their January release of the California State budget for the next fiscal year (i.e., 2023-2024). As part of the May revised budget, that was presented last week by Governor Newson, the State is looking to revise the MCO tax proposal which would substantially increase the MCO tax. For our Plan, the MCO tax would almost quadruple. The State is looking at a $31.5B budget deficit for State fiscal year 2023-2024, as such, they are trying to maximize the federal match dollars from the MCO tax. Also, the federal government has indicated they are tightening the rules around the MCO tax in future years. The revised MCO tax proposal would be effective retroactive to April 2023, as opposed to January 2024. June 15, 2023, it must pass through the California legislature, and June 30, 2023, the State has to send it to CMS for review and approval. The Plan is currently tracking this. If it passes as proposed, the Plan's FY 2024 budget would need to be revised.	
#6 Adjourn	Meeting was adjourned at 11:37 am	

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

Dated: July 20, 2023

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 7/20/23

Item #3

Attachment 3.C

QIUM Committee Minutes
dated 5/18/23

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
May 18th, 2023

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
✓	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers	✓	**Iris Poveda**, Senior Medical Management Specialist
✓	**Fenglaly Lee, M.D.,** Central California Faculty Medical Group	✓	**Zaman Jennaty,** Medical Management Nurse Analyst
✓	**Carolina Quezada, M.D.,** Family Health Care Network	✓	**Mary Lourdes Leone,** Chief Compliance Officer
✓	**DeAnna Waugh, Psy.D.,** Adventist Health, Fresno County	✓	**Maria Sanchez**, Compliance Manager
	Joel Ramirez, M.D., Camarena Health Madera County	✓	**Patricia Gomez,** Senior Compliance Analyst
	Rajeev Verma, M.D., UCSF Fresno Medical Center	✓	**Norell Naoe**, Medical Management Administrative Coordinator
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA (**Alternate**)		
	Guests/Speakers		

✓ = in attendance
* = Arrived late/left early

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D Chair	The meeting was called to order at 10:35 am. A quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: March 16, 2023 - CCC DMHC Expedited Grievance Report (Q1) - A&G Classification Audit Report (Q1) - A&G Inter-Rater Reliability Report (Q1) - Concurrent Review IRR Report (Q1) - California Children's Services	The March 16th, 2023, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	**Motion**: *Approve* Consent Agenda (Cardona/Lee) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Report (Q1) - Pharmacy Provider Updates (April) (Attachments A-G) **Action** Patrick Marabella, M.D Chair		
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (March) - A&G Executive Summary (Q1) - A&G Quarterly Member Report (Q1) - Quarterly A&G Member Letter Monitoring Report (Q1) - A&G Validation Audit Summary (Q4) (Attachments H-L) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard and Turnaround Time Report** through March 2023 were presented. Dr. Marabella explained how Members and providers submit grievances via phone, fax, email or online and each of these are categorized and reported on the dashboard and in other narrative reports. Standardized criteria as outlined in our policies and procedures are used to classify each case in order to include them in the appropriate area on the monthly dashboard. Each monthly Excel file includes lists or logs identifying each member who submitted a grievance that month and details about their issue and its resolution. These data logs are included on tabs such as Formal Resolved, CCC Exempt Grievances, and MHN Exempt. The Outlier tab provides analysis of the data trends. There was a total of 144 resolved grievances this month, 366 total for Q1. • For March, most grievances were Quality of Service related: Nineteen (19) Access-Other mostly Prior Authorization delays, six (6) Specialists, thirteen (13) Administrative; and Nineteen (19) categorized as Other- eleven (11) related to balanced billing. Monitoring to continue. • Exempt Grievances remained consistent compared to last month. • There were seven (7) Transportation Provider No-Shows reported under QOS and eleven (11) late arrivals causing the member to be late to their appointment. • Twenty-two (22) Total Standard Appeals for March with seventeen (17) cases related to Advanced Imaging: both trending downwards. • There were twelve (12) Surgery Appeals in March which is an increase compared to February (5). Seven (7) cases in March were Orthopedic procedures requiring documentation regarding smoking cessation and/or weight reduction guidance for approval. **Discussion:** o Dr. Cardona asked what documentation is needed to note smoking cessation. o Dr. Marabella indicated that providers need to document smoking status	**Motion**: *Approve* - A&G Dashboard and Turnaround Time Report (March) - A&G Executive Summary (Q1) - A&G Quarterly Member Report (Q1) - Quarterly A&G Member Letter Monitoring Report (Q1) - A&G Validation Audit Summary (Q4) (Lee/Waugh) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(current/remote), provide patient education (may include referral or nicotine replacement therapy), and document this in the History & Physical or medical record. • Behavioral Health Grievances also appear in this dashboard although in low numbers. CalViva is working to improve assessment, coordination, communication, and follow-up with Behavioral Health Services as state requirements continue to expand in this area. o DeAnna Waugh, Psy.D. has joined the Committee to aid with monitoring CalViva' s efforts related to Behavioral Health Management. The **Appeals & Grievances Executive Summary Q1** through March was presented noting the following trends: • Total Appeals have decreased in Q1 2023 compared to Q1 2022; at 93 down from 196. This was expected with the implementation of Medi-CalRx, the Pharmacy carve-out to the state. Total Grievances remained essentially unchanged at 320 compared to 314 in Q1 2022. • Total Exempt Grievances, Access, PCP Assignment, and Transportation Grievances have decreased in Q1 2023. The Transportation Exempt Grievances decreased but have shifted to formal (QOS) Grievances. • For Q1 2023, there were 93 Total Appeals & 320 Total Grievances reported. o Top Grievances for Quality of Service (QOS) include Transportation, Access, and Billing. o Top Grievances for Quality of Care (QOC) include QOC by PCP and Specialist and referral delay. • Transportation Grievances have increased slightly for Q1. No-shows remain an issue that is being monitored. • Turnaround Time and A&G IRR met standards. The **Appeals & Grievances Quarterly Member Report Q1** through March was presented noting the following additional trends: • The total number of Appeals & Grievances decreased when compared to Q4 2022. Data is evaluated on a Per Thousand Member Per Year (PTMPY) basis. The **Quarterly A & G Member Letter Monitoring Report** provides a summary of the daily audits of acknowledgment and resolution letters to ensure: • Required **bolding** of DMCH and Plan Phone numbers	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Correct branding. Should be branded as CalViva Health • Communication to members regarding decision documentation in Appeal Resolution Letters must be clear and concise. • Decision criteria and rationale are fully referenced. All errors identified by the A & G team in Table 1 were corrected prior to mailing. Analysis by the clinical team is pending. The updated report will be brought back to a future meeting. The **Appeals & Grievances Validation Audit Summary Q4 2022** was presented. CVH conducts ongoing Appeals & Grievances case validations to ensure each Grievance or Appeal case contains the appropriate documentation and evidence necessary for standard and expedited Quality of Service (QOS), Quality of Care (QOC), and Appeal cases. • 398 cases were monitored this quarter with 95% of cases meeting compliance standards when initially submitted. • All documents identified to be missing from the cases were obtained and added to complete the file before closing. There were thirty-six (36) cases with missing documents, with fifty-six (56) documents missing in total. The process of monitoring cases submitted is being computerized with an electronic *Data Entry Form* for easy data entry into an Access database where reports or Queries can be run to summarize results.	
#3 **QI Business** - Potential Quality Issues (Q1) (Attachment M) **Action** Patrick Marabella, M.D Chair	**The Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or Peer Review activity. 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 Q1 was reviewed for all case types including the follow-up actions taken when indicated. • There were zero non-member generated PQIs in Q1. • Member-generated PQIs decreased slightly based on previous quarters with a total of 87 cases. • A total of twelve Peer Review generated cases. Six cases are closed, and six cases are open. The number of peer review cases varies from quarter-to-quarter independent of the other case types. Follow-up has been initiated when appropriate.	**Motion**: *Approve* - Potential Quality Issues (Q1) (Cardona/Lee) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business** - Provider Office Wait Time Report (Q1) -QIUM Committee Charter 2023 Update (Attachment N, O) **Action** Patrick Marabella, M.D Chair	The **Provider Office Wait Time** Report for Q1 was presented. Health plans are required to monitor waiting times in providers' offices to validate timely access to care and services. This report provides a summary that focuses on Q1 2023 monitoring for Fresno, Kings, and Madera Counties. All counties are within the 30-minute office wait time threshold for both mean and median metrics. • The combined number of providers per county who submitted data in Q1 is Fresno-55, Kings-6, and Madera-3 for a total of 64 providers and 1431 patients monitored. • The number of providers submitting data increased slightly in Q1 2023 for Fresno County but decreased for Kings and Madera Counties, and the number of patients monitored increased compared to 1039 patients in Q4 2022. Provider Engagement staff will be reminding providers to submit monthly data with an emphasis on Kings and Madera counties. • Providers are given reports of their submitted data twice a year as well as educational materials on improving office wait times and scheduling patients. The **QIUM Committee Charter 2023 Update** was not reviewed at this meeting due to new DHCS and NCQA Accreditation requirements which are pending state approval. The Charter will be brought to a future meeting for final approval.	**Motion**: *Approve* - Provider Office Wait Time Report (Q1) (Quezada/Lee) 5-0-0-2
#4 **Health Equity & Health Education Business** - Heath Equity Work Plan End of Year Evaluation & Executive Summary 2022 - Health Equity Program Description & Change Summary 2023 - Health Equity Work Plan & Executive Summary 2023 - Health Equity Language Assistance Program Report (Attachments P-S)	The **Health Equity 2022 Executive Summary and Annual Evaluation; 2023 Change Summary and Program Description; and 2023 Executive Summary and Work Plan** were presented. All Work Plan activities for 2022 were completed in the following areas: • **Language Assistance Services:** 78 staff completed Bilingual assessment/re-assessment; Population Needs Assessment was completed with Quality Improvement (QI) and Health Education (HE); and participation in information technology projects to assist vendor record member gender identity, and preferred pronouns and name. • **Compliance Monitoring**: Investigated and completed follow-up on 53 grievances in 2022 with six interventions; and updated all Health Equity Policies. • **Communication, Training, and Education**: Conducted seven Call Center Training sessions; and 107 providers attended implicit bias training: Strengthening Cultural Humility, Dismantling Implicit Bias in Maternal Health.	**Motion**: *Approve* - Heath Equity Work Plan End of Year Evaluation & Executive Summary 2022 - Health Equity Program Description & Change Summary 2023 - Health Equity Work Plan & Executive Summary 2023

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	• **Health Literacy, Cultural Competency & Health Equity**: Completed review of 29 English materials; conducted annual Heritage/CLAS Month with 3,952 attendees; and collaborated on the intervention implementation for the Breast Cancer Screening & Childhood Immunizations PIPs. The **2023 Program Description** changes include: • Revised the Mission statement to remove "be an industry leader in ensuring health equity for all members and their communities." <u>Added the following:</u> • Improve structural determinants of health equity, by working within and across societal institutions and systems. • Improve neighborhood-level social determinants of health, by working with and across institutions in defined geographic communities. • Improve institutional drivers of health equity, by working within our institution, all lines of business, with providers, and with other key stakeholders. • Improve individual & household-level social needs & networks, by improving access, quality, and value of services for our members. • Edited and expanded on the Health Equity areas. • Add Armenian as a language to monitor. • Added sex, ethnic group identification, gender identity, medical condition, genetic information, and mental disability or physical disability to cultural competency training. • Edited the frequency of the PNA report from annually to every 3 years. • Edited and updated the Health Equity Department staff. • Included the Chief Health Equity Officer's role and responsibilities in this section. • Added CalViva Health Equity Officer as a new role section. Responsibility is listed as follows: • CalViva Health's Health Equity Officer reports to the Chief Executive Officer and is responsible for providing leadership and health equity services across the organization. The **2023 Work Plan** is consistent with 2022 while incorporating and enhancing the following: • Staff assignments are updated throughout the document. • Consolidated Population Needs Assessment activities into one element.	- Health Equity Language Assistance Program Report (Quezada/Lee) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Consolidated Provider Training activities. • Updated PIP projects and activities for the new 2023 PIPs Disparity Project for Childhood Immunizations & Well Child Visits in the African American population in Fresno County. • Replaced PDSAs with a SWOT analysis project for this year's Childhood Immunizations. • Added Disparity Leadership Program (DLP) project to improve food security for Fresno County. The **Language Assistance Program** Annual Evaluation analyzes and compares language service utilization at the end of each calendar year. A year-over-year analysis is also performed. The conclusions from the Language Assistance Program annual report are: • Spanish and Hmong continue to be CalViva Threshold Languages. Spanish (95%) consistently has the highest volume. • Most interpretation (74%) is telephonic, up from 68% in 2021. • 24% was face-to-face interpretation (down from 28% in 2021). • 2% was Sign language (down from 4% in 2021). • Video Remote Interpretation was zero (0) in 2022. • MHN results demonstrate similar language outcomes with lower volumes. (MHN is the HN affiliate that provides Behavioral Health care for CalViva members.) Limited English and non-English membership remain high for the CVH population and therefore interpreter services are integral to maintaining safe, high-quality care. **Discussion:** Dr. Lee asked if tracking individual interpreter identifiers in the medical record is required/recommended by CalViva, because hospitals are now requiring that information when consenting patients for surgical procedures. Tracking identifiers (name/identification number) of interpreters used was confirmed as best practice. Dr. Lee asked if Video Remote Interpretation is available. Video Remote Interpretation is available, but not widely used at this time.	
#4 **Health Equity & Health Education Business** - Health Education Work Plan End of Year Evaluation &	The **Health Education Executive Summary, the 2022 Work Plan Annual Evaluation, the 2023 Change Summary and Program Description, and the 2023 Work Plan** were presented. Overall, ten of the fifteen key Program Initiatives met or exceeded the year-end goals. Five	Motion: *Approve* - Health Education Work Plan End of Year Evaluation &

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Executive Summary 2022 - Health Education Program Description & Change Summary 2023 - Health Education Work Plan 2023 (Attachments T-V) **Action** Patrick Marabella, M.D Chair	initiatives with seven objectives did not meet the year-end goals. Of the seven objectives, one met the year-end goal, two partially met the year-end goal, and four did not meet performance goals. The ten (10) initiatives that were fully met are: 1. Chronic Disease-Asthma 2. Chronic Disease – Diabetes 3. Fluvention & COVID-19 4. Member Newsletter 5. Behavioral health 6. Pediatric Education 7. Population Needs Assessment 8. Women's Health 9. Compliance 10. Department Promotion The five initiatives did not meet or partially met were: 1. Chronic Disease Education: Hypertension 2. Community Engagement 3. Obesity Prevention 4. Perinatal Education 5. Tobacco Cessation The barriers identified are related to low enrollment. Program enrollment will be enhanced through an emphasis on promotion in the CalViva Member newsletter and email campaigns. For Tobacco Cessation a data exchange program will be explored to improve outreach efforts and a nicotine replacement kit program will also be evaluated. Changes to the **2023 Program Description** include: • Removed references to IHEBA/SHA throughout the document. • Deleted Fit Families for Life and Healthy Habits for Healthy People Community Classes description from the Weight Management Programs section. • Added: Member Services phone number to the Nurse Advise Line section. Changed title	Executive Summary 2022 - Health Education Program Description & Change Summary 2023 - Health Education Work Plan 2023 (Cardona/Waugh) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	description from myStrength Program to Behavioral Health Education. • Added information about Adverse Childhood Experiences (ACEs) education and resources. • Added information about MMCD Policy Letter 16-005 Member incentive programs to promote positive health behaviors. • Added "and available online" to the Member Newsletter section. • Added information on MMCD Policy Letter 16-005 Member Incentive Programs. CalViva follows guidance from DHCS Texting Program and Campaign Submission Form and Plan's Texting Policy to develop, administer and evaluate texting campaigns". Edited/revised the paragraph. • Rearranged Education standards. Deleted Nutrition & Exercise. • Other minor edits throughout the document such as updated titles, acronyms, and minor deletions. The 2022 **Work Plan** initiatives will continue into 2023 with the following enhancements: 1. Conduct patient-level evaluation once the Asthma In-Home program ends in July 2023. A study being conducted of a sub-group of CalViva members with asthma to see if remediation efforts have improved Asthma patient conditions. 2. Vet and onboard new vendor for the Diabetes Prevention Program. 3. Collaborate with community partners to address health disparities in breast cancer screening rates in Fresno, Kings, or Madera County.	
#5 **UM/CM Business** - Key Indicator & TAT Report (March) - Utilization Management Concurrent Review Report (Q1) (Attachments W-X) **Action** Patrick Marabella, M.D Chair	The **Key Indicator Report and Turn Around Time Report** through March were presented. Membership has leveled off but is expected to decline with the unwinding of the Public Health Emergency and the re-starting of the member redetermination process. • Utilization for all risk types increased in March 2023 compared to last year but is consistent with January 2023 figures. • SPD population for Acute Admits and ALOS Acute did not follow trends of other populations in March with noted declines. • Turn- around Times were not met for Routine Deferrals in March 2023. The issue associated with this failure has been addressed and follow-up completed. • Case Management results remained robust in all categories except for Palliative Care, which remained consistent.	Motion: *Approve* - Key Indicator & TAT Report (March) - Utilization Management Concurrent Review Report (Q1) (Quezada/Lee) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The **Utilization Management Concurrent Review Report** presents inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness during Q1 2023. • All Populations are better than the goal for bed days and admissions for Q1 2023. • All Populations experienced a decrease in Q1 2023 for Average Length of Stay compared to Q4 2022. Daily UM Huddles occur with Care Management, Member Connections, Public Programs, and Medical Directors including Pharmacy. There is an onsite Non-Clinical Discharge Navigator at Community Regional Medical Center to support this process with plans to expand to a similar process at Saint Agnes Medical Center in the near future.	
#5 **UM/CM Business** - TurningPoint Musculoskeletal Utilization Review (Q4) (Attachments Y) **Action** Patrick Marabella, M.D Chair	**TurningPoint Musculoskeletal Utilization Review for** Q4 2022 provides a summary of compliance for the musculoskeletal prior authorization review process. TurningPoint reported the following results: • One-hundred-forty-nine (149) authorizations were finalized (Table 4). • Compliance was not achieved in Q1 for standard/non-urgent prior authorization turnaround times (TAT). A Corrective Action Plan (CAP) was issued in February 2023 to be completed by March 31, 2023. • The Call Center established metrics were met. • Forty-nine (49) authorizations were denied (32.9% denial rate) consistent with the previous quarter. Two appeals were upheld and four were overturned. TurningPoint will continue to monitor denials and educate providers.	Motion: *Approve* - TurningPoint Musculoskeletal Utilization Review (Q4) (Cardona/Quezada) 5-0-0-2
#5 **UM/CM Business** - PA Member Letter Monitoring Report (Q1) (Attachments Z) **Action** Patrick Marabella, M.D Chair	The **PA Member Letter Monitoring Report Q4** monitors Notice of Action (NOA) letters for compliance with regulatory standards including Prior Authorizations, Concurrent, and Post Service denials. Findings are discussed with the UM Management Directors monthly. All metrics are expected to meet the standard of 100% compliance. The Medical Management Monitoring and Reporting Team collects CAP information on metrics that fall below the 100% threshold. • There was a total of four unique denial letters and three unique deferral letters impacted by letter opportunities.	Motion: *Approve* - PA Member Letter Monitoring Report (Q1) (Lee/Quezada) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Denial and Deferral LTR Codes 48, 49, & 57 will continue to be monitored. In follow-up, Medical Management implemented staff/physician coaching focused on the use of clear and concise language with no medical jargon.	
#5 **UM/CM Business** - Medical Policies Provider Updates (Q1) (Attachments AA) **Action** Patrick Marabella, M.D Chair	The **Medical Policies Provider Updates** (Q1) were presented to the committee. The *Provider Update* Newsletter is compiled based on a national review by physicians and sent monthly to providers featuring new, updated, or retired medical policies for the Plan. New policies include: • CP.MP.247 – Transplant Services Documentation Requirements • CP.MP.248 – Sleep Center Polysomnography for Obstructive Sleep Apnea Updated policies include but are not limited to: • CP.BH.104 – Applied Behavioral Analysis • CP.BH.300 – Biofeedback for Behavioral Health Disorders • CP.MP.91 – Obstetrical Home Care Program • CP.MP.102 – Pancreas Transplant • CP.MP.117 – Spinal Cord Stimulation • CP.MP.120 – Pediatric Liver Transplant	Motion: *Adopt* - Medical Policies Provider Updates (Q1) (Cardona/Quezada) 5-0-0-2
#6 **Policy & Procedure Business** - A&G Policy & Procedure Grid (Attachment BB) **Action** - Patrick Marabella, M.D Chair	The **Appeals & Grievances Policy Annual Review Grid** was presented to the committee. The policies were updated to comply with APL 21-011 and other minor edits. The policy edits were discussed and approved. • AG-001 Member Grievance Process o Added reference to ADA and section 508 of the Rehabilitation Act of 1973. • AG-002 Member Appeal Process o Added Deemed Exhaustion definition. • AG-004 Handling DMHC Calls Regarding Urgent Grievances o Annual review, no changes. • AG-005 Managing DMHC Cases o Added language regarding the RHPI and naming conventions for submission. Added RHPI form as an attachment.	Motion: *Approve* - A&G Policy Annual Review 2023 (Quezada/Lee) 5-0-0-2
#7 **Compliance Update** - Compliance Regulatory Report	Mary Lourdes Leone presented the **Compliance Report**.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment CC)	**Oversight Audits**. The following annual audits are in-progress: Waste & Abuse, and the Member Call Center. The following audits have been completed since the last Commission report: 2020-2021 Credentialing (CAP); Q3 2022 PDR (CAP). **Fraud, Waste & Abuse Activity.** Since the last report, there have not been any new MC609 cases filed. **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 Managed Health Care ("DMHC") 2022 Medical Audit.** The Plan is awaiting DMHC's Preliminary Report. **Department of Health Care Services ("DHCS") 2022 Medical Audit – CAP.** The Plan received the DHCS' CAP request on November 30, 2022. The CAP identified three audit findings: two concerned the lack of documentation related to the provision of blood lead screening of young children, and one related to the lack of documentation of a Physician Certification Statement (PCS) form for member's request for non-emergency medical transportation (NEMT). The Plan will continue to file a monthly report on the transportation finding until the DHCS accepts the Plan's actions as having been satisfactorily completed. **Department of Health Care Services ("DHCS") 2023 Medical Audit.** The DHCS medical audit took place via teleconference from April 17, 2023, through 4/28/2023. The 2023 audit also included two additional "focus audits": one related to Behavioral Health and the other to Transportation. In addition to the formal interview questions, there were many additional formal audit requests to which the Plan provided written responses. The Plan is awaiting the DHCS' Preliminary Final Report which is to be sent in advance of the formal "Exit Conference". **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 on 7/1/23, specifically, those pertaining to Children and Youth. The Plan is awaiting DHCS approval of the MOC. **Medi-Cal Adult Expansion** Effective January 1, 2024, full-scope eligibility will be expanded to include individuals who are 26 to 49 years of age, who do not have satisfactory immigration status (SIS) or who are unable to establish satisfactory immigration status (USI). The expected count by the county to transition to full-cope Medi-Cal is as follows: 13,994 (Fresno); Kings (1,468); 4,615 (Madera). **Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Starting January 1, 2024, DHCS will expand the availability of Medi-Medi Plans (EAE D-SNPs) for dually eligible Medicare and Medi-Cal members to five additional central valley counties, including Fresno, Kings, and Madera. The Plan continues to work with Health Net as it stands up its EAE D-SNP product that affiliates with CalViva's Medi-Cal Managed Care plan for benefits not covered by Medicare (e.g., ECM/CS, CBAS, etc.). Health Net is responsible for executing its D-SNP contract with CMS and its SMAC with DHCS. CalViva has been in contact with both DHCS and DMHC to discuss its role in the implementation process and will make any required filings with each of the Departments, especially as it concerns member communications and co-branding. **Member Handbook/Evidence of Coverage** On 3/3/23, the Plan received DHCS' 2023 EOC Errata A which included language related to the California Cancer Equity Act, and the removal of the word "brief" under Cognitive health assessments. The Plan posted the Errata A on its website on May 1, 2023 On April 10, 2023, the Plan received DHCS' 2023 EOC Errata B which includes language related to Street Medicine. The Plan is required to post Errata B to its website by July 1, 2023. DHCS is planning to release the 2024 Model EOC by the end of May 2023. **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. **Public Policy Committee** The next PPC meeting will be held on June 7, 2023, at 11:30 am in the CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711	
#10 **Old Business**	None.	
#11 **Announcements**	Next meeting July 20th, 2023	
#12 **Public Comment**	None.	
#13 **Adjourn**	Meeting adjourned at 11:57 pm.	

NEXT MEETING: July 20th, 2023

Submitted this Day: July 20th, 2023

Submitted by: Amy K Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

X Patrick Marabella

Patrick Marabella, MD Committee Chair

Item #3

Attachment 3.D

Compliance Report

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 YTD Total
# of DHCS Filings													
Administrative/ Operational	22	20	28	18	25	23	19	25	6				186
Member Materials Filed for Approval;	2	3	4	3	3	3	4	6	0				28
Provider Materials Reviewed & Distributed	15	12	23	13	10	14	9	17	8				121
# of DMHC Filings	11	8	12	10	8	5	4	9	1				68

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	3	1	3	2	2	2	1				18
High-Risk	0	0	0	0	0	0	0	0	0				0

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 YTD Total
# of New MC609 Cases Submitted to DHCS	0	0	2	0	1	0	1	0					4
# of Cases Open for Investigation (Active Number)	10	12	12	10	9	11	11	14					

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 7/20/23 Compliance Regulatory Report to the Commission, there have not been any new MC609 cases filed.

Compliance Oversight & Monitoring Activities:	Status
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: Pharmacy, Appeals & Grievances; Emergency Room, Claims/PDR, UMCM and Privacy & Security. The following audits have been completed since the last Commission report: FWA (No CAP)

Regulatory Reviews/Audits and CAPS:	Status
2021 Department of Managed Health Care ("DMHC") 18-Month Follow-Up Audit	The Plan is still awaiting the DMHC's final determination on our 2021 CAP response.
Department of Managed Health Care ("DMHC") 2022 Medical Audit	The Plan is awaiting DMHC's 2022 Preliminary Audit Report.
Department of Health Care Services ("DHCS") 2022 Medical Audit	After submitting all the monthly CAP updates, DHCS closed the CAP on 7/27/2023.
Department of Health Care Services ("DHCS") 2023 Medical Audit	The DHCS held its exit conference with the Plan on 8/24/23. The DHCS' draft 2023 Final Report for the State Supported Services Audit had no findings. The DHCS' draft 2023 Medical Audit Report cited one finding: "The Plan did not classify, process, review or resolve all expressions of dissatisfaction as grievances." The DHCS' recommendation to the Plan was to revise policies and procedures to monitor inquiry calls and ensure all member expressions of dissatisfaction are classified, processed, reviewed, and resolved as grievances. On 9/1/23, the Plan responded to DHCS stating that we agreed with the finding. The Plan is waiting for DHCS' Final Report and to see if the Department will issue a formal CAP.

New Regulations / Contractual Requirements/DHCS Initiatives:	Status
California Advancing and Innovating Medi-Cal (CalAIM)	• **Enhanced Care Management (ECM**): The next ECM MOC submission scheduled for 10/2/23 will focus on the Justice Involved POF and Birth Equity MOC questions that will go live 1/1/24. • **Population Health Management and Population Needs Assessment (PNA):** Effective January 1, 2023, MCPs are no longer required to submit an annual PNA and PNA Action Plan as previously required. The annual PNA Action Plan deliverable to DHCS is to be replaced by the annual PHM Strategy, which is informed by the redesigned PNA process. The new annual PHM Strategy requires MCPs to demonstrate that they are meaningfully responding to community needs as well as provide other updates on the PHM Program to inform DHCS' monitoring efforts. To that end, the DHCS is requiring plans to submit their first "modified PHM Strategy" by the end of 2023 (CalViva's initial PHM Strategy document was approved 12/27/22). CalViva's Plan Administrator, Health Net has begun to reach out to the LHDs in Fresno, Kings and Madera Counties.
Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP	In August of 2023, the Plan submitted two Amendments to the DMHC under its Knox-Keene license application. These were related to the Plan's request to co-brand with Health Net in support of HN's Exclusively Aligned Enrollment ("EAE") Dual Special Needs Plan ("D-SNP") in which CalViva Health is the affiliated Medi-Cal plan in Fresno, Kings, and Madera Counties. Health Net holds the SMAC contract with the DHCS. The Plan's co-branding request would not apply to the RHA's Medi-Cal Managed Care Plan activities and obligations as required by its own contract with DHCS. As part of these amendments, the Plan provided to the DMHC HN's DHCS and DMHC-approved integrated Member materials (i.e., EOC, Member ID Card, the Annual Notice of Change, and Summary of Benefits). The Plan is waiting for DMHC's approval.
Member Handbook/Evidence of Coverage	The Plan submitted the 2024 CalViva version EOC and Member ID Card on 8/31/24 to DHCS and DMHC and is awaiting approval from both Departments.
Plan Administration:	**Status**
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 August 2023 and has received approvals on most but is still responding to additional DHCS information requests for some of the items. On 9/1/23, the DHCS informed the Plan's CEO that it is approved to go live on 1/1/24 contingent on closing out any Outstanding Operational Readiness Contract deliverables.

New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2023 as of September 2023.
Committee Report:	**Status**
Public Policy Committee (PPC)	The PPC meeting was held on September 6, 2023 at 11:30 in the Camerena Health Conference Room, 344 E. Sixth Street, Madera, CA 93638. The PPC did not have a quorum which rendered the meeting agenda/reports as "informational only". Informational items presented consisted of the Enrollment Dashboard, Member Incentive Program Semi-Annual Report, and the Q2 2023 Appeals and Grievance Report. Dr. Marabella presented the A&G Dashboard and discussed trends. [Note: Due to the lack of quorum on 9/6/23, a separate ad-hoc PPC meeting has been scheduled for 9/27/23 @ 11:00 AM in CalViva Health's Commission Room, 7625 N. Palm Ave., Fresno, CA 93711. The following actions items will be presented: the 6/7/23 Meeting Minutes, the Proposed 2024 PPC Meeting Calendar, and the Annual PPC Charter.]

APPENDIX A

2023 DHCS All Plan Letters:

APL 23-001 Annual Network Certification (ANC) (Supersedes 21-006)
APL 23-003 CalAim Medical Incentive Payment Program (IPP)
APL 23-004 Skilled Nursing Facilities-LTC Benefit Standardization
APL 23-005 Requirements for Coverage of EPSDT
APL 23-006 Delegation and Subcontractor Network Certification
APL 23-007 Telehealth
APL 23-008 Prop 56 Directed Payments for Family Planning
APL 23-009 Authorization for Post-Stabilization Care Services
APL 23-010 Responsibilities for Behavioral Health Treatment for Mrbs Under 21
APL 23-011 Treatment of Recoveries of Overpayments to Providers
APL 23-012 ENFORCEMENT ACTIONS ADMINISTRATIVE AND MONETARY
APL 23-013 Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework
APL 23-014 PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS
APL 23-015 PROPOSITION 56 DIRECTED PAYMENTS FOR PRIVATE SERVICES
APL 23-016 DIRECTED PAYMENTS FOR DEVELOPMENTAL SCREENING SERVICES
APL 23-017 DIRECTED PAYMENTS FOR ADVERSE CHILDHOOD EXPERIENCES SCREENING SERVICES
APL 23-018 MANAGED CARE HEALTH PLAN TRANSITION POLICY GUIDE & 2024 MCP TRANSITION POLICY GUIDE
APL 23-019 PROPOSITION 56 DIRECTED PAYMENTS FOR PHYSICIAN SERVICES
APL 23-020 REQUIREMENTS FOR TIMELY PAYMENT OF CLAIMS
APL 23-021 PNA and PHM Strategy
APL 23-022 COC for Beneficiaries Who Newly Enrollee
APL 23-023 ICF-CC and Model Contract Language
APL 23-024 Doula Services

2023 DMHC All Plan Letters:

APL 23-001 - Large Group Renewal Notice Requirements (1.5.2023) - NA to CVH.pdf
APL 23-002 - SB 979 - Health Emergencies Guidance APL (OPL 1.12.23).pdf
APL 23-005 Network Service Area Confirmation Process (2.13.23).pdf
APL 23-006 - Independent Medical Review Application Form (2.24.23).pdf
APL 23-007 - Provider Directory Annual Filing Requirements (3_23_23).pdf
APL 23-008 - Health Plan Requirements to Timely Pay Claims (3.24.2023).pdf
APL 23-009 - Health Plan Coverage of Preventive Services (3.30.2023).pdf
APL 23-012 - 2023 Health Plan Annual Assessments.pdf
APL 23-015 - Supplemental Provider Directory Policy Filing (5.16.23).pdf
APL 23-016 - Implementation of SB 1338 (2022) - Community Assistance, Recovery, and Empowerment (CARE) (6.29.2023).pdf
APL 23-017 - Impact of the end of federal Public Health Emergency on health plan coverage of COVID-19 tests, immunizations, and therapeutics.pdf
APL 23-018 -RY 2024-MY 2023 PAAS NPMH Provider Follow-Up Appointment Initial Performance Target for Corrective Action.pdf

Item #5

Attachment 5.A

Provider Network Plan

BL 23-008

Jeffrey Nkansah
Chief Executive Officer

7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: September 28, 2023

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: Provider Network Plan

BL #: **23-008**
Agenda Item **5**
Attachment **5.A**

On January 21, 2010 (BL 10-005) recommended action of a Provider Network Plan and described how the Health Authority could organize a network to meet the Medi-Cal Managed Care contract requirements. The Health Authority approved the Health Authority Provider Network Plan unanimously (10-0).

The discussion acknowledged the Health Authority's Capitated Provider Network Agreement with Health Net which provides a complete network that can meet the Medi-Cal Managed Care contract requirements under Health Net's contractual arrangements with providers and practitioners. The discussion acknowledged the opportunity for the Health Authority to use contract templates that are currently used by Health Net. Lastly, the discussion noted DHCS's requirement at the time for the Health Authority to have some direct contracts.

The Health Authority continues to rely on the Health Authority's Capitated Provider Network Agreement with Health Net to meet the Medi-Cal Managed Care contract requirements and the three direct contracts it has with Federally Qualified Health Centers in Fresno, Kings, and Madera Counties.

The Health Authority is pursuing NCQA Health Plan and NCQA Health Equity Accreditation and must demonstrate review and adoption of Health Net Provider Contract Templates. Health Net has historically and continues to provide the Health Authority all of their confidential Provider Contract Templates which are used to organize a network to meet the Medi-Cal Managed Care Contract requirements as part of the Health Authority's Compliance Program oversight activities. These provider contracts allow for the Health Authority's members to receive care from providers (e.g. organization providers and practitioners) under the Capitated Provider Agreement as well as a template to be used for any applicable Health Authority direct contracts.

RECOMMENDED ACTION:

1. Review and Approve the continuance of the Health Authority's Provider Network Plan.
2. Review and Approve the Health Authority's continued adoption of Health Net's Provider Contract Templates for organizing a network to meet the Medi-Cal Managed Care contract requirements which includes organizational providers and practitioners.

Item #6

Attachment 6.A

2023 Quality Improvement Work Plan
Mid-Year Evaluation
Executive Summary

REPORT SUMMARY TO COMMITTEE

TO:	QI/UM Committee Members Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Amy Wittig, Quality Improvement Department
COMMITTEE DATE:	September 21, 2023
SUBJECT:	Quality Improvement Mid-Year Work Plan Evaluation Executive Summary 2023

Summary:

CalViva Health's 2023 Quality Improvement (QI) Program monitors improvement in clinical care, service and satisfaction 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 2023, quality improvement initiatives are focused on (but not limited to) improving preventive 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 Mid-Year 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:

CalViva carried out numerous targeted programs to improve performance metrics by mid-year 2023. Critical interventions that address data and targeted analysis, member supportive and direct care services, provider engagement and compliance, all worked cohesively to support goal achievement. The following table reflects the activities, by measure domain sections, from the workplan presented and approved earlier this year.

QI Mid-Year Activity Summary

Table 1. QI Mid-Year Work Plan Activities

Work Plan Sections	Activities Completed
1.1 Behavioral Health	3/3 (100%)
2.1 Respiratory Health	3/5 (60%)
2.2 Heart Health / Blood Pressure	4/4 (100%)
2.3 Diabetes	4/4 (100%)
3.1 Perinatal Care	1/5 (20%)

4.1 Initial Health Appointment (IHA)	3/3 100%
4.2 CAHPS Improvement	1/1 (100%)
5.1 Hospital Quality/ Patient Safety	27/28 (97%)
6.1 Pediatric Program for Infants and Children 0-3 Years of Age	0/1 (0%)
6.2 Pediatric Program for Children and Adolescents ages 3 – 21 years	1/1 (100%)
7.1 Cancer Screening	5/5 (100%)
7.2 Childhood Blood Lead Screening	3/4 (75%)
8.1 Quality EDGE	N/A at mid-year.
8.2 Provider Access, Availability, and Service	3/3 (100%)
Total	58/67 (87%)

As shown in the QI Mid-Year Activity Summary in Table 1 above, 87% of activities were completed as planned from January through June 2023. The remaining 9 activities, in addition to activities that are planned from July to December, will be implemented by the end of the year.

Details for the outcomes are included in the 2023 QI Mid-Year Work Plan Evaluation. Key program highlights include:

1. Access, Availability, and Service

1.1 Improve Access to Care:

For measurement year (MY) 2022, CalViva Health adopted DMHC's regulatory compliance goals for Urgent and Non-Urgent Appointment Availability, at 70%, to allow for consistency within the health care industry. In an effort to provide alignment with performance goals for Provider Appointment Availability Survey (PAAS), goals for all appointment measures were revised to 70%. After-hours access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS). Sutherland Global conducted the MY 2022 surveys between September and December 2022. Results indicated a need for improvement in several areas.

For PAAS Urgent Care Primary Care Physicians (PCPs), overall results for MY 2022 were reflected with a slight decrease of 1.9 percentage points at a rate of 49.0% compared to MY 2021, which was at 50.9%. Urgent Care Specialists overall scores for MY 2022 showed a 2.6 percentage point decrease from 37.6% compared to MY 2021, which was 40.2%. Non-Urgent Care PCPs overall scores increased in MY 2022 by 3.0 percentage points to 74.4% compared to MY 2021, which was at 71.4%. Non-Urgent Care Specialist overall scores for MY 2022 also decreased by 8.7 percentage points to 56.1% compared to the MY 2021 rate of 64.8%. Ancillary Non-Urgent overall scores for MY 2022 also decreased by 4.6 percentage points to 89.5% compared to the MY 2021 rate of 94.1%

For PAHAS, the performance goal of 90% for After-Hours Emergency Instructions for MY 2022 was met in all the three CalViva counties with a decrease in percentage points of 1.7, at 98.3% compared to the MY 2021 rate of 100%. A slight decrease in Fresno County was noted. Finally, for the Ability to Contact On Call Physicians After Hours, a

statistically significant increase of 9.6 percentage points was noted overall for MY 2022 for all counties, at 89.5% compared to MY 2021 rate of 82.0%.

Corrective Action Plan (CAP)

- For MY 2022 deficiencies are identified through analysis of the survey results and Corrective Action Plan (CAP) and educational packets will be issued to PPGs and providers who failed in one or more of the timely access or after-hours measures. PPGs who receive a CAP are required to complete an Improvement Plan (IP) within 30-days of receipt and attend a Timely Access webinar.
- A total of twenty-one (21) Tier 1 CAP packets will be issued, with ten (10) PPGs and eleven (11) direct network providers.
- A total of fifty-four (54) Tier 2 educational packets will be issued, with twelve (12) PPGs and forty-two (42) direct network providers.
- Both Tier 1 & Tier 2 PPGs were required to complete an attestation to be returned within 30 days.
- For 2023, the Access & Availability team has scheduled thirteen (13) provider training webinars all through October, with eight sessions already completed. A total of 940 participants registered with 459 attended, including 166 with CalViva affiliation. The web-based trainings started in May 2023 and will continue through October 2023, with topics specific to Timely Access survey preparation, how to improve performance in access and availability, and how to respond to CAP requests. Webinar certificates will be required and tracked. A self-study option of the webinar with a certificate of completion, is available to those who are unable to attend the webinars.

1.2 Improve Member Satisfaction:

CalViva participated in the regulatory CAHPS survey and it launched in Q1 2023. Root cause analysis on appeals and grievances data is conducted on a quarterly basis to identify trends in member pain points, as well as areas for improvement. Findings are shared with appropriate internal stakeholders and teams. The CAHPS Team continues to meet regularly with departments to track progress of the various activities around CAHPS performance and general member experience. These meeting spaces are also a platform to brainstorm any new ideas or projects to address any member issues that come up during the year. CAHPS related improvement activities in Q1 2023 include:

- The Sullivan Luallin Webinar Training for provider groups consisting of 3 CAHPS focused topics.
- The CAHPS Playbook highlighting the importance of CAHPS and best practices around key measures.

The CAHPS Team continues to connect regularly with stakeholder teams and departments to track progress of improvement initiatives that may impact CAHPS and member experience.

2. Quality and Safety of Care: Meet or Exceed the MCAS Minimum Performance Levels (MPLs)

Table 2. HEDIS® Measure Rates RY 2023 (Fresno, Kings, Madera)

HEDIS Measure	Fresno	Kings	Madera	MPL	HPL
Breast Cancer Screening (BCS)	52.14	58.61	61.03	50.95	61.27
Cervical Cancer Screening (CCS)	57.08	58.95	61.58	57.64	66.88
Chlamydia Screening (CHL)	58.86	62.15	59.38	55.32	67.84
Childhood Immunizations - Combo 10 (CIS-10)	27.49	23.84	48.42	34.79	49.76
Follow-Up After ED Visit for Mental Health Illness-30 days (FUM)	25.47	**70.07**	52.00	54.51	70.01
Follow-Up After ED Visit for Substance Abuse-30 days (FUA)	18.48	31.79	18.32	21.24	32.38
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%) (inverted rate) (CDC >9%)	37.47	**30.05**	35.93	39.90	30.90
Controlling High Blood Pressure (CBP)	61.73	**71.81**	67.49	59.85	69.19
Immunizations for Adolescents: Combination 2 (IMA)	39.17	29.68	**53.00**	35.04	48.42
Lead Screening in Children (LSC)	49.88	53.77	66.42	63.99	79.57
Prenatal Care (PPC-Pre)	89.62	87.76	90.37	85.40	91.89
Postpartum Care (PPC-Post)	**84.23**	84.18	**87.04**	77.37	84.18
Child and Adolescent Well-Care Visits (WCV)	48.14	39.56	57.71	48.93	62.70
Well-Child Visits in the First 15 Months of Life-Six or more Well-Child Visits (W30-15)	50.01	53.48	56.71	55.72	67.56
Well-Child visits for age 15 Months to 30 Months- Two or more Well-Child Visits (W30-30)	62.69	55.59	75.65	65.83	78.07

LEGEND	
NONBOLD	Result below DHCS MPL for that RY (IP)
BOLD	Result above DHCS High Performance Level (HPL) for that RY

CalViva is required to meet or exceed the 50th percentile performance benchmark as set by DHCS Managed Care Accountability Set (MCAS) for each reporting year. Final rates were reported for 2023 as shown in Table 2.

In 2023, CalViva Health did not meet the MPL and needs improvement for the following measures:

Fresno	Kings	Madera
• Cervical Cancer Screening • Childhood Immunizations - Combo 10 • Follow-Up After ED Visit for Mental Health Illness-30 days • Follow-Up After ED Visit for Substance Abuse-30 days • Lead Screening in Children • Child and Adolescent Well-Care Visits • Well-Child Visits in the First 15 Months of Life-Six or more Well-Child Visit	• Childhood Immunizations - Combo 10 • Immunizations for Adolescents: Combination 2 • Lead Screening in Children • Child and Adolescent Well-Care Visits • Well-Child Visits in the First 15 Months of Life-Six or more Well-Child Visit • Well-Child visits for age 15 Months to 30 Months- Two or more Well-Child Visits	• Follow-Up After ED Visit for Mental Health Illness-30 days • Follow-Up After ED Visit for Substance Abuse-30 days

Fresno	Kings	Madera
• Well-Child visits for age 15 Months to 30 Months- Two or more Well-Child Visits		

CalViva met the MPL and were compliant for all counties for the following measures:

- Breast Cancer Screening
- Chlamydia Screening
- Controlling Blood Pressure
- Diabetes – HbA1c Poor Control, and
- Prenatal and Postpartum Care.

CalViva Health will likely continue to be in the Quality Improvement Monitoring Program Orange Tier pending DHCS' assessment. The Quality Improvement Program will continue to have focused initiatives that address data acquisition improvements, member engagement strategies and provider operations and strategies to address priority HEDIS and MCAS under performance. Work to improve rates will be prioritized by highest impact, direct care gap closure projects and engagement strategies with providers.

3. Performance Improvement Projects (PIPs)

Two PIPs started in 2023. The first submission is due to DHCS in September 2023.

- Clinical PIP: Well-Child Visits in the First 30 Months of Life – 0 – 15 months – Six or More Well-Child Visits (W30-6+) targeting African-American/Black members in Fresno County.
- Non-clinical PIP: Follow-up After Emergency Department Visit for Mental Illness (FUM); the percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up for mental illness; and Follow-up After Emergency Department Visit for Substance Abuse (FUA), the percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, for which there was a follow-up. Two rates are reported:
    - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
    - The percentage of ED Visits for which the member received follow-up with 7 days of the ED visits (8 total days).

  The non-clinical PIP will be focusing the 7-day follow-up of the ED visits (8 total days). The project includes Fresno, Kings, and Madera Counties.

3.1 Well-Child Visits in the First 30 Months of Life – 0 – 15 Months (W30-6+):

The California Department of Health Care Services (DHCS) implemented a new PIP process in 2023. Health Services Advisory Group (HSAG) provided a 2023-2026 PIP Overview Training to Managed Care Organizations on April 26, 2023. CalViva Health identified 244 African-American/Black members in the W30-6+ denominator in MY 2021

with a rate of 31.56%. This target population was approved by HSAG/DHCS as having an adequate denominator for the PIP.

CalViva has submitted the data request for a barrier analysis of the African-American/ Black population in the W30-6+ denominator. The barrier analysis should be available in late July 2023.

CalViva Health has also identified the primary rate of measure for the W30-6+ PIP to be two or more visits by 120 days of life. Previous analysis indicates that when infants have completed three or more visits by 120 days of life, they are much more likely to complete all six visits by 15 months of life.

Steps 1 – 6 of the PIP process are due to HSAG/DHCS on September 8, 2023.

3.2 Non-Clinical PIP-focused on FUM/FUA measures

The California Department of Health Care Services (DHCS) implemented a new PIP process in 2023. Health Services Advisory Group (HSAG) provided a 2023-2026 PIP Overview Training to Managed Care Organizations on April 26, 2023. For the non-clinical PIP, CalViva will leverage CalAIM data to track county referrals. The referral will be a community support agency or facility within seven days of an ED visit for both FUA, (Follow-up After Emergency Department Visit for Substance Use) and FUM (Follow-Up After Emergency Department Visit for Mental Illness). The FUA denominator will be calculated by determining the number of current eligible members that are being referred to a community support agency or facility. A barrier analysis using HEDIS data will assess why members are not getting community support services.

Next steps include combining barrier analysis data and CalAIM data; begin PIP workgroups; leverage barrier analysis results to identify SMART Aim Goal; submit QIRA request; and evaluate data.

4. Strength, Weaknesses, Opportunities, and Threats (SWOT)

CalViva Health is implementing a SWOT analysis and strategy implementation targeting CIS-10 and W30 in Fresno and Kings Counties. CalViva Health submitted three SWOT strategies on February 28, 2023 that were approved by DHCS. The three strategies are:

1. Retrieve the Hep B immunization data for the vaccine given to newborns in the hospitals.
2. Increase the conversion of sick visits to well-care visits for children under 30 months of age.
3. Implement a process in pediatric provider offices to vaccinate children under the age of two years at every visit, not just well-care visits.

The first SWOT Progress submission was sent to DHCS on July 17, 2023. CalViva Health is working on retrieving Hep B data from the 3 highest-volume delivery hospitals in Fresno and Kings Counties (two hospitals are in Fresno and one is in Kings). Two FQHC providers are partnering with CalViva Health to convert sick visits to well-care visits and vaccinate all children under the age of two years while they are in the clinic. The second SWOT Progress submission is due to DHCS on November 30, 2023.

Item #6

Attachment 6.B

2023 Quality Improvement
Mid-Year Work Plan Evaluation

CalViva Health
Quality Improvement
Mid-Year Work Plan Evaluation
2023

09/13/2023

TABLE OF CONTENTS

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

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

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 2023. The development of this document requires resources of multiple departments.

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances
A&I:	Audits and Investigation
ADA:	American Diabetes Association
AH:	After Hours
AWC:	Adolescent Well-Care
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CalAIM:	California Advancing and Innovating Medi-Cal
CAP:	Corrective Action Plan
CCAC:	Central California Asthma Collaborative
CCHRI:	California Cooperative Healthcare Reporting Initiative
CCM:	Chronic Conditions Management
CDC:	Comprehensive Diabetes Care
CM:	Care Management
CMQCC:	California Maternity Quality Care Collaborative
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
HAIs:	Hospital acquired infections
HE:	Health Education
HEDIS®:	Healthcare Effectiveness Data and Information Set
HPL:	High Performance Level
HN:	Health Net
HSAG:	Health Services Advisory Group
HQPP:	Hospital Quality Performance Program
IHA:	Initial Health Assessment
ICE:	Industry Collaborative Effort
IP:	Improvement Plan
IVR:	Interactive Voice Response
MCAS:	Managed Care Accountability Sets
MCL:	Medi-Cal
MH:	Mental Health
MMCD:	Medi-Cal Managed Care Division
MPL:	Minimum Performance Level
NCQA:	National Committee on Quality Assurance
PCP:	Primary Care Physician
PDSA:	Plan, Do, Study, Act
PIP:	Performance Improvement Project
POD:	Program Owners and Drivers
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
PNM:	Provider Network Management
PRR:	Provider Relations Representative
PTMPY:	Per Thousand Members Per Year
QC:	Quality Compass
QI:	Quality Improvement
SMART:	Specific, Measurable, Achievable, Relevant, and Time-Bound
SPD:	Seniors and Persons with Disabilities
SWOT:	Strengths, Weaknesses, Opportunities, and Threats
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 Amy R. Schneider, RN Director Medical Management
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 (MY 2021)** (%, ratio)**:** • FUA-30: 0%, (0/3) • FUM-30: 0%, (0/3) **Final rate (MY 2022)** (%, ratio)**:** • Unavailable, not reported for 2022. Refer to Quality Initiatives 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, %):	N/A at mid-year.
Mid-Year Activities Update: *(Populate at mid-year)*	*Completed at (ratio, % range):* 3/3, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)*

Number of Activities Completed at Mid-Year/Total Activities Planned for Year; (Percent Completed)	*Updates:* • Will leverage CalAIM data to track county referrals. The referrals will need to be to a community support agency or facility within seven days of an ED visit for both FUA and FUM. • FUA denominator will be calculated by determining the number of current eligible members that are being referred to a community support agency or facility. • Completion of barrier analysis is in progress using HEDIS data to assess why members are not getting community support services. Next steps: Combine barrier analysis data and CalAIM data. • Begin PIP workgroups. • Leverage barrier analysis results to identify SMART aim goal.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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 (MY 2021)** (%, ratio)**:** 100%, (3/3) **Final rate (MY 2022)** (%, ratio)**:** N/A at mid-year. Refer to Quality Initiatives 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, %):	N/A at mid-year.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 3/5, (60%) ☒ *Off track (<75%)* ☐ *On track (=>75%)* *Updates:* • Multigap HEDIS calls for Medi-Cal, which included members with AMR care gaps, started in May. • Corporate Pharmacy calls to Medi-Cal members in specific counties who had AMR gaps started in February. Calls were focused on education of proper asthma controller medication usage (MCL ≅ 2K sent) • Provider update in April on asthma education was to go out in Q2 but was slightly delayed due to compliance review delay and went out in early July. • Social media post in April for asthma awareness of triggers. There was a 1% engagement rate with 66 reactions, 4 shares and 1 post comment. • CCAC In-Home Asthma Support Program finished in June. Reporting and evaluation to follow.

Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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 (MY 2021)** (%, ratio)**:** 100%, (3/3) **Final rate (MY 2022)** (%, ratio)**:** 100%, (3/3) Refer to Quality Initiatives 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, %):	3/3, (100%)

Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range): 2*/2, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Multigap HEDIS calls for members with care gaps including controlling blood pressure started in May. As of 8/4/23, the overall reach rate for Medi-Cal is 13.59%, with an attempted rate of 51.17%. The actual number of members reached was 2,868 (of the 21,102 attempted), and this had been progressively increasing since the beginning of the multigap HEDIS call. • Final remediated CBP provider tip sheets were available June 2023 and posted to the provider library. CalViva data on the number of CBP provider tip sheets downloaded is not available. Currently, provider tip sheets are being moved from the provider library to a new section of the portal landing page (https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/hedis-measure-specifications.html). This link provides access to CalViva branded provider tip sheets and reporting analytics can be requested from the Web team.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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 (MY 2021)** (%, ratio): 100%, (3/3) **Final rate (MY 2022)** % ratio)**:** 100%, (3/3) Refer to Quality Initiatives 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, %):	3/3, (100%)
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 4/4, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Multigap HEDIS calls for members with care gaps including A1c control started in May. As of 8/4/23, the overall reach rate for Medi-Cal is 13.59%, with an attempted rate of 51.17%. The actual number of members reached was 2,868 (of the 21,102 attempted), and this has been progressively increasing since the beginning of the multigap HEDIS call. • Final remediated diabetes provider tip sheets were available February 2023, and posted to the provider library. There were 7 downloads of the CalViva provider tip sheet on HbA1c control for patients with diabetes from February to July 2023. Currently, provider tip sheets are being moved from the provider library to a new section of the portal landing page (https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/hedis-measure-specifications.html). This link will provide access to CalViva branded provider tip sheets and reporting analytics can be requested from the Web team.

	• Social media post "Healthy Vision Month" posted on 4/29/2023 directed members to ADA video https://youtu.be/IcTtkYGsAw4 with a 2% engagement rate on Facebook and Instagram, respectively. • Project Extension for Community Healthcare Outcomes (ECHO) tele-mentoring program to support primary care providers in targeted rural counties of California with high rates of diabetes to improve provider self-efficacy and knowledge, patient care, and outcomes launched in February 2023. The one-year, 12-session Project ECHO utilizes virtual communities of practice, including specialists and PCPs to address clinical inertia and health disparities. As of 6/16/23, there were 27 registered PCPs, and attendance varied per session. Ongoing efforts to improve attendance included outreach by Weitzman Institute (vendor) and HN provider engagement team via phone text to encourage participation of registered PCP, nurse practitioners, and physician assistants, and asking attendees to help promote the ECHO program. Additionally, there are currently 19 registered providers in Project ECHO that supports the CalViva service areas.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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	• Achieve 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%

	▪ MY 2021 overall CalViva PPC-pre rate for A-A: 81.30%; Hispanic: 86.49%; White: 82.49%; and Asian: 83.16%. There was a 5.19 percentage points difference between A-A and the highest performer, Hispanic. ○ PPC-post: 70% ▪ MY 2021 overall CalViva PPC-post rate for A-A: 64.31%; Hispanic: 73.98%; White: 68.79%; and Asian: 76.66%. There was a 12.35 percentage points difference between A-A and the highest performer, Asian. **Prior rate (MY 2021)** (%, ratio)**:** • MCAS rates: 66.67% (4/6) • PPC-pre A-A: 82% • PPC-post A-A: 64% **Final rate (MY 2022)** (%, ratio)**:** • MCAS rates: 100%, (6/6) • PPC-pre A-A: N/A at mid-year. • PPC-post A-A: N/A at mid-year. Refer to Quality Initiatives 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, %):	MCAS: 6/6, (100%)
Mid-Year Activities Update: *(Populate at mid-year*)	*Completed at (ratio, % range):* 1/5, (20%) ☒ *Off track (<75%)* ☐ *On track (=>75%)*

Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)	*Updates:* • Perinatal training of Provider Engagement completed. The training included a review of the HEDIS technical specifications for each MCAS measure and best practices to improve rates. • The *CalViva Health Pregnancy Program* is an ongoing program. Referrals of all identified African-American/Black pregnant members in Fresno County to the CalViva Health Pregnancy Program started in May 2023 and will continue monthly. • Planning for a Confirmation of Pregnancy provider incentive for PCPs to launch Q3, 2023.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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 (MY 2021)** (%, ratio)**:** N/A **Final rate (MY 2022)** (%, ratio)**:** 13.85%

	Refer to Quality Initiatives 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, %):	N/A.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 3/3, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Updated provider materials in accordance with APL 22-030. Materials updated included a provider tip sheet, IHA non-compliance provider notices, IHA trainings, provider portal website, Medi-Cal Operations Guide, a provider update with the listed APL changes, welcome packet, member handbook, IHA call scripts, and CalViva IHA policy. • Ongoing IHA quarterly reporting: Reported quarterly on plan outreach and IHA compliance. • Ongoing IHA provider notice: Providers who were found non-compliant during FSR/MRR audits were sent IHA provider notices on IHA requirements. • By 6/30/2023 PE conducted 509 outreaches to providers regarding IHA and IHA trainings. Outreaches included in-person meetings, online meetings, phone, and email. PE outreaches and trainings included training providers on how to access and use new member reports on the provider portal to determine which members are due for an IHA, documentation and coding of IHA, and handoff of supporting materials (process flow, provider tip sheet, and Step Guide). Providers also had access to an online training on IHA. • Providers with low performance were offered training and additional interventions to resolve barriers to IHA completion.

Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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	Frances Arce, Program Manager III, CAHPS Team Amy R. Schneider, RN Director Medical Management
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 directional rate improvement of 1-5% by MY 2023 for the following measures: o Access to Care o Customer Service o Doctor Communication o Care Coordination o Overall Rating Measures (Health Plan, Health Care Quality, Provider, Specialist) • YOY improvement on all measures. Please refer to internal CAHPS tracker. **Prior rate (MY 2021)** (%, ratio)**:** RY 2022 Access Survey Measures YOY Improvement: 50%, (2/4) **Final rate (MY 2022)** (%, ratio)**:** N/A at mid-year.

	Refer to Quality Initiatives 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, %):	N/A at mid-year.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 1/1, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • The regulatory CAHPS Survey for CalViva members launched on-time in Q1 2023.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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	• Engage hospitals with poor performance on priority metrics: Obtain quality updates from targeted hospitals either verbally or in writing. • Hospitals with reportable data: Directional improvement, based on appropriate scores (Standardized Infection Ratio (SIR)=<1.0) or outliers (SIR>2) for target hospital acquired infections (HAIs) (Catheter-

	associated urinary tract infections (CAUTI), central line-associated bloodstream infection (CLABSI), Clostridioides difficile (C.Diff), Methicillin-resistant Staphylococcus aureus (MRSA), and Surgical Site Infection following Colorectal Surgeries (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 (MY 2021)** (%, ratio)**:** 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% **Final rate (MY 2022)** (%, ratio)**:** N/A at mid-year. Refer to Quality Initiatives 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, %):	N/A.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 15/16, (94%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* Hospital Quality activities: C-section overuse: • Launched initiative to promote new Medi-Cal doula benefit. Collaborated with Health Equity Officer to send letter to all maternity hospitals in Medi-Cal about doula care and the new doula benefit. (Note these included CalViva's 5 maternity hospitals, although the mailings were not branded as such.) In consultation with Doula Workgroup, developed member letter on doula benefit and C-section overuse, as well as preeclampsia prevention and warning signs that urgent medical care is needed. Currently in DHCS review. Monthly mailings to pregnant members planned for launch once materials receive full approval from all parties (will be submitted for CalViva review to confirm permission to conduct this outreach to CalViva members). • Mailed outreach was conducted to all maternity hospitals across LOBs about C-section overuse; the opportunity to engage with California Maternity Quality Care Collaborative (CMQCC); California Health Care Foundation implicit racial bias training resources; and maternal health/birth equity reporting and assessment. (Included CalViva maternity hospitals. Future mailings will be submitted for CalViva review and branded as CalViva for these hospitals.) • Collaborated with the California Quality Care Collaborative (CMQCC) to support maternal health quality improvement among network hospitals, primarily on C-section rates, including individual hospital engagement, and maternal health/birth equity initiatives. Patient Safety:

	• Served as co-chair of the Leapfrog Group's Partners Advisory Committee. Chaired both quarterly meetings, including in-person DC meeting and attended related events. Participated in Data Users Group meetings and activities. • Collaborations with Cal Hospital Compare and Cynosure Health support quality improvement among hospitals through promotion of Honor Rolls, use of Poor Performer report, coordination/consultation with staff about specific hospitals' performance, and promotion of QI resources to address patient safety metrics. • Conducted outreach to network hospitals that did not earn a place on the Patient Safety Honor Roll list. Included promotion of Leapfrog Hospital Survey and forthcoming Sepsis Care Honor Roll from Cal Hospital Compare. Administrative delay prevented Q2 distribution, but letters went out the first week of August. • Social media outreach promoting informed hospital choice based on quality performance was conducted on Facebook in April, May and June. April and May posts generated over 350,000 impressions. The June post generated over 100,000 impressions. Overall Quality and Poor Performer: • Conducted follow-up with repeat poor performers, based on end of year performance on Hospital Scorecard metrics and other key indicators. Phone outreach sought to obtain status updates about poor performing metrics that were highlighted in end-of-year mailed outreach to the hospitals. Two CalViva network hospitals were included in this initiative.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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, Juli Coulthurst, Program Manager III, Meena Dhonchak, Sr. QI Specialist Amy R. Schneider, RN Director Medical Management
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 (MY 2021)** (%, ratio)**:** 33%, (1/3) **Final rate (MY 2022)** (%, ratio)**:** 33%, (1/3)

	Refer to Quality Initiatives 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, %):	1/3, (33%)
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 0/1, (0%) ☒ *Off track (<75%)* ☐ *On track (=>75%)* *Updates:* • First clinical PIP (W30-6+ targeting African-American/Black members) submission on track for due date on 9/8/2023. • Attended HSAG training for new 2023-2026 PIP requirements on April 26, 2023.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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; Meena Dhonchak, Sr. QI Specialist Amy R. Schneider, RN Director Medical Management
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 (CIS-10, W30-6+). **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 (MY 2021) (%, ratio)**:** 33%, (2/6) **Final rate (MY 2022)** (%, ratio)**:** 33%, (2/6) Refer to Quality Initiatives 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, %):	2/6, (33%)
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 1/1, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • SWOT was submitted to DHCS on 7/17/23. Next submission is due 11/30/23. • The top three delivery hospitals were identified in Fresno and Kings Counties. Contact has been made with all hospitals and a process has been established to receive the Hep B data from each hospital. • Two FQHCs identified to participate with CalViva on converting sick to well-care visits for children under the age of 30 months and vaccinate children under the age of two years any time they are in the clinic. Providers have been trained for converting sick to well-care visits and provided the CDC handout on communicating with parents about vaccines.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.

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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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 Amy R. Schneider, RN Director Medical Management
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 (MY 2021) (%, ratio)**:** • BCS: 33.3% (1/3) • CCS: 66.7% (2/3) • CHL: 33.3% (1/3) **Final rate (MY 2022)** (%, ratio)**:** • BCS: 100%, 3/3 ○ Madera 61.03%, met ○ Kings 58.61%, met ○ Fresno 52.14%, met • CCS: 100%, 3/3 ○ Madera 61.58%, met ○ Kings 58.95%, met ○ Fresno 57.08, not met • CHL: 100%, 3/3 ○ Madera 59.38%, met ○ Kings 62.15%, met ○ Fresno: 58.86, met Refer to Quality Initiatives 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, %):	8/9, (89%)
Mid-Year Performance goal update and improvement opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.

Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 3/3, (100%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* BCS: 1/1 • CalViva held 19 mobile mammography events with Pacific Coast. Nine of those were in Fresno. Two additional dates with Pacific Coast are planned for Dec 8th and 9th.Mammography Incentive Program – Information was shared with Clinical Program Managers. In the process of receiving opt-in documents from PPGs/radiology facilities. CCS and CHL: 2/2 • Tip sheets for both CCS and CHL. Both posted on the provider library at the link below: https://providerlibrary.healthnetcalifornia.com/medi-cal/materials.html#c. • PE action plans completed for both CCS and CHL statewide.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *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, Senior Manager, QI Amy Wittig, Director, QI Pam Carpenter, Director, QI Amy R. Schneider, RN Director Medical Management
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 (LSC) 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 (MY 2021)** (%, ratio)**:** N/A **Final rate (MY 2022)** (%, ratio)**:** 52.09% Refer to Quality Initiatives 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, %):	2/4 (50%)
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 3/4, (75%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Ongoing quarterly monitoring of HEDIS LSC administrative rate and anticipatory guidance. • Updated provider trainings and education materials including the Medi-Cal operations manual and HEDIS provider tools on LSC. • Three providers were trained by the Fresno County Lead Poisoning Prevention Program Nurse.

	• Completed annual blood lead level screening DHCS submission. CVH identified lower rates in the mid-age group. CVH is currently investigating the lower rates in the mid-age group. • Updated P&Ps to reflect anticipatory guidance documentation. • Identified high volume providers to assess their process for lead screening to identify providers not currently offering point of care capillary lead screening. Developed process to purchase Lead Care II analyzers and one kit of 48 individual tests for offices.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. The California Department of Public Health issued a letter in January 2023 indicating that filter paper would no longer be an acceptable blood lead screening method. The Health Net Vice President, Medical Director escalated this issue to the DHCS hosted health plan medical directors meeting on January 26, 2023 and to CDPH, followed by an email to CDPH. CDPH sent an email response on February 3, 2023 indicating that filter paper lead testing will no longer be accepted. Lead Care II point of care testing is an acceptable lead screening method. CVH had been promoting MedTox, a newer filter paper for lead screening to providers. CalViva discontinued the promotion of MedTox filter paper and is now identifying providers not currently offering point of care capillary lead screening to receive Lead Care II point of care analyzers.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*
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, Sr. Quality Program Development Manager, Quality Improvement Amy Wittig, Director, QI Tanya Demirjian, Manager, QI Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Have incremental performance improvement (greater than 10%) in EDGE key performance indicator (KPI) categories for CalViva, relative to previous measurement year. **Rationale:** CalViva Health relies on its provider network to improve the quality of care CalViva members receive. Quality EDGE a collaborative approach between three teams, QI + Dyad (Provider Engagement + Medical Affairs), to help network providers overcome barriers to improving care and HEDIS performance.

Program Objectives	• Incrementally improve quality metrics performance across for high impact priority providers, through the Dyad + QI partnership and implementation of Quality EDGE. **<u>EDGE KPI Categories Performance for MCAL CalViva (Year-end MY 2022), N=112 Priority Providers:</u>** • Priority provider measure performance, MY 2022: final MY 2022 data are pending. ○ Preliminary MY 2022 final, care gap data through April 2023: 13% (Target=65%). • Cozeva adoption for priority providers, YTD 2023*: 97% (Target= 75%). • Priority provider (PE) action planning - adult measures, YTD 2023*: 12% (Target=80%). • Priority provider (PE) action planning - pediatric measures, YTD 2023*: 12% (Target=80%). *Sources: MCAL EDGE KPI Report, 202303 Footnotes: • Cozeva data thru 2/27/23, from Cozeva Practice Mapping File, reflecting adoption rates for MY 2022 priority providers. • Action planning data thru 4/14/23 for action plans with start and end date in MY 2022. • Action planning targets and volume of priority providers are subject to change for MY 2023. Refer to Quality Improvement EDGE Fund activities log (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	Baseline Year, see above KPIs and EDGE Fund activities log.
Mid-Year Progress Update: *(Populate at mid-year)* *Number of Requests at Mid-Year*	*Completed at (ratio, % range):* N/A at mid-year. ☐ *Off track (<10% increase towards KPI target)* ☐ *On track (=>10% increase towards KPI target)* ☐ *Off track (<10% increase in Quality EDGE requests from prior year)*

	☐ *On track (=>10% increase in Quality EDGE requests from prior year)* *Updates:* Number of Quality EDGE funding requests (baseline MY 2023 YTD): Medi-Cal: 50 The strategy this year for Quality EDGE was updated, therefore progress is N/A at mid-year. The same strategy will be used for 2024 and will be able to compare requests volume and KPI data in 2024.
Mid-Year Performance goal update and improvement opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need a higher level of attention are being escalated timely. To support the Quality EDGE process, some of the action plans provider-facing teams (Provider Engagement and Medical Affairs) created in partnership with providers and provider groups needed support to reach jointly agreed upon action plan goals. From January-June 2023, Quality EDGE supported 50 action plans financially. The top three categories of support given are: Mobile Mammography Events, Member Incentives, and Material Support. The total funds granted to providers for January-June 2023 is $227,502.00. Support to providers was also given by provider-facing teams in the form of HEDIS measure trainings, barrier analysis identification, and implementing change management processes to achieve action plan goals.
Year End Progress Update: *(Populate at year end)* *Number of Requests at Year End*	*Completed at (ratio, % range):* ☐ *Off track (<10% increase towards KPI target)* ☐ *On track (=>10% increase towards KPI target)* ☐ *Off track (<10% increase in Quality EDGE requests from prior year)* ☐ *On track (=>10% increase in Quality EDGE requests from prior year)*

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 Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Improve access to care: Timely appointments to primary care physicians, specialists, 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 CalViva 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 (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% **Final rate (MY 2022)** (%)**:** PAAS: • PCP Urgent: 49.0% • PCP Non-Urgent: 74.4% • Specialists (All) Urgent: 37.6% • Specialists (All) Non-Urgent: 56.1% • Ancillary Non-Urgent: 89.5% PAHAS:

	• Appropriate Emergency Instructions: 98.3% • Ability to Contact On-Call Physicians: 91.6% Supporting activities: • By year-end (Q3-Q4 2023), the Plan is working with a new survey vendor to ensure provider barriers to survey responses are addressed for MY 2023 to obtain accurate responses on the survey. • By year-end, implement the annual 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. • By year-end, implement the annual Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability. • By year-end, based on the Provider Appointment Availability and After-Hours Survey results, the Plan implements a Corrective Action Plan (CAP) for providers. On 7/12/23, CAP packets were sent to 10 PPGs and 11 direct network providers. Educational packets were sent to 12 PPGs and 42 direct network providers. CAP review process continues until the end of the year. As of 8/18/23, there were 3 completed CAP reviews. Consecutive Non-compliant PPGs, Groups/Clinics and Direct Network Providers receive the CAP and are also encouraged to attend the Provider Training Webinar and complete an attestation of participation/attendance. • Develop and distribute the annual Provider Updates, with alerts of upcoming appointment and after-hours surveys (in 3rd quarter of every year), and with results of surveys (by 3rd quarter of every year), will include recommendations, tips and tools for improving after-hours access. CalViva will be publishing the provider update and the MY 2022 Provider Appointment Availability Survey Excellence Letter and Certificate. • By year end, the Plan's Provider Engagement field staff will annually outreach to providers (PCP offices only) that were found to be non-compliant on Non-Urgent timely access standards year-over-year to understand/discuss barriers and determine next steps for improvement. • The Plan and MHNS reminds all PAAS eligible providers on an annual basis the importance and obligation to respond to the PAAS. • Annually by year-end, the Plan will recognize providers that met both Urgent and Non-Urgent appointment standards for MY 2022. • CalViva Health utilizes a dashboard to address several access reporting metrics at the delegated group level. The dashboard results are discussed at quarterly Management Oversight Meetings to address deficiencies and key activities for improvement.

Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	PAAS measures: (2/5), 40% met the 70% performance goal. PAHAS measures: (2/2), 100% met the 90% performance goal.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, % range):* 3/3, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • The MHN reminder outreach was completed in Q2 2023. Additional outreach planned for Q3 2023. • The PPG Dashboard was presented to MOM Committee. ○ Q4 2022 update was reported in February 2023. ○ Q1 2023 update was reported in May 2023.
Mid-Year Performance goal update and improvement opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. Based on MY 2022 Provider Appointment Availability and After-Hours Survey results, the Plan implements CAPs for providers. Non-compliant PPGs, group/clinics and direct network providers receive the CAPs and are encouraged to attend the provider training webinars. Nonresponsive issues are escalated to Provider Network Management and have open dialogue with providers. For MY 2023, the Plan is working with a new survey vendor to ensure provider barriers to survey response are addressed.
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):* ☐ *Off track (<75%)* ☐ *On track (=>75%)*

Year-end barriers/ lessons learned *(Populate at year end)*	
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *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.	B. Head, Sr. Health Education Specialist	Ongoing. December 2023	Ongoing. Information on PSGs are distributed via the annual member newsletters and the new member welcome packets.	☐		Need to approve at QIUM.
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	CalViva Health/HN J. Serratore Director, Clinical Programs	Ongoing. December 2023	CPG grid was updated in May 2023. Provider Communication update planned for July and providers are directed to the healthnet.com site to view the CPG grid.	☐		Need to take to QIUM in Sept. We tried for July but not ready
3. Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	C. Patnuade, Director, Care Management	Ongoing. December 2023	On target.	☐		
4. 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	On target. QI is in the process of onboarding Meridian Bioscience as a	☐		

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
			vendor for the Leadcare II Analyzer machine. Provider-facing team members will be able to request funding to purchase Leadcare II Analyzer machines through Quality EDGE to support the updated LSC strategy.			
CONTINUITY OF CARE						
1. Monitor opportunities and interventions for NCQA Standards QI.3 & QI.4 Coordination of Care (COC) requirements (non-BH and BH reports).	L. Ciotoli/ M. Rosales Program Manager III, Quality Improvement	Ongoing. December 2023	QI.3 report on track for Q3 reporting. QI.4 report on track for Q3 reporting.	☐		
DISEASE/CHRONIC CONDITIONS MANAGEMENT						
1. Monitor Chronic Conditions (Disease) Management Program for appropriate member outreach.	M. Nuno, Clinical Accounts Manager; B. Collier, Manager of Clinical & Vendor Programs	Ongoing. December 2023	Ongoing. June 2023	☐		
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE						
1. Health Equity Report: Analyze and report on Cultural and Linguistics.	D. Fang, Manager, Health Equity	Q2, Q3 2023.	Language Assistance Program End of Year Report and	☒	May 2, 2023	

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
			Annual Work Plan Evaluation were completed in Q2 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	PAAS, PAHAS and Telephone Access surveys are conducted in Q3 – Q4.	☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date.	P. Fuentes, PR Specialist, Access & Availability	March 2023	MY 2022 DMHC TAR filing completed timely 5/8/23. DMHC revised due date from 3/31/23 to 5/8/23.	☒	May 8, 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	CAPs for MY 2022 scheduled to be distributed Q3-Q4.	☐		
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	P. Fuentes, PR Specialist, Access & Availability	Q1, Q2, Q3, Q4 2023.	Provider Training webinars were held in Q2 & July to October (13 more) In Q3: 940 registered 459 attended 166 CVH Webinar completion certificate required to	☐	5/17/23 5/31/23 6/14/23 6/28/23	

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
			validate attendance.			
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	P. Fuentes, PR Specialist, Access & Availability	Q1, Q2, Q3, Q4 2023.	Sutherland (3rd party vendor) conducted telephone access survey Q3-Q4 2022. CAP and Educational Packets will be issued to non-compliant providers during Q1-Q2 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.	CAPs and educational packets issued to non-compliant providers in Q1 & Q2. Provider training webinars held throughout the year to educate providers on timely access.	☐		
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.	On track. Ongoing.	☐		
9. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement.	D. Fang, Manager, Health Equity	Q3 2023.	Geo Access report will be completed in Q3.	☐		

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.	On track.	☐		
12. Engage with CalViva provider offices to complete MY 2022 MCAS training focused on best practices for closing care gaps.	A. Wittig, Director, Quality Improvement Jose Gonzalez, Manager, Provider Engagement	Ongoing. December 2023.	On track. From January thru June, there were 520 CalViva providers who received HEDIS trainings.	☐		
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.	On track. Please refer to the Quality Edge initiative in Section 8 as well as the attachment provided.	☐		
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.	On target.	☐		
CREDENTIALING / RECREDENTIALING						

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
1. Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	M. Catello, Manager, Credentialing	Ongoing. December 2023.	On track.	☐		
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.	For the 2023 mid-year, activity remains on track for monitoring the PPGs' delegated activities. Correction Action Plans are issued as applicable. Report findings and ongoing monitoring are reported to CalViva quarterly, annually, and as applicable.	☐		
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.	On track: MHN QI has presented required performance tracking reports and has initiated the annual surveys (member satisfaction,	☐		

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
			provider satisfaction and PAAS). There were no instances of non-compliance to correct.			
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 APL 22-107 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023.	P. Carpenter, Director, Quality Improvement	Ongoing. December 2023.	On track.	☐		
2. Complete all potential quality issues (PQIs) received within 90 day TAT to maintain compliance with regulatory requirements.	P. Carpenter, Director, Quality Improvement	Ongoing. December 2023.	To date, all cases were completed within TAT.	☐		
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.	Completed in Q1.	☒	2/8/2023	

Item #7

Attachment 7.A

2023 Utilization Management Case Management
Work Plan Mid-Year Evaluation
Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Jennifer Lloyd, Senior Vice President Population Health and Clinical Operations
COMMITTEE DATE:	September 21, 2023
SUBJECT:	2023 CalViva Utilization Management/Case Management Work Plan Mid-Year Evaluation Executive Summary

Summary:

Activities are currently on target for this mid-year evaluation with the exception of the following metrics listed below. These metrics are indicated as Too soon To Tell for the mid-year evaluation reporting.

- 3.3 PPG Profile

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

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 Mid 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, Delegation Oversight, Compliance, Information Technology, Medical Informatics, Member Services, Pharmacy, Provider Oversight, Provider Network Management, Provider Operations, Quality Improvement, Medical Management and Behavioral Health.

Analysis/Findings/Outcomes:

I. Compliance with Regulatory & Accreditation Requirements

All Compliance activities are currently on target for this mid-year evaluation with no barriers identified.

II. Monitoring the Utilization Management Process

UM Process Monitoring activities are currently on track for this mid year evaluation with no barriers identified.

III. Monitoring Utilization Metrics

All Monitoring Utilization Metrics activities are currently on target for this mid-year evaluation with the exception of work plan activity 3.3. PPG Profile which is listed as Too Soon To Tell.

a. Improve Medi-Cal shared risk and FFS UM acute in-patient performance (work plan activity 3.1)

Acute inpatient performance is currently ahead of target 2% reduction in bed day, average length of stay (ALOS) and readmission utilization. SNF facility staffing continues to be a challenge which creates barriers to finding placement in SNF for some higher acuity patients leaving the acute hospital.

Metric	2022	2023 Q1-Q2	% Change
Bed Days Acute PTMPY	238.2	216.3	-9%
Admits PTMPY	63.7	63.2	-1%
ALOS Acute	5.3	5.1	-4%
Readmit 30 Day	9.8%	9.2%	-6%

b. Over/under utilization (work plan activity 3.2)

Activities are on target however barriers include:

- CVMP is working with a new MSO.
- LaSalle is also transitioning to new MSO on 09/01. Hiring continues to be a challenge for quality director and data positions with high staff turnover.
- Sante's quality director position is open since spring.
- Meritage cites financial difficulties in incentivizing providers for quality improvement. Paper-based charts and slow Cozeva adoption remain barriers. Cultural, linguistic and health equity concerns in serving diverse populations with unique needs and beliefs in accessing care.

c. PPG Profile (workplan activity 3.3)

Activities related to PPG Profile performance and monitoring are listed as Too Soon To Tell for the mid year evaluation due to one PPG falling below turn around time targets in the first quarter. The following barriers identified include:

- Specialty access continues to be a challenge for PPGs. We have partnered with provider network management to address delays in access.
- Sante urgent turn-around time (TAT) was below 95% in the first quarter due to office closure on holidays. Sante was educated on 72 hour TAT requirements and added provisions to address future holidays.

IV. Monitoring Coordination with Other Programs and Vendor Oversight

All activities related to monitoring coordination with other programs and vendor oversight are currently on target for this mid-year evaluation.

a. Care Management (CM) Program (workplan activity 4.1)

   Activities are on target however barriers identified include: Fewer than expected number of satisfaction surveys completed. Care Managers encourage members to take survey and gain preferred contact method by member for survey.

b. Behavioral Health (BH) Case Management Program workplan (activity 4.3)

   Activities are on target however barriers identified include: reduced referrals from MHN and county partners as all referrals now handled via MHN process. MHN continues to refer members that need additional follow up.

c. Behavioral Health Performance Measures (workplan activity 4.7)

   Activities are on target however barriers identified include: there were 35 non-ABA reviews in Q1 2023 and 34 were compliant with timeliness standards. Even though non-ABA authorization timeliness did not meet the 100% target, it exceeded the threshold for action of 95%.

V. Monitoring Activities for Special Populations

All monitoring activities for special populations are currently on target for this mid-year evaluation and no barriers were identified.

Next Steps:

Teams are continuing progress towards completion of all activities. Ongoing monitoring of interventions will be essential for all areas to ensure appropriate actions are being taken to meet goals.

Item #7

Attachment 7.B

2023 Utilization Management
Case Management
Mid-Year Work Plan Evaluation

CalViva Health
2023
Utilization Management (UM)/ Case Management (CM)
Mid Year Work Plan Evaluation

Last updated: September 8, 2023

TABLE OF CONTENTS

Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

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**	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 2023: **January:** Post Partum Depression **February:** Covid and the immunocompromised **March:** Palliative Care **May:** Riding the Waves of Change 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 are 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 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**	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 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**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire. Annual reminders will be distributed in Q3-2023. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None	None	Ongoing
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**	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 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**	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 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**	The 2022 Year End UM/CM Work Plan Evaluation, 2023 UM/CM Work Plan, 2022 UM Program Description and the 2023 CM Program Description were submitted and approved in Q1 2023. 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 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

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

☒ ACTIVITY ON TARGET

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

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

A Long-Term Care (LTC) Specialist Social Worker based in Fresno was onboarded in 2023 to support the transition to Skilled Nursing Facility (SNF). The LTC Specialist attends clinical rounds, engages with SNFs and supports acute hospitals with challenging discharges.

<table>
<tr><th></th><th colspan="3">Authorization Volume</th></tr>
<tr><th>Months</th><th>Approved</th><th>Denied</th><th>Modified</th></tr>
<tr><td>January</td><td>5171</td><td>810</td><td>53</td></tr>
<tr><td>February</td><td>4662</td><td>483</td><td>32</td></tr>
<tr><td>March</td><td>5719</td><td>941</td><td>42</td></tr>
<tr><td>April</td><td>4667</td><td>521</td><td>73</td></tr>
<tr><td>May</td><td>5284</td><td>535</td><td>66</td></tr>
<tr><td>June</td><td>6005</td><td>1035</td><td>72</td></tr>
<tr><td>Totals</td><td>31508</td><td>4325</td><td>338</td></tr>
</table>
</td>
<td>None identified</td>
<td>Q3-Q4: Contract, educate and train 49 Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) homes on how to work with the health plan in preparation for carve-in on 1/1/24.</td>
<td>Ongoing</td>
</tr>
</table>

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

<table>
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<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.

<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>96.85%</td><td>100%</td></tr><tr><td>Pre-Service Expedited</td><td>100%</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>N/A</td><td>N/A</td></tr><tr><td>Concurrent</td><td>100%</td><td>100%</td></tr></table></td><td>None</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2024</td><td></td><td></td><td></td><td></td></tr>
</table>

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**	Training focused on IRR testing CAP documentation and monitoring provided to leadership Q1-2023. IRR testing and training will be held Q3-4 2023	None identified	Repeat training to leadership regarding CAP documentation and monitoring in for IRR testing in Q3-2023.	12/31/2023
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

<table>
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<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 (184) and Balance Billing (2) appeals remain two top trends during the review period. The top two subclassifications were diagnostic – MRI (46) and Surgical - Arthroscopy with 26.

Same specialty matched physicians were engaged when appropriate.

Turnaround Time Compliance for resolved expedited and standard appeals was 100% for all 189 cases.
<table><tr><th colspan="3">2023 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>107</td><td>56.61%</td></tr><tr><td>Uphold</td><td>77</td><td>40.74%</td></tr><tr><td>Partial Uphold</td><td>4</td><td>2.12%</td></tr><tr><td>Withdrawal</td><td>1</td><td>0.53%</td></tr><tr><td>Case Total</td><td>189</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 2024</td><td></td><td></td><td></td><td></td></tr>
</table>

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

<table>
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<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.

Member Connections support of on-site bed side enrollment to be executed in Q4.
2023 Utilization goals established as:
• ALOS: 2% overall decrease
• Bed day per 1K: 2% overall decrease
• Readmission: 2% overall decrease

Key Indicator Report thru 6/30/2023:
<table>
<tr><th>Metric</th><th>2022</th><th>2023 Q1-Q2</th><th>% Change</th></tr>
<tr><td>Bed Days Acute PTMPY</td><td>238.2</td><td>216.3</td><td>-9%</td></tr>
<tr><td>Admits PTMPY</td><td>63.7</td><td>63.2</td><td>-1%</td></tr>
<tr><td>ALOS Acute</td><td>5.3</td><td>5.1</td><td>-4%</td></tr>
<tr><td>Readmit 30 Day</td><td>9.8%</td><td>9.2%</td><td>-6%</td></tr>
</table>
</td>
<td>SNF facility staffing continues to be a challenge which creates barriers to finding placement in SNF for some higher acuity patients leaving the acute hospital.</td>
<td>None</td>
<td>Ongoing</td>
</tr>
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<td></td><td></td><td></td><td></td>
</tr>
</table>

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

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☐ 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.

Q4 2022 – Q1-2023 Utilization (Q2 not yet available)
<table>
<tr><th>Metric</th><th>Q</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 rowspan="2">CVMP</td><td>Q4</td><td>106.7</td><td>642</td><td>6.01</td><td>15.60%</td><td>527.7</td></tr>
<tr><td>Q1</td><td>87.9</td><td>511.1</td><td>5.81</td><td>19.7%</td><td>536.6</td></tr>
<tr><td rowspan="2">MMN</td><td>Q4</td><td>68.9</td><td>368.2</td><td>5.35</td><td>14.20%</td><td>407.9</td></tr>
<tr><td>Q1</td><td>63.3</td><td>375.9</td><td>5.9.4</td><td>13.10%</td><td>422</td></tr>
<tr><td rowspan="2">Dignity /IMG</td><td>Q4</td><td>34.6</td><td>108.6</td><td>3.14</td><td>0.00%</td><td>401.4</td></tr>
<tr><td>Q1</td><td>16.5</td><td>134</td><td>8.1</td><td>0.00%</td><td>451.8</td></tr>
<tr><td rowspan="2">LSMA</td><td>Q4</td><td>61.2</td><td>317</td><td>5.18</td><td>9.70%</td><td>426.8</td></tr>
<tr><td>Q1</td><td>63.6</td><td>331.2</td><td>5.21</td><td>12.90%</td><td>442.7</td></tr>
<tr><td rowspan="2">SCP</td><td>Q4</td><td>79.9</td><td>400.6</td><td>5.01</td><td>16.20%</td><td>479.4</td></tr>
<tr><td>Q1</td><td>79.7</td><td>461.2</td><td>5.79</td><td>14.20%</td><td>501.1</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>• CVMP is working with a new MSO.
• LaSalle is also transitioning to new MSO on 09/01. Hiring continues to be a challenge for quality director and data positions with high staff turnover.
• Sante's quality director position is open since spring.
• Meritage cites financial difficulties in incentivizing providers for quality improvement. Paper-based charts and slow Cozeva adoption remain barriers. Cultural, linguistic and health equity concerns in serving diverse populations with unique needs and beliefs in accessing care.</td>
<td>• Working with palliative care vendor and CRMC to expand home based palliative care.
• Weitzman Diabetes ECHO series is ongoing to upskill providers in managing diabetes.
• ECM programs are improving.
• Working with providers in supporting workforce development.
• Leveraging QI EDGE funding for PPGs with funding problems.
• eConsults being leveraged to ease specialty access
• QI funding has been offered to Meritage for quality improvement initiatives with providers.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

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<td></td><td></td><td></td><td></td>
</tr>
</table>

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, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, 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**	Q1 2023 PPG Profile and Narrative was provided 05/22/23 and reviewed at MOM on 07/11/23 PPG's profile reports are made available quarterly. Q2 - 8/22/23 Q3 - 11/20/23, Q4 - TBD Q1 & Q2 Annual Reviews - La Salle Medical Providers had 1 CAP for Timeliness issue. - Meritage Medical Network – Central Valley had 1 CAP for Denial issue. Pending Annual Reviews for Q3 & Q4 - Adventist Health Plan - Central Valley Medical Group - Independence Medical Group - Santé Physicians IPA Medical Corp 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. Q4 2022-Q1 2023 Prior Authorizations:	• Specialty access continues to be a challenge for PPGs. • Sante Urgent TAT was below 95% in Q1 due to office closure on holidays. • Sante experienced high OON authorizations in Q1 due to transition from Community Health.	• Methodology updated to include: Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance. • We have partnered with provider network management to address delays in access. • Sante was educated on 72 hour TAT requirements and added provisions to address future holidays. • Partnered with new MSO and CVMP on opportunities for improvement and implementation of corrections were made and improvement seen in denial letter files post actions.	Ongoing

Q4-2022 PTMPY

PPG	AHP	CVMP	MMN	Dignity	LSMA	SCP
Total Auths	**1,274**	**1,714**	**525**	**528**	**900**	**106**
I-Net	1,192	1,669	510	520	895	77
OON	81	46	15	8	5	28
TAT % Compliance						
Urgent	100.0%	99.31%	99.51%	100.0%	99.69%	98.85%
Routine	99.95%	99.97%	99.88%	100.0%	100.0%	99.84%

Q1-2023 PTMPY

PPG	AHP	CVMP	MMN	Dignity	LSMA	SCP
Total Auths	**1,254**	**2,950**	**548**	**565**	**1,170**	**176**
I-Net	1,169	2,748	534	554	1,162	101
OON	85	202	15	11	8	74
TAT % Compliance						
Urgent	99.74%	95.79%	99.88%	98.63%	99.66%	93.79%
Routine	99.91%	97.44%	99.97%	100.0%	99.99%	98.91%

Annual Evaluation

☐ **MET OBJECTIVES**

☐ **CONTINUE ACTIVITY IN 2024**

4. 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**	Number of Health Information Forms (HIFs) completed in January-June by member and returned or Envolve People Care outreach was 3,751 and 541 members subsequently referred to Case Management through June. Total members managed through Q2 across physical, behavioral health, and Transitional Case Management programs was 2,529. 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 1/1/2023 & 3/31/2023 & remained eligible 90 days after case open date. 238 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 15.6% difference • Volume of ED claims/1000/year decreased by 1,200 • 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 20 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	Fewer than expected number of satisfaction surveys completed.	CM's to encourage members to take survey, gain preferred contact method by member for survey.	Ongoing
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**	Referrals increased from 439 in Q1 to 450 in Q2. Through Q2 565 members managed in PCM program. Quarterly average engagement rate remained steady at 43% in both Q1 and Q2. 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 2023 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 36 members met the outcome inclusion criteria for visits; 17 members met preterm delivery criteria • Members enrolled in the High Risk Pregnancy Program demonstrated: o 2.1% greater compliance in completing the first prenatal visit within their first trimester, o 4% greater compliance in completing their post-partum visit 0.5% less pre-term deliveries in high risk members	None identified	None	Ongoing
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**	Data reported is a subset of information provided in 4.1. Referrals to behavioral health program decreased from 235 in Q1 to 167 in Q2. Total members managed decreased from 307 in Q1 to 246 in Q2. Total members managed through Q2 was 419. Calendar Year engagement rate 68%. 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 and Q2 include members with active or closed case on or between 1/1/2023 & 6/30/2023 and remained eligible. Outcome results are consolidated across Physical Health, Behavioral Health, & Transitional Case Management programs and are reported in 4.1.	Reduced referrals from MHN and county partners as all referrals now handled via MHN process. MHN continues to refer members that need additional follow up.	Increased referrals from ADT reports	Ongoing
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

<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>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment YTD = 203.

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, per the below rankings. These 3 conditions continue to be among those with the top inpatient and/or ED visits.

<table>
<tr><th>Condition</th><th>Prevalence</th></tr>
<tr><td>Asthma</td><td>5th</td></tr>
<tr><td>Diabetes</td><td>3rd</td></tr>
<tr><td>Heart Health</td><td>10th</td></tr>
</table>
</td>
<td>None identified</td>
<td>The Q1 2023 Disease/Chronic Condition Management redesign proposal was put on hold.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2024</td>
<td></td><td></td><td></td><td></td>
</tr>
</table>

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**	UMQI reporting continues in 2023 based on the 2022 Medi-Cal RX changes and shift to medical benefit drug tracking. SHP Quarterly meeting topics for 2023: • Continuous view of Medi-Cal Rx program updates and status post implementation. Discussion of retirement of the 180 day transition policy and reimplementation of PA requirement by Medi-Cal RX DHCS audits completed • DSNP expansion in CalViva counties • Annual CMS DUR survey completed and submitted to DHCS with no errors reported. A&G trends and concerns reviewed for medical benefit drugs. QA/IRR results for medical benefit drug reviews in Q1 2023 completed and Q2 results are pending final review at the Q3 QI meeting.	None identified	None	Ongoing
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**	MHN has fully implemented the use of the DHCS Screening and Transition of Care Tools for members under 21 and for members 21 and over with Fresno, Kings and Madera counties. The adult and youth Screening Tools for Medi-Cal Mental Health (MH) Services determine the appropriate MH delivery system referral for members **not** currently receiving MH services. The Transition of Care Tool is utilized to ensure members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system. 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, 2023 through June, 2023, MHN received 339 referrals from Fresno, Kings and Madera counties. MHN referred 29 members to the county for Specialty Mental Health or Substance Abuse Services.	None Identified	Implementation of the DHCS provided Screening and Transition of Care tools. Implementation of an automated referral tracking system in the MHN care management system.	Ongoing

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**	In Q1 2023, 14 of the 15 metrics met or exceeded their targets. The Non-ABA authorization timeliness metric result was under 100%, but it exceeded the threshold for action of 95%. Q2 data is not yet available.	There were 35 non-ABA reviews in Q1 2023 and 34 were compliant with timeliness standards. Even though non-ABA authorization timeliness did not meet the 100% target, it exceeded the threshold for action of 95%.	None	Ongoing
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

<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 6%.

2023 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>8.70%</td><td>7.68%</td><td>7.81%</td><td>8.06%</td></tr>
<tr><td>Feb</td><td>8.19%</td><td>7.36%</td><td>7.39%</td><td>7.65%</td></tr>
<tr><td>Mar</td><td>8.14%</td><td>7.34%</td><td>7.38%</td><td>7.62%</td></tr>
<tr><td>Apr</td><td>8.11%</td><td>7.27%</td><td>7.34%</td><td>7.57%</td></tr>
<tr><td>May</td><td>8.06%</td><td>7.22%</td><td>7.32%</td><td>7.54%</td></tr>
<tr><td>Jun</td><td>8.07%</td><td>7.18%</td><td>7.28%</td><td>7.51%</td></tr>
</table></td><td>None identified</td><td>Leadership engage 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 2024</td><td></td><td></td><td></td><td></td></tr>
</table>

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**	Member stratification being conducted monthly using Impact Pro/related report to identify members for Integrated Case Management (ICM) as noted under 4.1. 842 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). 13,149 members were outreached from January through June 2023.	None identified.	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2024**				

Item #8

Attachment 8A

Population Health Management

Attachment X

Population Health Management Strategy Program Description

HEALTH NET – CALVIVA HEALTH

2023

Table of Contents

Introduction

The CalViva Health robust population health framework leverages community partnerships, clinical programming, and data analytics to strategically deploy resources to enhance the Member and provider experience, improve whole-person care, mitigate social determinants of health (SDoH), and match Members with clinical programs designed to serve their unique clinical, cultural, social, functional, and behavioral health needs.

This document describes the strategy for managing the health of the CalViva Health enrolled population. It provides an overview of how the needs of the population are identified and stratified for intervention, summarizes the population health management (PHM) programs used to address the needs of the population across the entire health and wellness continuum, and explains enabling strategies used to promote the transition to value-based care in its contracted network. We contract with providers to conduct assessments and integrate the results with care and care management processes.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for population health 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.

Population Needs Assessment (PNA)

We evaluate the needs of the enrolled population and uses that information to assess whether current programs need modification to better address the needs of our Membership. We examine data to evaluate the needs of Member subpopulations, including:

- Evaluation of the characteristics and needs of the Member population, including an analysis of the impact of relevant SDoH:
    - We assess the SDoH impacting our Membership through a geographic analysis using external data sources
    - We use an external SDoH tool, The California Healthy Places Index to create a custom selection using counties where we have Members.
    - We use the Healthy Places Index to determine regional SDoH performance on the following categories:
        - Economics
        - Education
        - Transportation
        - Social
        - Neighborhood
        - Clean Environment
        - Housing
        - Healthcare Access

- Evaluation of health status and risks by using utilization data broken out into cohorts based on NCQA and DHCS age-based stratification guidance.
- Evaluation of the needs of Members with disabilities:

  - Annually, a cohort of Members with disabilities are identified and assessed for needs to determine the appropriateness and adequacy of available clinical programs. A disabled Member is defined as needing assistance with Activities of Daily Living (ADL).
  - Identification criteria example: Members with one or more of the following: 1) Power Wheelchair 2) Home Hospital Bed 3) Hoyer Lift 4) In Home Supportive Services.
  - Analysis of this cohort consists of diagnostic categories and utilization trends for acute inpatient admits, readmits, and emergency department utilization.
- Evaluation of the needs of Member with Severe and Persistent Mental Illness:
  - Annually, a cohort of Members with severe and persistent mental illness are identified and assessed for needs to determine the appropriateness and adequacy of the available clinical programs. Severe and persistent mental illnesses are defined as diagnosis such as schizophrenia, psychosis, and bipolar disorder.
  - Identification criteria example: Members prescribed one or more of the medications on the Health Effectiveness Data and Information Set (HEDIS) schizophrenia, schizoaffective disorder (SSD) National Drug Code (NDC) list (See attachment in "Appendix A").
  - Analysis of this cohort consists of diagnostic categories and rates of acute inpatient readmits, emergency department utilization, and those receiving at least 2 outpatient medication management visits in 12 months.

PNA Activities

When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources to meet the unique needs of our population and offer timely services and supports. In addition, there is an evaluation of the extent to which PHM 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.

Stakeholder Engagement

Public Policy Committee (PPC) participants help serve as advisors to PNA development, and implementation of the PNA action plans. CalViva will continue to employ multiple approaches to inform contracted providers of PNA highlights and recommendations. Communication channels may include:

- Provider Updates: Provider Updates extend immediate information to the provider network, which include Physicians, Participating Physician Groups, Hospitals, and Ancillary Providers. Provider Updates are also available online through the provider portal.

- Provider On-Site Outreach: The Provider Engagement team conducts site visits regularly, allowing opportunities to discuss with providers PNA findings and recommendations.

- Community Provider Lunch and Learns: Lunch and Learn sessions bring together multiple providers in a community setting, planned regularly throughout the year. Hosted by Provider Engagement, these events provide important health plan program updates and information to support providers in better servicing their patients. PNA findings will be shared with those in attendance. Provider feedback about the PNA and/or proposed action plans will be considered for further enhancement.

- Available Online: For easy access to our members and community stakeholders, the PNA report will be available on the health plan's website.

Population Stratification

Population stratification is performed to support clinical decision making both at the point of care, as part of resource allocation and healthcare management to improve patient outcomes. PMH risk stratification segmentation and tiering (RSST) algorithms include clinical and sociodemographic variables, bias testing using Delta (quantitative method), and measures of healthcare utilization. Data sources, clinical criteria, and stratification tiers are reviewed periodically to ensure the PHM approach incorporates feedback from different departments including medical directors, provider and member engagement teams which allows for continuous improvement. Data elements and standards used in RSST are compliant with NCQA PHM standards.

The RSST approach and Health Equity Improvement Model (HEIM) is designed to avoid and reduce biases to prevent the exacerbation of health disparities and address inequities in a variety of ways, including urban versus rural; race, ethnicity, and language; and the unhoused and special needs population. We combine data from multiple sources and multiple data points (like race, ethnicity, primary language, disability data, social risk information, social determinants of health, comorbidities, and mental health issues) for RSST of the population and obtain a 360 view of population needs and strengths. Our bias tested PHM model considers:

- Screening or assessment data
    - Screenings and assessments data is captured by our Health Information Form and additional screening conducted by the Plan including SDoH survey, CalViva Pregnancy Program (perinatal/postpartum program including maternal risk: history, age, or SUD) screening data etc. The inputs from the form are incorporated into member level data to assign members based on RSST model as well as at an aggregate population health level data set.
- Claims and Encounter data, including Fee-For-Service data
    - Claims and encounter data, including Fee-For-Service data is captured by various sources of data and based on member's utilization pattern (High Utilizer, Prospective High Utilizer) members are assigned into appropriate category and that flows into our RSST model.
- Available social needs data
    - CalFresh, WIC, CalWORKs, In Home Services, Z-Codes and Supports (IHSS), Safety risk factors (e.g., available caregiver support and environment) are captured from various sources of data and incorporated into our RSST model.
- Electronic health records
    - Electronic Health Record (EHR) data is captured by EHR integration as well as other data feeds and using that information members are assigned to appropriate category; this data feeds into and informs our RSST model.
- Referral data
    - Referral data is captured by Find Help/Community Connect, customer contact center data, provider portal, authorization data, and other sources. Referral data is being used for identifying individuals who are at higher risk for adverse health outcomes or high healthcare costs. Using referral data, the model identifies members who have been referred to specialists or specialty services for high-risk conditions such as cancer, heart disease, or chronic illnesses. Subsequently, based on frequency and intensity of healthcare services need, the members are assigned to certain category

including members who require more coordinated and managed care of PHM model. Referral data combined with other member data, such as demographics, claims history, and clinical data is being used for risk stratification.

- Behavioral Health data (including SBIRT and other SUD data)
    - Behavioral Health data is captured by data exchange agreement to establish secure data exchange with all contracted counties to obtain Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health Services (SMHS) data available through the Short-Doyle/Medi-Cal claims system by use of HIE, secure file transfer protocol (SFTP), or other means to then be incorporated into RSST. We are also capturing Behavioral Claims from our Behavioral Health administrator to capture mental health needs of our members and assigning members to a PHM category based on their need.
- Pharmacy data
    - Pharmacy data is captured via data feed from Magellan/Okta portal. Pharmacy data helps to determine a member's adherence to prescribed medications. Poor medication adherence is associated with adverse health outcomes. Using pharmacy data, we identify individuals who are non-adherent to their medications, which may indicate a higher risk for future health complications or hospitalizations and this information is being used for the RSST model. In addition to medication adherence data, pharmacy data is also being used to identify members with chronic diseases who are prescribed specific medications for disease management. By analyzing medication usage patterns, we are identifying individuals with suboptimal disease control, escalating medication needs, or frequent medication changes. These members may require additional support and care management to optimize their disease management and reduce the risk of complications. This information is also being used in the RSST model.
- Utilization data
    - Utilization data is captured via claims and encounters data. Utilization data helps to identify individuals with frequent or intensive healthcare service utilization. This includes emergency department visits, hospital admissions, and outpatient utilization. Members with high utilization patterns are often at a higher risk of future healthcare utilization or adverse health events. Utilization data provides us insights into the level of care coordination and management required for individuals.

      Utilization data highlight the extent to which individuals engage in preventive services such as vaccinations, screenings, or wellness visits. Low utilization of preventive services may indicate an increased risk of undiagnosed or unmanaged health conditions. Targeting interventions towards individuals with low preventive service utilization helps us identify and address potential health risks earlier. Utilization data helps to identify individuals who utilize high-cost healthcare services, such as expensive procedures, specialty medications, or complex surgeries. Individuals with high-cost service utilization are more likely to have higher healthcare costs and may require targeted interventions to manage costs and improve outcomes.
- Disengaged Member reports (e.g., assigned Members who have not utilized any services)

    - Disengaged member reports are captured via our zero encounters (zero encounter / no office visit / no utilization members) report. The monthly Zero Encounter enables the Plan to reconnect members to care, tracking disengagement with PCP.
- Lab results data
    - Lab results data is captured via EMR integration, quality data, among other sources.
- Admissions, Discharge and Transfer (ADT) data
    - ADT data is captured via HIE connections with various facilities and providers.
- Race/ethnicity data
    - Race/ethnicity data including disparity data is captured from various sources of data including but not limited to member enrollment data, customer contact center data.
- Sexual orientation and gender identity (SOGI) data
    - SOGI data is collected from our customer contact center data and we are in the process of identifying sources for collection of SOGI data.
- Oral health data:
    - We receive a data feed from DHCS that includes dental claims.

Our algorithms include bias testing and stratify our entire membership into a Risk Tier (low, medium, and high) and CM level (Level-1 to Level-5) to assign appropriate resources, interventions, and programs. To identify SDoH need, we have used:

- ICD 10 Z-Code from Claim,
- Encounter data,
- Admission discharge and transfer (ADT) data;
- TruCare Assessment including health risk assessment (HRA),
- SdoH Mini-screen;
- Other data feed including State eligibility data, (San Diego (SD)211 etc.)

The SdoH report allows to drill down into the SdoH needs of selected geographies and/or subsets of membership.

In addition to Risk Tier and level, PHM also include information from Impact Pro, a predictive modeling tool that uses multiple data sources that are stored in the data warehouses (EDW and ODW or Snowflake). In addition to Impact Pro, a web-based customizable report generating system, Micro Strategies, is used to produce adjunctive analytical reports that support tracking of goals of clinical programs. 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.

Additionally, we use our system, Impact Pro, to segment and risk stratify the entire enrolled population into meaningful subsets for targeted interventions. These subsets, or levels, are listed below with detailed descriptions in the appendix. This system is used on a regular basis (weekly or monthly)to identify, enroll, track and coordinate eligible Members for clinical programs. Information about the process used is defined in the description of specific programs in the sections which follow.

We conduct continuous improvement evaluation and the incorporation of inputs that explicitly aim to reduce bias or existing disparities that may exist in basic cost or utilization data (e.g., care gaps,

ambulatory care sensitive conditions, underutilization of primary care). We have found and rectified biases in utilization data, for example: prioritization based solely on high utilization, access to care by zip code, or homeless members with no utilization.

Upon enrollment, the Health Information Form (HIF)/Member Evaluation Tool (MET) is completed within 90 days of enrolling new members. Enrolled populations are further broken out into Population Health Analytic Groups designed to segment the entire population into mutually exclusive categories based on their utilization pattern (institutional, pharmacy, behavioral health), acute events, co-morbidity, risk scores and any clinical indications use the Member's most recent 12 months of claims and pharmacy history and care gap information. With each monthly refresh of the Population Health Analytic Grouping, each Member is reassessed based on the most up-to-date utilization information and may be re-classified to a new grouping. The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in Members' health status or level of care and in this way, Members are monitored to ensure appropriate re-stratification.

We will provide DHCS, upon request, our processes to identify significant changes in member's health status and appropriate re-stratification via this Strategy Description.

We monitor the penetration rate of PHM Programs and Services by Tier including the number of members by risk tier who need further assessment and received it, and who were enrolled in eligible programs.

We define a significant change in health status and/or a change in a member's level of care monthly. Each Member is re-assessed based on the most up-to-date utilization information and therefore may be re-classified to a new grouping. We also deploy industry leading SdoH data analytics to inform our PNA and PHM interventions. The PNA will be similar to previous years and will include information spanning the needs of our entire Member population.

The goals of PHM are to improve health conditions of current patients, understand patient needs that might have been overlooked, design better health services, make better use of resources, prevent diseases and predict future health issues. To achieve the goal and effect on outcomes, we monitor PHM performance using a Key Performance Indicators (KPI) report. The KPI includes:

- Admit/K,
- Emergency room (ER)/K,
- Readmission %,
- Ambulatory Care Sensitive Admissions (ACSA) %,
- Average Length of Stay (ALOS),
- Days/K,
- Avoidable ER%,
- Per member per month (PMPM) Cost,
- PMPM Cost by Service Category, and
- Pharmacy (Rx) Utilization
- DHCS PHM monitoring requirements

Along with that we also use SdoH dashboard to track and trend Member SdoH needs.

We use these reports to set benchmarks, identify outliers and high performing Providers, address performance issues, share best practices, and invest in additional capacity.

- Members are assessed/re-assessed who are/have:
  - Seniors and Persons with Disabilities (SPD)
  - Receiving: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) Services
  - LTSS needs
  - Entering Enhanced Care Management (ECM), Complex Care Management (CCM)
  - Children with Special Health Care Needs (CSHCN)
  - Residing in acute hospital
  - Hospitalized w/in 90 days or 3 + hospitalizations in last year
  - 3 + ER visits in last year w/ high utilization of services (e.g., multiple Rx for chronic diseases)
  - BEH dx or developmental disability and > 1 chronic medical diagnoses or social need (e.g., homelessness)
  - Multiple Outpatient Surgeries
  - Readmission risk
  - Preventable Admit
  - Avoidable Emergency Use
  - Multiple prevalence conditions including end stage renal disease (ESRD), acquired immunodeficiency syndrome (AIDS), or recent organ transplant, Cancer, Asthma, Diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), serious and persistent mental illness (SPMI), serious emotional disturbance (SED), Opioid use etc.,
  - Pregnancy state
  - On antipsychotic medication
  - On 15 or more prescriptions in the past 90 days
  - Self-report of a deteriorating condition
  - Other conditions as determined based on local resources.

- We work with network providers for shared decision making with the member about the services a member needs, including through use of real-time information

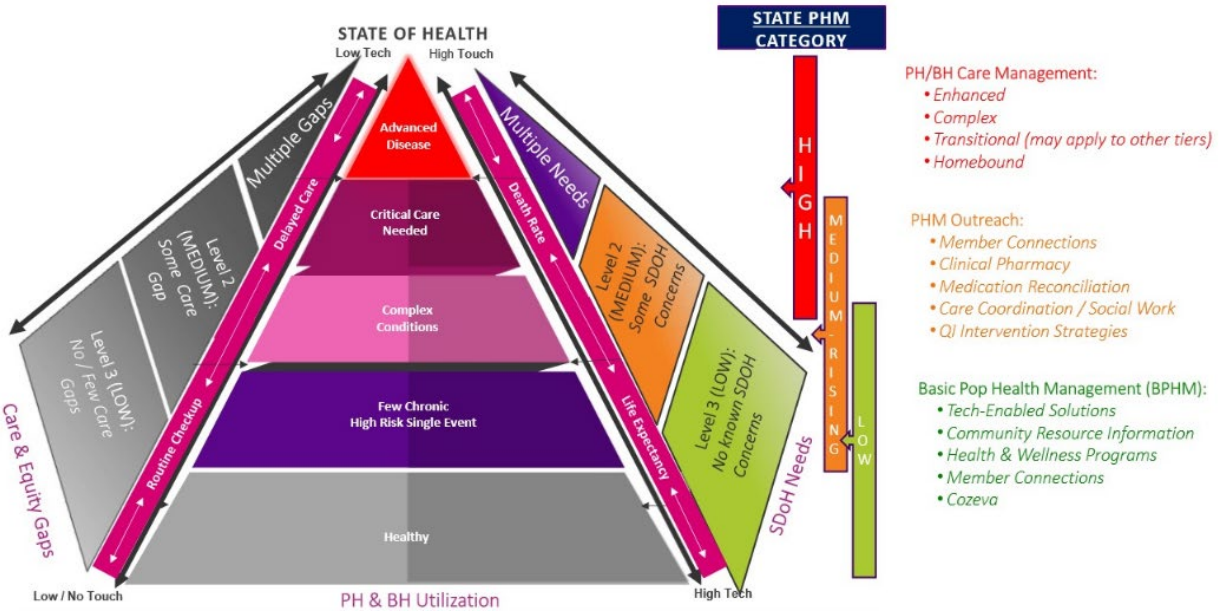
Once the statewide RSST and risk tiers are available through the PHM Service, at a minimum Members who are identified as high-risk through the PHM Service will be assessed.

ImpactPro Population Health Categories* consist of the following:

- 01: Healthy
- 02: Acute Episodic
- 03: Healthy, At Risk Level and
- 04A: Chronic Big 5 Stable
- 04B: Chronic Other Condition Stable
- 04C: BH Primary Stable
- 05A: Health Coaching
- 05B: Physical Health CM
- 05C: Behavioral Health CM
- 06: Rare High Cost Condition
- 07A: Catastrophic: Dialysis
- 07B: Catastrophic: Active Cancer

- 07C: Catastrophic: Transplant
- 08A: Dementia
- 08B: Institutional (custodial care)
- 09A: LTSS and Medicare-Medicaid Plan (MMP) – Service Coordination
- 09B: LTSS and MMP – High Needs Care Management
- 10: End of Life

* Definition of each category appears in "Appendix C".



A description of subsets and the type of intervention offered to Members is described in the PHM Programs and Services portion of this document below.

PHM Programs and Services Overview

Basic Population Health Management (BPHM)

Health equity is a guiding principle. Population Health Management (PHM) is the framework to achieve health and wellness for all, free from barriers, using the Health Equity (HE) Improvement Model to identify and design community-anchored interventions. We offer BPHM services that promote health equity and aligns with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A multi-pronged, non-delegated, empanelment approach is used for BPHM which directly facilitates connections to primary care. New Member welcome packets are sent to ask Members to schedule their initial health appointment (IHA), and conduct new Member outreach to facilitate appointment scheduling, and survey Members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new Member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who don't select a PCP

within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible Members are not required to select a PCP).

A proactive outreach to Members without a PCP visit in the past year is used to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach Members, including those with unstable housing or no phone, are assigned to the MemberConnections® Field Team for in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant). Native American Members can select an Indian Health Services (IHS) Provider within the 'network as their PCP. SPD Members may select a Specialist or Clinic as a PCP if they are qualified. PCPs are notified of Member assignments within 10-days from selection/assignment by file sharing and provider web portal.

We use KPIs (e.g., encounters, Member engagement, HEDIS care gaps) and stratifications to address disparities in PCP engagement including identifying Members with open HEDIS care gaps for targeted outreach campaigns. Our Modeling Engagement project predicts levels of Member engagement, stratifies Members into 4-categories of likeliness-to-engage based on engagement history and tracks both PCP and Member engagement. This project informs the 'outreach approach, including monthly Care Gap reports distributed to provider, which helps prioritize and adapt outreach. The monthly Zero Encounter enables us to reconnect Members to care, tracking disengagement with PCP. We also stratify data to identify health disparities and are excited to leverage community health workers and doulas to ensure outreach is targeted with a focus on advancing health equity, and that post-partum Members are supported for their newborn pediatrician visits into the first year of life.

On a monthly basis, we review disengaged Member reports to proactively identify Members who have not established care with their PCP in the last 12 months. Then, we match Members to the level of support needed leveraging our Population Health telephone outreach teams to connect Members to PCP, or MemberConnections Field Team (our field-based team that performs proactive home visits), assigning continuous support, reporting disengaged Member who have not received their IHA to providers, and introducing Member engagement strategies such as Cozeva, quality improvement projects, and discussions during Joint Operations Meetings (JOM). Support is available over the phone, through self-service tools, and in the field, leveraging Member Services, Care Management, Community Engagement, and Health Education staff.

Key aspects of member navigation support include:

- Establishing a relationship with a usual source of care through their PCP that meets Member's geographic, clinical, and cultural needs.
- Ensuring PCPs have successfully engaged Members in ongoing care and are familiar with the holistic needs of the Member, through systematic monitoring of the initial health appointment, preventive visits every 12 months, care gaps, and sharing insights with PCPs. Our provider engagement teams, who perform onsite and virtual meetings with providers, regularly encourage providers to leverage engagement strategies, provide them disengaged Member lists with contact information, engage ability scores, and provide routine progress on how well engaged their Member are with required care. Providers can request funding to address specific barriers to engaging Members.
    - As part of the implementation of the Community Health Worker (CHW) benefit, providers are encouraged to leverage new ways to support Members who have significant clinical needs, health equity or SDoH barriers, or are lost to follow up
    - Members and their family are supported with community resources and carved-out services

- The Quality Improvement Team supports systematic evaluations to assess why Members are not engaged with their PCP or other healthcare needs and provide findings to the engagement team and providers for intervention. Providers are not delegated responsibilities, however, are provided with incentive and support tools to engage and outreach to Members.
- We use a quality and health equity framework to ensure all Members under age 21 receive all screening, preventive and medically necessary diagnostic treatment services and immunizations required by early periodic screening, diagnosis and treatment (EPSDT), American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and the ACIP Childhood Immunization Schedule. Our strategy includes 1) service tracking and early identification, 2) connecting to services, and 3) meaningful innovation to continuously improve outcomes with a focus on the life course perspective. To achieve this, we:
    - Invest in preventive programs, coordinate/collaborate with Local Health Departments, Local Government Agencies, and local organizations to address SDoH and identified health disparities.
    - Support Members with culturally relevant health education, Member incentives; reminder outreach programs; and community engagement to promote prevention, screening, remove SDoH barriers.
    - Activate our plan CHW model to work with families with historical gaps in screenings to proactively outreach and remove barriers.
    - Prioritize partnerships with Providers to support our effective EPSDT program. Our pediatric Providers receive training and support tools to help identify care gaps timely and are audited for adherence to medical record requirements including EPSDT services. We incentivize providers for quality care and provision of preventive services, including EPSDT.
    - Track and report EPSDT screenings, AAP Bright Futures and ACIP Childhood Immunization periodicity adherence and monitor follow-up service needs. Tracking and stratification are at the population, community, subpopulation, and individual Member level. KPIs include annual and monthly HEDIS metrics (e.g., W30 (Well-Child Visits in the First 30 Months of Life) , WCV (Child and Adolescent Well-Care Visits), CIS (Childhood Immunization Status), IMA (Immunizations for Adolescents), AAP (Adults' Access to Preventive/Ambulatory Health Services), IHA). Additional claims/encounters codes are evaluated for specific assessments and screenings (e.g., Oral Evaluation, Dental Services (OED), topical fluoride for children (TFC)).

We monitor utilization patterns including preventive services, ER/admissions, PCP visits, and the use of behavioral health services, as well as condition/situation specific outcomes by race/ethnicity to evaluate and improve the effectiveness of ECM, CHWs and other PHM programs in improving health outcomes, reducing disparities, and achieving health equity.

Transitions of Care Program

The purpose of the Transitions of Care Program (TOC) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care with an identified care manager as the single point of contact for all transitional care management services. Communication of care management assignment and Care Manager Responsibilities (including: Information sharing, Discharge risk assessment, Discharge planning documentation, Medication reconciliation, Referrals) are addressed when updating the Transitions of Care policy and procedures. 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 TOC 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.

PHM Programs and Services

We offer several PHM programs and services to its enrolled Members:

Program Name	Eligible Population
Improve Preventive Health: Flu Vaccinations	All Members 6 months and older, especially high-risk populations
Improve Preventive Health: Breast Cancer Screening	Women ages 50-74 years
Improve Behavioral Health: Depression and Antidepressant Medication Management a bidirectional data exchange process	Members ages 18 and older that have been newly prescribed antidepressant medications and are diagnosed with major depression
CalViva Pregnancy Program	Pregnant Members at risk for complications of pregnancy as determined by having an NOP score >34 and/or provider determination
Care Management	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health.

Program Name	Eligible Population
Palliative Care	Members with chronic, severe, progressive or terminal illness
Transition Care Management	Members with high complexity profile: Member is inpatient with anticipated discharge or recently discharged, hospital readmissions risk, 2 or more admissions within the past 6 months, 3+ emergency department visits within the past 6 months, multiple medications/high cost medications/high-risk medications, recent catastrophic event or illness, unmanaged/poorly managed chronic or behavioral health issues, psychosocial issues/barriers impacting access to care and/or services, history of non-compliance and/or complexity of anticipated discharge
Chronic Condition Disease Management	Members with Asthma, COPD, Diabetes, Cardiovascular Conditions, and Heart Failure
Chronic Condition Management: Substance Use Disorder-Opioid (SUD-O) Program	SUD-O program timely/effective care in collaboration with providers for members on dangerous combinations (benzodiazepines, opioids, muscle relaxants, other), high doses and prolonged use.
Tobacco Cessation – Kick It California	Members 13 years and older
Diabetes Prevention Program	Members 18 years and older with pre-diabetes and/or abnormal glucose.
Diabetes Management Program	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Cardiac + Diabetes	Members that have diabetes with hypertension and/or cardiovascular disease
Fit Families for Life – Home Edition	Adults and children
Health Information Form	All Members
Health Risk Questionnaire	Members 18 years and older
Digital Behavioral Health Platform (MyStrength)	Ages 13 years and above - Mental health and substance use (behavioral health) educational support for depression, anxiety, substance use, pain management, and insomnia/sleep health
Behavioral Health Care Management	All members
Chronic Condition: Congestive Heart Failure (CHF)	Members with Congestive Heart Failure diagnosis with pharmacy claims who are either not adherent to their medications, have ER visits in the last 12 months, or both
Chronic Condition: Respiratory Conditions (Chronic Obstructive Pulmonary Disease (COPD) and Asthma)	Members with Chronic Obstructive Pulmonary Disease or Asthma diagnosis with pharmacy claims who are either not adherent to their medications, have ER visits in the last 12 months, or both
Emergency Room Diversion Program	Members visiting the ER for avoidable chief complaints
Chronic Condition: Oncology	Members with diagnosis of breast, prostate or colon cancer with pharmacy claims who are either not adherent to their medications, have ER visits in the last 12 months, or both

Program Name	Eligible Population
Chronic Condition Management App	Maternity Members
Telemedicine	All Members
Telemedicine	All Members

Focus Areas

Programs related to the four focus areas are described in greater detail below.

Improve Preventive Health: Flu Vaccinations	
Eligible population:	All Members 6 months and older, especially high-risk populations
Focus area:	Keeping Members healthy
Program goal(s):	Reach or maintain (≥50% and <55%) for CAHPS Annual Flu Vaccine Question (Yes Response)
Program services:	Member education promoting flu vaccination through: ○ Emails ○ Proactive Outreach Manager (POM) messaging ○ Boosted Facebook posts ○ Adult flu shot flyer ○ Web landing page and web pop-up/notification banner
Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations, enrollment data

Tobacco Cessation	
Eligible population:	Members 13 years and older
Focus area:	Keeping Members Healthy
Program goal(s):	Increase member participation in smoking cessation programs by 5% from prior year.
Program services:	CalViva Health 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. 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.
Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations using ICD-10 identifiers. Program is opt-in. Members can also be referred by their PCP, or Care Management.

Improve Preventive Health: Breast Cancer Screening	
Eligible population:	Women ages 50-74 years
Focus area:	Managing Members with Emerging Risk
Program goal(s):	Meet/exceed the Quality Compass national 50th percentile for reporting year (RY)
Program services:	Member education promoting breast cancer screenings through: • Mobile mammography events
Methods and data sources used to identify the eligible population	HEDIS care gap reports, enrollment data

Diabetes Management Program	
Eligible population:	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Focus area:	Managing Members with emerging risk
Program goal(s):	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: • CDC >9
Program services:	Member education on diabetes management through – o Social media post to create awareness to members and community for heart health, diabetes and medication adherence o Diabetes Pocket Guide will be sent to targeted Members with diabetes via either email or mail o Pharmacy medication adherence outreach by phone o Live calls to Members that have not completed A1C testing to offer A1c home test kits o Multi-gap live calls

	Provider partnerships on diabetes management o Project ECHO® - Collaborating with Wietzman Institute to offer 12 session ECHO series to primary care providers managing diabetes care in rural counties of CA. o Provider tipsheets on HEDIS Diabetes measures: HBD (Hemoglobin A1c Control for Patients With Diabetes), EED (Eye Exam for Patients With Diabetes), BPD (Blood Pressure Control for Patients With Diabetes) and KED (Kidney Health Evaluation for Patients With Diabetes)
Methods and data sources used to identify the eligible population	HEDIS care gap reports, pharmacy claims

CalViva Pregnancy Program (CPP) / High-Risk Obstetrics (OB) CM	
Eligible population:	Pregnant Members at risk for complications of pregnancy as determined by having a notification of pregnancy (NOP) score >34 and/or provider determination
Focus area:	Patient safety or outcomes across settings
Program goal(s):	- Members managed in OB program have 5% greater completion of the 1st pre-natal visit within the 1st trimester or 42 days of enrollment than pregnant Members not managed. - Members managed in OB program have 5% greater completion of the post-natal visit between 7-84 days post-delivery than pregnant Members not managed. - High-risk Members managed have 2% lower rate of pre-term delivery than high-risk Members not managed. - Member experience survey – each question and overall >90%
Program services:	Care manager completes the CPP OB CM Assessment, Edinburgh Depression Screen, Post-Partum Assessment with Member. - Education Materials are sent to Member - Members who received a medium or high score receive outreach to be enrolled in High-Risk OB Program - The OB Care manager coordinates care with the BH Care manager for Members with behavioral health needs.
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims

Improve Behavioral Health: Depression and Antidepressant Medication Management	
Eligible population:	Members ages 18 and older that have been newly prescribed antidepressant medications and are diagnosed with major depression
Focus area:	Patient safety or outcomes across settings
Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® antidepressant medication management (AMM) Acute and Continuation Phase of Treatment Measure

Program services:	Behavioral health administrator live calls to members that were newly prescribed antidepressant medications, diagnosed with major depression, and are showing refill gaps between 15 to 50 days, for members in Kings and Madera counties
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, pharmacy claims, Membership data

Cardio-Protective Bundle Project - SHAPE	
Eligible population:	Members that have diabetes with hypertension and/or cardiovascular disease.
Focus area:	Managing multiple chronic illnesses
Program goal(s):	Improve cardio-protective bundle medication adherence by performing successful outreach to 1550 Members annually who were flagged for non-adherence and provide education/counseling to encourage compliance
Program services:	Member education and outreach through - o A "live call" by health care coaches to engage the Member and help ensure that they are compliant with their medications. The health care coaches, consisting of pharmacists, diabetes educators, nutritionists, or dieticians, can conduct follow-up visits as needed. o Multimodal communications: online newsletters and mailings. o Connecting Members with care management and disease management.
Methods and data sources used to identify the eligible population	Medical claims, encounter data, pharmacy claims

Care Management	
Eligible population:	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health. A predictive modeling tool, reports and health risk screening are used to identify Members who have higher risk and more complex health needs. Members may self-refer and/or be referred to the program by other internal and external entities. The person-centered approach allows us to link Members to a tailored variety of Complex Care Management (CCM) programs and interventions (inclusive of BPHM) to address Members' unique needs. Types of interventions and conditions the Program addresses include: health promotion, disease management, maternal and child health, Behavioral Health (BH), telehealth, transition of care, palliative care, oncology, nursing facilities, and ED diversion. Depending on the Member's preferences, the CCM program uses a variety of communication modalities to initiate and sustain Member support (e.g., in-person contacts, face-to-face virtually, calls, texts, email). Using Digital Health Connect, this Member-friendly mobile app solution drives deeper Member engagement, self-care, and ease of secure communication.

Focus area:	Managing multiple chronic illnesses
Program goal(s):	• Member experience survey – each question and overall > 90% • Reduce Non-Emergent ER Visits > 3% annual • Reduce Readmissions > 3%
Program 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 (CM):** 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. If the CM program is delegated to the Participating Physician Group (PPG) and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up. **Complex Care management:** 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. If the CM program is delegated to the PPG and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims, focused Population Health Management reports, referrals

Care Coordination

We provide care coordination to our members from each of the following populations based on the member needs that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

- Mental Health Plans (or specialty mental health system): We coordinate care through interdisciplinary care team (ICT) discussions with MH resources and with the county Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) to address the holistic needs of members including transitioning between SMHS and NSMHS. CM provides education on and referrals to SMHS and NSMHS. For members who are medically and BH

complex, we perform an ICT round, and work with the county to coordinate care. We monitor individual cases, and we also have enhanced and global reporting on trends across cases for provision to providers. We can now track how many members have been linked to BH Therapist and/or Psychiatrist, as well as how many members we facilitated ICT meetings with county Mental Health Providers for SMI services.

- Drug Medi-Cal or a Drug-Medical Organized Delivery System: CM and Clinical Pharmacy refers members to appropriate level of care/provider for SUD needs. CM staff outreach to Drug Medical provider to ensure member needs are being addressed. ICT meetings scheduled as needed.
- Long Term Services and Supports (LTSS), including 1915(c) waivers and In-Home Supportive Services: CM staff will refer to our dedicated Public Programs team who specialize in supporting LTSS members. In addition, CM staff educate the Member on IHSS and supports the Member through the IHSS application process. Finally, we outreach to the Member's PCP or specialist to help advocate for member and encourage the provider to complete the remaining components of the IHSS and Physician Certification Statement (PCS) forms as necessary. In 2023 we are implementing additional KPIs to improve monitoring and tracking of care coordination outcomes (e.g., coordination with providers, facilitating referrals, linkage to services).
- CBAS: We measure completion of Face-to-Face assessment within 30 days of notification for CBAS and we review the reassessments completed by CBAS every 6 months to determine appropriateness and program eligibility.
- LTC: We review the annual assessments completed by LTC to determine appropriateness and eligibility.
- Waiver Programs: We make referrals to waiver programs, as appropriate, and partner with waiver agencies for all care coordination opportunities.
- Overarching CM supporting: CM staff complete Health Risk Screenings with members to help identify when additional support may be needed. CM staff refer members to any of the programs above including ECM or CS (if member meets population of focus). CM staff outreach to providers to coordinate care, share assessment information as needed, and case conference as appropriate. CM provides members with information for community and social services based on recommendations from the Interdisciplinary Care Team (ICT). CM also assists the members with 3-way calls to those entities or submits referrals on the member's behalf. The CM team primarily interfaces with providers and outside entities telephonically and by secure email.

External partnerships

Entity	Description:
Schools and Local Education Agencies	CalViva Health has agreements in place with three Local Education Agencies (LEAs), Fresno County Office of Education (FCOE), Fresno Unified School District (FUSD) and Clovis Unified School District (CUSD). We will be working to execute memorandum of understandings (MOUs) with LEAs in all service areas under the new State contract requirements. We meet regularly with FCOE, FUSD and CUSD, and will maintain, at minimum, quarterly engagement with LEA partners in all service areas under the new State contract requirements as well. CalViva Health partnership activities with schools and LEAs include, but are not limited to, participation in on-site health fairs, support for back-to-school events and trainings, etc. We also provide grant support to schools and LEAs for workforce

	training and development, as well as infrastructure and support for the expansion of telehealth services in schools. We do not currently participate on any School or LEA boards, but this is something in which will look to more involved in the future.
Local Health Departments	MOUs with all local health departments in our services areas and meet with them quarterly. Example of how Plan and LHDs work together include but are not limited to: Collaborating to ensure COVID-19 vaccinations were/are available to homebound members; Collaborating to deliver provider trainings (e.g., CPSP); Collaborating to deliver certain member-facing events (e.g., breastfeeding mom's lunch and learn).
California Work Opportunity and Responsibility to Kids (CalWorks)	Plan provides warm-handoffs and referrals to support our members who can benefit from CalWorks services. Example of warm-handoff: While speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalWorks program, we will 3-way call the CalWorks Customer Service number (California Department of Social Services) and connect our members to a CalWorks representative to ensure our member is connected to CalWorks benefits.
CalFresh	Plan provides warm-handoffs and referrals to support our members who can benefit from CalFresh services. Example of warm-handoff: While we are speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalFresh program, we will 3-way call the California Department of Social Services and connect our member to a CalFresh representative to ensure our member is connected to CalFresh benefits.
Women, Infants and Children (WIC) Supplemental Nutrition Programs	CalViva Health has an MOU in place with Fresno Economic Opportunity Commission (EOC) concerning the arrangement and coordination of Women, Infant, and Children Supplemental Nutrition Program (WIC) services to CalViva members who are enrolled in Fresno County.
First Five programs and providers	Plan works with First Five through local health departments. We participate in coalitions and help establish processes for local programs. We meet on an as-needed basis. We provide First Five with sponsorships as needed or requested.
Early Start	Plan works with Early Start through local health departments. We participate in coalitions and help establish processes for local programs. We meet on an as-needed basis. We provide Early Start with sponsorships as needed or requested.
Supplemental Security Income (SSI)	Plan provides warm-handoffs and referrals to support our members who can benefit from SSI services. Warm hand-off Example: While we are speaking to a member on the phone, and we identify through listening to our member that they might be eligible for SSI, we will 3-way call the Social Security Administration and make an appointment for our member to apply for SSI. 2. We do not provide

	financial support or investments to SSI. 3. We do not have involvement with SSI boards or governance structures.

Activities Which Support PHM Programs and Services

In order to support network providers as they strive to achieve their population health management goals, we provide the following:

Delivery System Supports

Data and information sharing with practitioners

We share an extensive amount of data with providers partners. Data shared with providers includes pharmacy, enrollment, care gaps, claim/encounters, financial, and various utilization (inpatient, outpatient and ED) information. In addition, disease management program enrollment reports are also shared with our strategic provider partners. Data is shared at various frequencies (daily, weekly, monthly, yearly) via the Plan provider portal, secure email, SFTP, fax or mail. The method of data transmission varies based on the data being shared as well as provider preference. We exchange admission, discharge transfer (ADT), Observation Result (ORU), and consolidated clinical document architecture (C-CDA) data through Health Information Exchanges (HIEs).

We are in the process of implementing additional bidirectional data exchange processes with other CoCs as well as exchanging Behavioral Health data with various counties across California throughout 2023.

We have improved our IT Capabilities under the umbrella of our Cal Aim program including:

1. We've invested CalAIM Incentive Payment Program (IPP) funding in our ECM and Community Supports (CS) providers to:
    1) increase the number of contracted Enhanced Care Management (ECM) providers that engage in bi-directional Health Information Exchange (HIE);
    2) ensure our contracted ECM providers have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan; and
    3) ensure our contracted ECM and Community Supports providers have the ability to submit a claim or invoice to the Plan or have access to a system or service that can process and send a claim or invoice to the Plan with the information necessary for the MCP to submit a compliant encounter to DHCS.
2. We are connected to the local Homeless Management Information Systems (HMIS) for member matching and receiving timely alerts when a Member experiences a change in housing status. We also support data sharing with housing-related services Community Supports providers on Member's housing status information.
3. ECM is an end-to-end solution that provides a whole-person approach to care that are medically appropriate and addresses the clinical and non-clinical needs of the member. ECM providers receive a monthly member information file (MIF) and are required to submit a return transmission file (RTF) of enrolled members.
4. Findhelp is an online platform with a network of social programs across the state. We can create a closed-loop referral system to appropriate Community Supports and other community and social services including financial assistance, food pantries, medical care, transportation,

and other free or reduced-cost services. The referral process ensures a seamless experience for the provider and member.

Exchange of member information and medical records is done in accordance with professional standards and state and federal privacy laws and regulations.

Value-based payment arrangements

We encourage providers to participate in value-based payment arrangements. Our value-based incentive programs reward both professional and hospital providers who achieve program goals in areas critical to the success of PHM such as quality outcomes, care coordination, access to care, overall medical costs and patient satisfaction. Data used to inform provider performance within incentive programs align with industry standard benchmarks/metrics and is sourced from health plan data. Below you will find incentive program components detail.

Incentive Payments

Description: The Plan offers incentives to network providers who achieve program goals in the below areas.

Capitation: Pre-paid PMPM payments for professional or professional and hospital services place responsibility for cost management on the providers and hospitals.

Incentive Program Components

- Quality – Providers delivering high value, quality care, and not just a high volume of care, are eligible to earn an incentive payment for meeting Medicaid thresholds for HEDIS clinical quality measures.
- Encounter Data – Sharing patient encounter data is an essential aspect of assessing patient risk for subsequent clinical intervention as well as assessing providers for the quality of care they are delivering. Providers earn an incentive by meeting encounter data delivery thresholds.
- Access to care – the Plan offers incentives to PPGs to ensure their primary care providers and specialists have appointment availability for both urgent and non urgent visits.

Ability to view evidence-based practice guidelines on demand

We provide clinical practice guidelines to network providers via access to the Plan's provider portal. The clinical practice guidelines are recommendations intended to optimize patient care for specific clinical circumstances to all network providers. They are based on professionally recognized standards and systemically developed through a formal process with input from practitioners and based on authoritative sources including clinical literature, studies, and expert consensus. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based. Board-certified practitioners who will utilize the guidelines are given the opportunity to review and give advice on the guidelines through the Centene Corporate Clinical Policy Committee (CPC). Guidelines are updated at least every two years or upon significant new scientific evidence or changes in national standards.

Providing practice transformation support

We offer provider communication and webinars to support the sharing of updates and best practices. In addition, we offer 1-to-1 training with providers, clinics and medical groups and design integrated workflows to streamline transition of care. We share population health risk data with Medical Groups to support the identification of Member needs. Ultimately, all of this fosters care collaboration, provider engagement and holistic care. Enhancing provider engagement can have a dramatic impact on

health plan performance, lead to improved clinical outcomes, quality ratings, member retention, member satisfaction, and overall efficiency.

Coordination of Member programs

We use the following tactics to coordinate across Member programs and services, including programs Members may receive through their provider care team:

Copy of care plan and/or interventional program description sent to Member's practitioner inviting them to participate in the development of the care plan and attend interdisciplinary care team meetings as needed.

- Defining a program hierarchy so Members don't receive outreach from multiple programs. The following hierarchy is used to determine which entity will be the primary point of contact, unless Member specific evaluation demonstrates otherwise:
    1. Delegated Participating Physician Group (PPG) Concurrent Review and Care Management
        a. Example: To avoid duplicative outbound calls, a data analyst reviews potential care management list in Impact Pro and excludes Members who are assigned to a Delegated PPG as well as those already enrolled and engaged with Care Management
    2. Health Plan Concurrent Review (e.g., Inpatient Concurrent Review, Transition Care Management)
    3. Plan Complex Care Management
    4. Plan Care Management
    5. Special or Disease Specific Clinical Programs (e.g., Palliative Care, CPP)
    6. Disease Management
    7. Auxiliary services may run concurrently as coordinated and requested by the primary Care Manager with the consent of the Member.
        a. Examples: Wellness Coaching (smoking cessation, weight management), Life Solutions evaluation for home safety, field-based MemberConnection outreach for difficult to engage Members, Licensed Clinical Social Worker (LCSW) assessments, special PPG programs, ECM providers, Doulas and CHWs, etc.

  EXAMPLE OF HIERARCHY IMPLEMENTATION:
  - Care Management participates in Utilization Management inpatient concurrent review rounds to determine if Care management services are needed post discharge.
  - Participating Physician Groups (PPGs) and Providers may submit referral directly (via fax/email referral form) to plan CM. If care management is delegated to the PPG, the plan refers the Member to the PPG for follow up.
  - While the Member is enrolled in CM, the care manager will look at open care gaps and assist the Member to fulfill them.
  - If an enrolled Member enters an inpatient setting the Concurrent Review staff identifies the Care manager involved and keeps the CM updated on status and discharge.

- Clinical program documentation processes are in a single medical management system platform (TruCare): Members actively enrolled in clinical programs are flagged in the common documentation platform to avoid duplication of outreach calls.

  EXAMPLES:

- Alerts placed Member record in the Medical Management System are visible to staff when the Member record is accessed.
- Tasks generated within the system from one process to another informing the recipient of activity to complete.
- Inbound and outbound calls related to CM programs, tasks, notes, assessments, and correspondence are captured and dated within the medical management system and are visible to associates with access to the Member record.

- Assigning a single care coordinator and/or Co-Management to address all of the Member's needs:
  - Integrated Care Management: Integrated Care involves managing the Member's physical, behavioral, and psychosocial needs (including SDoH needs) with the care manager as the primary point of contact for the Member. This holistic approach lessens the complexity for our Members and aligns with our overall population health program.
  - Behavioral Health (BH) and Physical Health (PH) Care Management Coordination: for new BH CM referrals of Members enrolled in open PH CM, the PH Care manager coordinates with the referring party and BH CM to determine which CM staff will be the primary Care manager. Co-management may occur between BH and PH during CM rounds, and by documentation in a common platform. With Member's express permission, both BH and PH CM may work with Member, but always coordinating outreach and discussing during rounds.
  - The BH CM coordinates with Regional Centers to coordinate services falling within their domain.
  - The Care Manager coordinates with county programs and other external entities to facilitate services and programs available to the Member.

- Multi-disciplinary, cross functional rounds and/or workgroups to develop and maintain strategies for efficient clinical program coordination:
  - Preventative Health Work group QI, Health Education, Medical Management, Health Programs, Care Management, Member Services, Community Grants, Provider Relations, HEDIS, Enrollment Services, Member Experience, Health Equity, and Practice Transformation departments meet regularly to review Member outreach for various health measures, coordinate efforts and minimize duplication.

- Interdisciplinary/Integrated Care Management Team Rounds:
  - Care Management rounds are routinely conducted with a team-based approach, using Care Managers, Social Workers, Registered Dietitian, Pharmacists, Behavioral Health, and Medical Directors to coordinate between departments for specific Members, and develop and/or support a comprehensive care plan. Reports are shared with key internal stakeholders for care coordination. Members and Providers are invited to participate in these rounds (for their own care plans only) for the Special Needs Plan (SNP) Model of Care.
  - On an annual basis, we report on population health metrics including a population health summary and risk factor analysis based on a Health Risk Questionnaire.

- CalViva Pregnancy Program:
  - Care Managers may discuss the Member during utilization or care management rounds, the Member will be referred as appropriate when it is identified a Member may benefit from information in another program and/or when care coordination is required across processes.

- Disease Management Reports

- Key operational and clinical measures for each Disease Management program are reported annually which summarize key enrollment and engagement metrics by program and describe utilization performance and quality measures for the Disease Management population and population health metrics including a population health summary.

- Sharing of Member outreach data:
  - Information regarding our preventive health programs, such as influenza immunizations, and documentation of member outreach/activities is provided to our Customer Contact Center (CCC) via notification and available in our internal database (Central Point) in order to increase awareness so that Customer Service Representatives can answer incoming questions from our members and direct members to the available resources.

- Standardized Protocols for Unable to Reach Members: Each clinical program follows a standard protocol for the number and frequency of outbound attempts to reach Member to avoid multiple or intrusive calls to Members. All outreach is documented in the common platform.
  - Integrated Care Management: A standard number of outbound call attempts are followed by a letter and/or enlistment of field-based outreach staff (MemberConnections).
  - Disease Management: Establishes a set number of call attempts for Members with a valid phone number, then sends an outreach letter.

- Standardized Protocols for Members opting out of clinical programs:
  - Members wishing to opt out of clinical programs are flagged and set for future outbound calls according to protocol, respecting their wishes while adhering to regulatory compliance guidelines.

Informing Members about Available PHM Programs

We provide Members with information about all available PHM programs and services through the following:

- New Member Welcome letter sent via United States (US) Postal Mail
- Unsolicited Phone Call Outreach based on identified health needs post risk stratification
- Solicited Phone Calls for Members who agree to be actively enrolled in programs
- E-mail
- Plan Website
- Annual Plan Newsletter
- Face to face visits

Informing Members about PHM Programs – Interactive Contact

Staff engage Members that are eligible for programs which include interactive contact with the Plan to notify them of the following key information: See Appendix C

Key Program Attributes Communication Check list

- To inform Member of how they became eligible to participate in the specific program
- How they can opt-in the individual program
- How they can opt-out of the individual program

Key Modes of Communicating Program Information

- Welcome letter to welcome the Member to get them oriented with the program and all of the available program benefits, including all of the aforementioned key program elements.

- Unsolicited Phone Call Outreach based on identified health needs post risk stratification.
- Solicited Phone Calls for Members who agree to be actively enrolled in programs and are identified as eligible for other potential beneficial programs.
- On occasion the CM staff may request a MemberConnections Representative make a face to face visit with the Member.
- Members may opt in to an automated texting program to receive reminders, and pregnancy health education.

Appendix A

This table contains guidance to determine specific HEDIS SSD NDC list

HEDIS SSD NDC list	HEDIS SSD NDC List.xlsx

Appendix B

This table contains guidance to PHM Level and KPI tools Overview

PHM Level and KPI tools Overview	PHM Level and KPI tools Overview.pdf

Appendix C

This table contains guidance to determine specific medical conditions that are included within each population health category

Level 01: Healthy	Includes Members that meet *ALL* of the following criteria: No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx Risk of future costs for the next 12 months: • When age <65 then risk of future costs < 2 ○ When age >= 65 then risk of future costs < 4 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits regardless of the reason in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities.

	No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx
Level 02: Acute Episodic	Includes Members that meet both of the following criteria: No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx AND *one* or more of the criteria below 1 or more emergency room visits regardless of the reason in the last 12 months 1 or more inpatient stays regardless of reason in the last 12 months
Level 03: Healthy, At Risk	Includes Members that meet both of the following criteria: No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx AND NOT in any of the following categories 01: Healthy 02: Acute Episodic
Level 04a: Chronic, Big 5: Stable	Includes Members that meet *all* of the following criteria: Diabetes or COPD or Asthma or CHF or CAD Risk of future costs for the next 12 months: ○ When age <65 then risk of future costs < 2 ○ When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits with a primary diagnosis of diabetes, CAD, CHF, asthma or COPD in the last 12 months No medication adherence gaps: See Attachment

	Medication Adherence Gaps.doc No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx AND NOT in any of the following categories: 04b: Chronic, other condition, stable 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 04b: Chronic, Other Condition: Stable	Includes Members that meet *all* the following criteria: 1 or more non big 5 chronic conditions See Attachment Chronic Conditions.docx Risk of future costs for the next 12 months: ○ When age <65 then risk of future costs < 2 ○ When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No "True" emergency room visits in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.doc No 'clinically important' care opportunities See Attachment

	Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx AND NOT in any of the following categories: 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 04c: BH Primary: Stable	Includes Members that meet *all* of the following criteria: 1 or more behavioral health conditions that are not flagged as high needs See Attachment Behavioral Health Conditions.docx Risk of future costs for the next 12 months: • When age <65 then risk of future costs < 2 • When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits regardless of reason in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.doc No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment

	Drug Safety Care Opportunities.docx OR A behavioral health condition that is not flagged as high needs AND NOT in any of the following categories: 04a: Chronic Big 5, Stable 04b: Chronic, other condition, stable 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05a: Health Coaching	Includes Members that meet both the following criteria: Diabetes or COPD or Asthma or CHF or CAD or HbA1c over 9 Behavioral Health Risk Score < 20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: ○ When age <65 then risk of future costs between 2 ○ When age >= 65 then risk of future costs between 4 Risk of an admission in the next 12 months between 10% 1 or more inpatient stays with a primary diagnosis of diabetes, CAD, CHF, asthma, or COPD in the last 12 months 1 or more “True” emergency room visits in the last 12 months 1 or more emergency room visits with a primary diagnosis of diabetes, CAD, CHD, asthma or COPD in the last 12 months 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.doc 1 or more ‘clinically important’ care opportunities See Attachment Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment

	Drug Safety Care Opportunities.docx A Big 5 condition with 1 or more diagnosis of: • Artherosclerosis • Hyperlipidemia • Obesity • Hypertension AND NOT in any of the following categories: 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05b: Physical Health Care Management	Includes Members that meet both the following criteria: 1 or more non big 5 chronic conditions See Attachment Chronic Conditions.docx Behavioral Health Risk Score <20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: • When age <65 then risk of future costs greater than or equal to 2 • When age ≥ 65 then risk of future costs greater than or equal to4 Risk of an admission in the next 12 months greater than or equal to10% 1 or more inpatient stays regardless of reason in the last 12 months 1 or more “True” emergency room visits in the last 12 months 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.doc 1 or more ‘clinically important’ care opportunities See Attachment

	 Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx PRG risk greater than 10 AND NOT in any of the following categories: A Big 5 condition with 1 or more diagnosis of: • Atherosclerosis • Hyperlipidemia • Obesity • Hypertension 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05c Behavioral Health Care Management	Includes Members that meet the following criteria: Flagged as having a high behavioral health needs status based on either having: • High mental health risk • High substance-use disorder risk AND NOT in any of the following categories: 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL

Level 06: Rare High Cost Condition	1 or more rare, high cost conditions See Attachment  Rare High Cost Conditions.docx AND NOT in any of the following categories: 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07a: Catastrophic: Dialysis	1 or more claims indicating dialysis services in the most recent 12 months AND NOT in any of the following categories: 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07b: Catastrophic: Active Cancer	1 or more episodes of care indicating active cancer treatment in the most recent 12 months AND NOT in any of the following categories: 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07c: Catastrophic Transplants	1 or more of the following transplants in the most recent 12 months: • Bone Marrow • Heart • Liver • Lung • Pancreas

	• Renal AND NOT in any of the following categories: 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 08a: Dementia	2 or more claims indicating dementia in the most recent 12 months AND NOT in any of the following categories: 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 08b: Institutional (custodial care)	1 or more claims with a place of service code=33 (Custodial Care Facility) AND NOT in any of the following categories: 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination	Includes Members that meet *one* or more of the criteria below: Be enrolled in an LTC or MMP product, that do not have a high-needs condition AND NOT in: 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
Level 09b: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – High Needs Care Management	Includes Members that meet *one* or more of the criteria below: Be currently enrolled in at least one of the LTSS/MMP products 1 or more claims in the last 12 months with any of the following diagnoses in any position ○ Traumatic Brain Injury (TBI) ○ Cystic Fibrosis ○ Multiple Sclerosis ○ Hip or Pelvic Fracture ○ Ulcers ○ Spinal Cord Injury

	○ Acute Myocardial Infarction (AMI) ○ Muscular Dystrophy ○ Learning Disabilities ○ Spina Bifida ○ Fibromyalgia ○ Intellectual Disabilities ○ Other Developmental Delays ○ Migraine Please refer to attachment for a list of diagnosis codes that correspond to the above clinical groups.  LTSS High Needs Codes.xlsx
Level 10: End of Life (Non-LTSS)	Includes Members that meet one or more of the criteria below: 1 or more claims in last 12 months indicating hospice care OR Metastatic Cancer AND NOT in any of the following categories: 09a: Long-Term Supportive Services and Medicare-Medicaid Plan – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High Needs Care Management

References

Oversight	Reference	Cross Reference
DHCS	APL 22-024	
NCQA	PHM.1.A.1	Four Focus Areas
	PHM.1.A.2	Focus Areas Programs or Services Offered
	PHM.1.A.3	Activities Which Support PHM Programs and Services
	PHM.1.A.4	Coordination of Member programs:
	PHM.1.A.5	Informing Members about Available PHM Programs
	PHM.1.A.6	Basic Population Health Management (BPHM) (Health Equity Improvement Model)
	PHM.1.B	Informing Members about PHM Programs – Interactive Contact
	PHM.2.A	Population Stratification
	PHM.2.B	Population Needs Assessment (PNA)
	PHM.2.C	PNA Activities
	PHM.2.D	Population Stratification, Focus Areas,
	PHM.3.A	Activities Which Support PHM Programs and Services

Item #9

Attachment 9.A

Financial Report
Fiscal Year End June 30, 2023

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of June 30, 2023

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	146,193,996.63
5	Total Bank Accounts	$ 146,193,996.63
6	Accounts Receivable	
7	Accounts Receivable	153,237,918.56
8	Total Accounts Receivable	$ 153,237,918.56
9	Other Current Assets	
10	Interest Receivable	496,762.38
11	Investments - CDs	0.00
12	Prepaid Expenses	1,369,227.25
13	Security Deposit	23,662.50
14	Total Other Current Assets	$ 1,889,652.13
15	Total Current Assets	$ 301,321,567.32
16	Fixed Assets	
17	Buildings	5,986,731.32
18	Computers & Software	54,444.44
19	Land	3,161,419.10
20	Office Furniture & Equipment	100,693.70
21	Total Fixed Assets	$ 9,303,288.56
22	Other Assets	
23	Investment -Restricted	301,820.78
24	Lease Receivable	3,219,910.44
25	Total Other Assets	$ 3,521,731.22
26	TOTAL ASSETS	$ 314,146,587.10
27	LIABILITIES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	59,267.09
32	Accrued Admin Service Fee	4,897,684.00
33	Capitation Payable	117,545,662.25
34	Claims Payable	33,819.56
35	Directed Payment Payable	2,165,916.26
36	Total Accounts Payable	$ 124,702,349.16
37	Other Current Liabilities	
38	Accrued Expenses	1,093,840.00
39	Accrued Payroll	55,551.71
40	Accrued Vacation Pay	296,647.22
41	Amt Due to DHCS	42,291,066.28
42	IBNR	86,869.35
43	Loan Payable-Current	0.00
44	Premium Tax Payable	0.00
45	Premium Tax Payable to BOE	1,447,176.48
46	Premium Tax Payable to DHCS	0.00
47	Total Other Current Liabilities	$ 45,271,151.04
48	Total Current Liabilities	$ 169,973,500.20
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	$ 169,999,406.99
54	Deferred Inflow of Resources	2,808,623.69
55	Equity	
56	Retained Earnings	127,950,997.92
57	Net Income/(Loss)	13,387,558.50
58	Total Equity	$ 141,338,556.42
59	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 314,146,587.10

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2022 - June 2023

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Income	5,364,448.04	340,000.00	5,024,448.04
3	Premium/Capitation Income	1,289,511,475.60	1,154,644,182.00	134,867,293.60
4	**Total Income**	**1,294,875,923.64**	**1,154,984,182.00**	**139,891,741.64**
5	Cost of Medical Care			
6	Capitation - Medical Costs	1,122,512,458.24	994,674,057.00	127,838,401.24
7	Medical Claim Costs	1,384,579.86	1,080,000.00	304,579.86
8	**Total Cost of Medical Care**	**1,123,897,038.10**	**995,754,057.00**	**128,142,981.10**
9	**Gross Margin**	**170,978,885.54**	**159,230,125.00**	**11,748,760.54**
10	Expenses			
11	Admin Service Agreement Fees	56,171,137.00	51,243,500.00	4,927,637.00
12	Bank Charges	0.00	7,200.00	(7,200.00)
13	Computer/IT Services	186,214.58	233,476.00	(47,261.42)
14	Consulting Fees	69,015.00	300,000.00	(230,985.00)
15	Depreciation Expense	299,109.15	324,300.00	(25,190.85)
16	Dues & Subscriptions	258,912.56	205,200.00	53,712.56
17	Grants	3,391,817.00	4,565,000.00	(1,173,183.00)
18	Insurance	194,952.11	196,590.00	(1,637.89)
19	Labor	3,277,790.03	3,591,049.00	(313,258.97)
20	Legal & Professional Fees	87,447.35	190,800.00	(103,352.65)
21	License Expense	1,174,872.66	1,173,963.00	909.66
22	Marketing	1,393,787.02	1,500,000.00	(106,212.98)
23	Meals and Entertainment	20,596.99	24,250.00	(3,653.01)
24	Office Expenses	81,554.14	84,000.00	(2,445.86)
25	Parking	215.39	1,560.00	(1,344.61)
26	Postage & Delivery	3,103.03	4,080.00	(976.97)
27	Printing & Reproduction	1,789.83	4,800.00	(3,010.17)
28	Recruitment Expense	38,645.73	36,000.00	2,645.73
29	Rent	0.00	12,000.00	(12,000.00)
30	Seminars and Training	8,063.98	25,200.00	(17,136.02)
31	Supplies	9,258.71	11,400.00	(2,141.29)
32	Taxes	91,436,708.20	91,437,500.00	(791.80)
33	Telephone	31,018.51	39,900.00	(8,881.49)
34	Travel	15,342.01	24,400.00	(9,057.99)
35	**Total Expenses**	**158,151,350.98**	**155,236,168.00**	**2,915,182.98**
36	**Net Operating Income/ (Loss)**	**12,827,534.56**	**3,993,957.00**	**8,833,577.56**
37	Other Income			
38	Other Income	560,023.94	660,000.00	(99,976.06)
39	**Total Other Income**	**560,023.94**	**660,000.00**	**(99,976.06)**
40	**Net Other Income**	**560,023.94**	**660,000.00**	**(99,976.06)**
41	**Net Income/ (Loss)**	**13,387,558.50**	**4,653,957.00**	**8,733,601.50**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2023 vs FY 2022

		Total	
		July 2022 - June 2023 (FY 2023)	July 2021 - June 2022 (FY 2022)
1	Income		
2	Interest Income	5,364,448.04	550,705.02
3	Premium/Capitation Income	1,289,511,475.60	1,338,509,551.76
4	**Total Income**	**$ 1,294,875,923.64**	**$ 1,339,060,256.78**
5	Cost of Medical Care		
6	Capitation - Medical Costs	1,122,512,458.24	1,101,414,634.62
7	Medical Claim Costs	1,384,579.86	1,091,491.53
8	**Total Cost of Medical Care**	**$ 1,123,897,038.10**	**$ 1,102,506,126.15**
9	**Gross Margin**	**$ 170,978,885.54**	**$ 236,554,130.63**
10	Expenses		
11	Admin Service Agreement Fees	56,171,137.00	52,263,827.00
12	Bank Charges	0.00	8.22
13	Computer/IT Services	186,214.58	158,042.70
14	Consulting Fees	69,015.00	675.00
15	Depreciation Expense	299,109.15	286,517.01
16	Dues & Subscriptions	258,912.56	168,027.92
17	Grants	3,391,817.00	2,905,246.23
18	Insurance	194,952.11	183,519.40
19	Labor	3,277,790.03	3,507,356.31
20	Legal & Professional Fees	87,447.35	77,540.98
21	License Expense	1,174,872.66	797,075.15
22	Marketing	1,393,787.02	1,422,008.76
23	Meals and Entertainment	20,596.99	18,668.12
24	Office Expenses	81,554.14	58,580.01
25	Parking	215.39	289.62
26	Postage & Delivery	3,103.03	3,281.82
27	Printing & Reproduction	1,789.83	4,113.27
28	Recruitment Expense	38,645.73	20,049.97
29	Rent	0.00	0.00
30	Seminars and Training	8,063.98	10,292.33
31	Supplies	9,258.71	10,123.20
32	Taxes	91,436,708.20	166,249,006.31
33	Telephone	31,018.51	31,970.18
34	Travel	15,342.01	11,573.34
35	**Total Expenses**	**$ 158,151,350.98**	**$ 228,187,792.85**
36	**Net Operating Income/ (Loss)**	**$ 12,827,534.56**	**$ 8,366,337.78**
37	Other Income		
38	Other Income	560,023.94	346,688.12
39	**Total Other Income**	**$ 560,023.94**	**$ 346,688.12**
40	**Net Other Income**	**$ 560,023.94**	**$ 346,688.12**
41	**Net Income/ (Loss)**	**$ 13,387,558.50**	**$ 8,713,025.90**

Item #9

Attachment 9.B

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2023

Current as of End of the Month: July
Revised Date: 8/15/2023

CalViva - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	8	13	13	34	16	12	12	40	7	0	0	7	0	0	0	0	81	74
Standard Grievances Received	93	108	131	332	138	182	182	502	157	0	0	157	0	0	0	0	991	1109
Total Grievances Received	**101**	**121**	**144**	**366**	**154**	**194**	**194**	**542**	**164**	**0**	**0**	**164**	**0**	**0**	**0**	**0**	**1072**	**1183**
Grievance Ack Letters Sent Noncompliant	0	1	0	1	1	1	1	3	0	0	0	0	0	0	0	0	4	5
Grievance Ack Letter Compliance Rate	**100.0%**	**99.1%**	**100.0%**	**99.7%**	**99.3%**	**99.5%**	**99.5%**	**99.4%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.60%**	**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	12	13	32	17	13	12	42	7	0	0	7	0	0	0	0	81	74
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	79	116	288	118	157	182	457	162	0	0	162	0	0	0	0	907	1105
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.9%**
Total Grievances Resolved	**100**	**91**	**129**	**320**	**135**	**170**	**194**	**499**	**169**	**0**	**0**	**169**	**0**	**0**	**0**	**0**	**988**	**1180**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**65**	**68**	**100**	**233**	**102**	**134**	**158**	**394**	**136**	**0**	**0**	**136**	**0**	**0**	**0**	**0**	**763**	**826**
Access - Other - DMHC	13	12	19	44	26	29	30	85	17	0	0	17	0	0	0	0	146	176
Access - PCP - DHCS	5	7	2	14	14	7	11	32	13	0	0	13	0	0	0	0	59	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	3	6	15	9	10	5	24	7	0	0	7	0	0	0	0	46	57
Administrative	10	6	13	29	5	18	19	42	15	0	0	15	0	0	0	0	86	119
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	5	5	10	20	9	8	13	30	9	0	0	9	0	0	0	0	59	102
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	12	19	42	20	28	42	90	35	0	0	35	0	0	0	0	167	101
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	9
Transportation - Access	9	14	13	36	12	10	22	44	23	0	0	23	0	0	0	0	103	81
Transportation - Behaviour	3	4	10	17	4	12	8	24	6	0	0	6	0	0	0	0	47	66
Transportation - Other	3	5	8	16	3	12	8	23	6	0	0	6	0	0	0	0	45	30
Quality Of Care Grievances	**35**	**23**	**29**	**87**	**33**	**36**	**36**	**105**	**33**	**0**	**0**	**33**	**0**	**0**	**0**	**0**	**225**	**354**
Access - Other - DMHC	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	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	1	1	1	3	1	0	0	1	0	0	0	0	4	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7	2	6	15	3	2	8	13	9	0	0	9	0	0	0	0	37	43
PCP Care	8	9	6	23	8	13	6	27	9	0	0	9	0	0	0	0	59	93
PCP Delay	12	5	13	30	11	10	10	31	9	0	0	9	0	0	0	0	70	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	4	2	12	9	6	10	25	2	0	0	2	0	0	0	0	39	66
Specialist Delay	2	3	2	7	1	3	1	5	3	0	0	3	0	0	0	0	15	33
Exempt Grievances Received	144	208	218	**570**	163	199	132	**494**	145	0	0	**145**	0	0	0	**0**	**1209**	2429
Access - Avail of Appt w/ PCP	1	3	5	**9**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**11**	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	1	**1**	1	1	1	**3**	0	0	0	**0**	0	0	0	**0**	**4**	25
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	**2**	10
Access - Panel Disruption	3	3	2	**8**	3	1	0	**4**	0	0	0	**0**	0	0	0	**0**	**12**	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	1	0	**1**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	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	1	0	**1**	1	0	0	**1**	0	0	0	**0**	**2**	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	2	3	**6**	0	0	1	**1**	2	0	0	**2**	0	0	0	**0**	**9**	6
Attitude/Service - Provider	1	2	3	**6**	4	9	4	**17**	5	0	0	**5**	0	0	0	**0**	**28**	198
Attitude/Service - Office Staff	0	4	0	**4**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**5**	0
Attitude/Service - Vendor	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	15
Attitude/Service - Health Plan	0	2	0	**2**	0	1	2	**3**	2	0	0	**2**	0	0	0	**0**	**7**	5
Authorization - Authorization Related	0	0	1	**1**	0	0	0	**0**	2	0	0	**2**	0	0	0	**0**	**3**	14
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**	**2**	1
Eligibility Issue - Member not eligible per Provider	2	2	5	**9**	1	6	5	**12**	6	0	0	**6**	0	0	0	**0**	**27**	44
Health Plan Materials - ID Cards-Not Received	14	20	28	**62**	9	14	0	**23**	21	0	0	**21**	0	0	0	**0**	**106**	243
Health Plan Materials - ID Cards-Incorrect Information on Card	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	7
Health Plan Materials - Other	1	2	0	**3**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**4**	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	88	86	**227**	60	60	42	**162**	39	0	0	**39**	0	0	0	**0**	**428**	629
PCP Assignment/Transfer - HCO Assignment - Change Request	35	41	41	**117**	38	50	19	**107**	14	0	0	**14**	0	0	0	**0**	**238**	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	1	2	**3**	0	2	2	**4**	1	0	0	**1**	0	0	0	**0**	**8**	20
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	2	**3**	3	5	0	**8**	0	0	0	**0**	0	0	0	**0**	**11**	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	4	3	**15**	3	5	6	**14**	10	0	0	**10**	0	0	0	**0**	**39**	133
Transportation - Access - Provider Late	2	4	5	**11**	5	4	1	**10**	4	0	0	**4**	0	0	0	**0**	**25**	77
Transportation - Behaviour	13	10	14	**37**	10	3	2	**15**	10	0	0	**10**	0	0	0	**0**	**62**	139
Transportation - Other	0	2	1	**3**	1	5	16	**22**	2	0	0	**2**	0	0	0	**0**	**27**	12
OTHER - Other	0	1	1	**2**	1	0	1	**2**	0	0	0	**0**	0	0	0	**0**	**4**	7
Claims Complaint - Balance Billing from Provider	8	15	13	**36**	20	30	27	**77**	25	0	0	**25**	0	0	0	**0**	**138**	173
Appeals	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**June**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2022**
Expedited Appeals Received	0	1	1	2	7	0	3	10	3	0	0	3	0	0	0	0	15	42
Standard Appeals Received	29	43	22	94	17	43	38	98	29	0	0	29	0	0	0	0	221	396
Total Appeals Received	**29**	**44**	**23**	**96**	**24**	**43**	**41**	**108**	**32**	**0**	**0**	**32**	**0**	**0**	**0**	**0**	236	**438**
Appeals Ack Letters Sent Noncompliant	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	2	3
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**95.5%**	**98.9%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**96.6%**	**0.0%**	**0.0%**	**96.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.10%**	**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	1	2	**3**	7	0	3	**10**	3	0	0	**3**	0	0	0	0	16	42
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Standard Appeals Resolved Compliant	21	29	40	90	19	21	46	86	30	0	0	30	0	0	0	0	206	414
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**96.7%**	**0.0%**	**0.0%**	**96.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.52%**	**99.8%**
Total Appeals Resolved	**21**	**30**	**42**	**93**	**26**	**21**	**49**	**96**	**34**	**0**	**0**	**34**	**0**	**0**	**0**	**0**	**223**	**457**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**21**	**30**	**39**	**90**	**25**	**21**	**48**	**94**	**33**	**0**	**0**	**33**	**0**	**0**	**0**	**0**	**217**	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	2	2	1	1	0	2	0	0	0	0	0	0	0	0	4	7
DME	2	5	4	11	3	0	2	5	6	0	0	6	0	0	0	0	22	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	18	17	45	8	13	25	46	12	0	0	12	0	0	0	0	103	244
Other	2	0	2	4	2	1	8	12	3	0	0	3	0	0	0	0	19	33
Pharmacy/RX Medical Benefit	4	2	2	8	4	1	6	10	5	0	0	5	0	0	0	0	23	58
Surgery	3	5	12	20	7	5	7	19	7	0	0	7	0	0	0	0	46	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**	**3**	**3**	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	3
Consultation	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	2	2	1	0	1	2	0	0	0	0	0	0	0	0	4	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	10	15	**31**	15	9	22	46	14	0	0	14	0	0	0	0	91	196
Uphold Rate	**28.6%**	**33.3%**	**35.7%**	**33.3%**	**57.7%**	**42.9%**	**44.9%**	**47.9%**	**41.2%**	**0.0%**	**0.0%**	**41.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.8%**	**42.9%**
Overturns - Full	15	19	26	**60**	11	11	26	**48**	18	0	0	**18**	0	0	0	**0**	126	244
Overturn Rate - Full	**71.4%**	**63.3%**	**61.9%**	**64.5%**	**42.3%**	**52.4%**	**53.1%**	**50.0%**	**52.9%**	**0.0%**	**0.0%**	**52.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**56.5%**	**53.4%**
Overturns - Partials	0	0	1	**1**	0	0	1	**1**	1	0	0	**1**	0	0	0	**0**	3	9
Overturn Rate - Partial	**0.0%**	**0.0%**	**2.4%**	**1.1%**	**0.0%**	**0.0%**	**2.0%**	**1.0%**	**2.9%**	**0.0%**	**0.0%**	**2.9%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**1.3%**	**2.0%**
Withdrawal	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	0	**2**	8
Withdrawal Rate	**0.0%**	**3.3%**	**0.0%**	**1.1%**	**0.0%**	**4.8%**	**0.0%**	**1.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.9%**	**1.8%**
Membership	421,006	435,392	437,493		440,882	443,410	445,086		443,442	-	-		-	-	-			417,000
Appeals - PTMPM	0.05	0.07	0.10	0.07	0.06	0.05	0.11	0.07	0.08	-	-	0.08	-	-	-	-	0.07	0.09
Grievances - PTMPM	0.24	0.21	0.29	0.25	0.31	0.38	0.44	0.38	0.38	-	-	0.38	-	-	-	-	0.32	0.24

Fresno County - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	8	12	10	30	13	8	11	32	7	0	0	7	0	0	0	0	69	59
Standard Grievances Received	81	95	108	284	112	147	148	407	121	0	0	121	0	0	0	0	812	929
Total Grievances Received	**89**	**107**	**118**	**314**	**125**	**155**	**159**	**439**	**128**	**0**	**0**	**128**	**0**	**0**	**0**	**0**	**881**	**988**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	4
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.1%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	11	10	28	14	9	11	34	7	0	0	7	0	0	0	0	69	59
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	70	103	244	96	127	147	370	130	0	0	130	0	0	0	0	744	932
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.9%**
Total Grievances Resolved	**78**	**81**	**113**	**272**	**110**	**136**	**158**	**404**	**137**	**0**	**0**	**137**	**0**	**0**	**0**	**0**	**813**	**992**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**51**	**60**	**86**	**197**	**80**	**107**	**129**	**316**	**109**	**0**	**0**	**109**	**0**	**0**	**0**	**0**	**622**	**686**
Access - Other - DMHC	12	11	17	40	19	21	25	65	20	0	0	20	0	0	0	0	125	139
Access - PCP - DHCS	4	7	2	13	12	7	11	30	11	0	0	11	0	0	0	0	54	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	3	5	14	8	7	5	20	6	0	0	6	0	0	0	0	40	47
Administrative	7	6	12	25	4	16	19	39	12	0	0	12	0	0	0	0	76	97
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	2	4	8	14	7	6	10	23	9	0	0	9	0	0	0	0	46	90
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	9	9	18	36	16	18	34	68	28	0	0	28	0	0	0	0	132	83
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	6
Transportation - Access	7	11	9	27	8	9	15	32	14	0	0	14	0	0	0	0	73	65
Transportation - Behaviour	1	4	7	12	4	11	6	21	4	0	0	4	0	0	0	0	37	61
Transportation - Other	3	5	8	16	2	12	4	18	4	0	0	4	0	0	0	0	38	26
Quality Of Care Grievances	**27**	**21**	**27**	**75**	**30**	**29**	**29**	**88**	**28**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**191**	**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	1	1	1	3	1	0	0	1	0	0	0	0	4	3
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	2	6	13	3	1	6	10	8	0	0	8	0	0	0	0	31	35
PCP Care	4	9	6	19	8	11	6	25	7	0	0	7	0	0	0	0	51	76
PCP Delay	11	4	12	27	8	8	7	23	9	0	0	9	0	0	0	0	59	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	4	2	11	9	5	8	22	2	0	0	2	0	0	0	0	35	59
Specialist Delay	2	2	1	5	1	3	1	5	1	0	0	1	0	0	0	0	11	27
Appeals	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2022**
Expedited Appeals Received	0	0	1	1	7	0	3	10	3	0	0	3	0	0	0	0	14	33
Standard Appeals Received	23	37	21	81	17	33	30	80	26	0	0	26	0	0	0	0	187	320
Total Appeals Received	**23**	**37**	**22**	**82**	**24**	**33**	**33**	**90**	**29**	**0**	**0**	**29**	**0**	**0**	**0**	**0**	201	**353**
Appeals Ack Letters Sent Noncompliant	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**95.2%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**96.2%**	**0.0%**	**0.0%**	**96.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.5%**	**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	1	1	7	0	3	10	3	0	0	3	0	0	0	0	14	33
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Standard Appeals Resolved Compliant	19	23	35	77	19	17	39	**75**	25	0	0	**25**	0	0	0	**0**	177	336
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.7%**

CalViva Health Appeals and Grievances Dashboard 2023 (Fresno County)

Total Appeals Resolved	**19**	**23**	**36**	**78**	**26**	**17**	**42**	**85**	**28**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**191**	**370**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**19**	**23**	**33**	**75**	**25**	**17**	**41**	**83**	**28**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**186**	**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	1	1	1	1	0	2	0	0	0	0	0	0	0	0	3	7
DME	2	5	4	11	3	0	2	5	5	0	0	5	0	0	0	0	21	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	12	17	38	8	10	21	39	10	0	0	10	0	0	0	0	87	199
Other	2	0	0	2	2	2	8	12	3	0	0	3	0	0	0	0	17	29
Pharmacy/RX Medical Benefit	4	2	1	7	4	0	4	8	4	0	0	4	0	0	0	0	19	44
Surgery	2	4	10	16	7	4	6	17	6	0	0	6	0	0	0	0	39	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**	**3**	**3**	**1**	**0**	**1**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**5**	**2**
Consultation	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	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	2	2	1	0	1	0	0	0	0	0	0	0	0	0	2	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	5	7	12	**24**	15	7	21	**43**	14	0	0	**14**	0	0	0	**0**	81	164
Uphold Rate	**26.3%**	**30.4%**	**33.3%**	**30.8%**	**57.7%**	**41.2%**	**50.0%**	**50.6%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.4%**	**44.3%**
Overturns - Full	14	16	23	**53**	11	10	21	**42**	14	0	0	**14**	0	0	0	**0**	109	189
Overturn Rate - Full	**73.7%**	**69.6%**	**63.9%**	**67.9%**	**42.3%**	**58.8%**	**50.0%**	**49.4%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**57.1%**	**51.1%**
Overturns - Partials	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	9
Overturn Rate - Partial	**0.0%**	**0.0%**	**2.8%**	**1.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.5%**	**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	349,660	351,313		353,806	355,821	357,098		355,405									**335572**
Appeals - PTMPM	0.06	0.07	0.10	0.08	0.07	0.05	0.12	0.08	0.08	-	-	0.03	-	-	-	0.00	0.05	0.07
Grievances - PTMPM	0.23	0.23	0.32	0.26	0.31	0.38	0.44	0.38	0.39	-	-	0.13	-	-	-	0.00	0.19	0.18

Kings County - 2023

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022
Expedited Grievances Received	0	1	2	3	1	3	0	4	0	0	0	0	0	0	0	0	7	3
Standard Grievances Received	4	7	14	25	10	20	11	41	15	0	0	15	0	0	0	0	81	76
Total Grievances Received	**4**	**8**	**16**	**28**	**11**	**23**	**11**	**45**	**15**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**88**	**79**
Grievance Ack Letters Sent Noncompliant	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Grievance Ack Letter Compliance Rate	**100.0%**	**85.7%**	**100.0%**	**96.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**98.8%**	**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	1	2	3	1	3	0	4	0	0	0	0	0	0	0	0	7	3
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	9	5	5	19	16	11	19	46	12	0	0	12	0	0	0	0	77	75
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**9**	**6**	**7**	**22**	**17**	**14**	**19**	**50**	**12**	**0**	**0**	**12**	**0**	**0**	**0**	**0**	84	**78**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**4**	**5**	**6**	**15**	**15**	**11**	**16**	**42**	**9**	**0**	**0**	**9**	**0**	**0**	**0**	**0**	**66**	**57**
Access - Other - DMHC	0	0	1	1	5	4	2	11	1	0	0	1	0	0	0	0	13	15
Access - PCP - DHCS	1	0	0	1	2	0	0	2	1	0	0	1	0	0	0	0	4	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	1	1	1	1	0	2	1	0	0	1	0	0	0	0	4	7
Administrative	2	0	1	3	0	0	0	0	1	0	0	1	0	0	0	0	4	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	2	1	1	4	0	0	0	0	0	0	0	0	4	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	2	0	2	3	5	5	13	2	0	0	2	0	0	0	0	17	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	3	3	7	2	0	3	5	2	0	0	2	0	0	0	0	14	5
Transportation - Behaviour	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	4
Transportation - Other	0	0	0	0	0	0	4	4	1	0	0	1	0	0	0	0	5	3
Quality Of Care Grievances	**5**	**1**	**1**	**7**	**2**	**3**	**3**	**8**	**3**	**0**	**0**	**3**	**0**	**0**	**0**	**0**	**18**	**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	1	1	1	0	0	1	0	0	0	0	3	4
PCP Care	3	0	0	3	0	1	0	1	2	0	0	2	0	0	0	0	6	4
PCP Delay	1	1	0	2	2	1	1	4	0	0	0	0	0	0	0	0	6	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	1	1	2	0	0	0	0	0	0	0	0	2	6
Specialist Delay	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
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	3	0	4	0	0	3	3	1	0	0	1	0	0	0	0	8	16
Total Appeals Received	**1**	**3**	**0**	**4**	**0**	**0**	**3**	**3**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	8	**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%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**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	3	5	0	0	0	0	1	0	0	1	0	0	0	0	6	14
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**

CalViva Health Appeals and Grievances Dashboard 2023 (Kings County)

Total Appeals Resolved	**2**	**0**	**4**	**6**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**7**	**14**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**0**	**4**	**6**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**7**	**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	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
DME	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	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	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Surgery	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	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	2	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	5
Uphold Rate	**50.0%**	**0.0%**	**50.0%**	**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%**	**42.9%**	**35.7%**
Overturns - Full	1	0	2	**3**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	4	9
Overturn Rate - Full	**50.0%**	**0.0%**	**50.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**57.1%**	**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	38,617	38,772		39,184	39,372	39,665		39,611									**314148**
Appeals - PTMPM	0.05	-	0.10	0.05	-	-	-	0.00	0.03	-	-	0.01	-	-	-	0.00	0.02	0.03
Grievances - PTMPM	0.25	0.16	0.18	0.19	0.43	0.36	0.48	0.42	0.30	-	-	0.10	-	-	-	0.00	0.18	0.18

Madera County - 2023

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2023 YTD	2022
Expedited Grievances Received	0	0	1	1	2	1	1	4	0	0	0	0	0	0	0	0	5	12
Standard Grievances Received	8	6	9	23	16	15	23	54	21	0	0	21	0	0	0	0	98	104
Total Grievances Received	**8**	**6**	**10**	**24**	**18**	**16**	**24**	**58**	**21**	**0**	**0**	**21**	**0**	**0**	**0**	**0**	**103**	**116**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**93.3%**	**95.7%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	1	1	2	1	1	4	0	0	0	0	0	0	0	0	5	12
Expedited Grievance Compliance rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	13	4	8	25	6	19	16	41	20	0	0	20	0	0	0	0	86	98
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**13**	**4**	**9**	**26**	**8**	**20**	**17**	**45**	**20**	**0**	**0**	**20**	**0**	**0**	**0**	**0**	**91**	**110**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**10**	**3**	**8**	**21**	**7**	**16**	**13**	**36**	**18**	**0**	**0**	**18**	**0**	**0**	**0**	**0**	**75**	**83**
Access - Other - DMHC	1	1	1	3	2	4	3	9	0	0	0	0	0	0	0	0	12	22
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	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	2	0	2	0	0	0	0	0	0	0	0	2	3
Administrative	1	0	0	1	1	2	0	3	2	0	0	2	0	0	0	0	6	18
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	3	1	2	6	0	1	2	3	0	0	0	0	0	0	0	0	9	8
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	1	1	4	1	5	3	9	5	0	0	5	0	0	0	0	18	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	1	2	2	1	4	7	7	0	0	7	0	0	0	0	16	11
Transportation - Behaviour	2	0	3	5	0	1	1	2	2	0	0	2	0	0	0	0	9	1
Transportation - Other	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0	2	1
Quality Of Care Grievances	**3**	**1**	**1**	**5**	**1**	**4**	**4**	**9**	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**16**	**27**
Access - Other - DMHC	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	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	1	1	2	0	0	0	0	0	0	0	0	3	4
PCP Care	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	13
PCP Delay	0	0	1	1	1	1	2	4	0	0	0	0	0	0	0	0	5	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	1	1	0	0	0	0	0	0	0	0	2	3
Specialist Delay	0	1	0	1	0	0	0	0	2	0	0	2	0	0	0	0	3	2

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	9
Standard Appeals Received	5	2	1	8	0	10	5	15	2	0	0	2	0	0	0	0	25	60
Total Appeals Received	**5**	**3**	**1**	**9**	**0**	**10**	**5**	**15**	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	26	**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%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	1	0	1	0	0	0	0	4	0	0	4	0	0	0	0	5	9
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	0	6	2	8	0	4	7	**11**	0	0	0	**0**	0	0	0	**0**	19	64
Standard Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**0**	**7**	**2**	**9**	**0**	**4**	**7**	**11**	**4**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**24**	**73**

Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**7**	**2**	**9**	**0**	**4**	**7**	**11**	**4**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**24**	**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	6	0	6	0	3	4	7	2	0	0	2	0	0	0	0	15	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	1	1	0	0	2	2	1	0	0	1	0	0	0	0	4	11
Surgery	0	1	1	2	0	1	1	2	1	0	0	1	0	0	0	0	5	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	3	1	**4**	0	2	1	**3**	0	0	0	**0**	0	0	0	**0**	7	27
Uphold Rate	**0.0%**	**42.9%**	**50.0%**	**44.4%**	**0.0%**	**50.0%**	**14.3%**	**27.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**29.2%**	**37.0%**
Overturns - Full	0	3	1	**4**	0	1	5	**6**	3	0	0	**3**	0	0	0	**0**	13	46
Overturn Rate - Full	**0.0%**	**42.9%**	**50.0%**	**44.4%**	**0.0%**	**25.0%**	**71.4%**	**54.5%**	**75.0%**	**0.0%**	**0.0%**	**75.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**54.2%**	**63.0%**
Overturns - Partials	0	0	0	**0**	0	0	1	**1**	1	0	0	**1**	0	0	0	**0**	2	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**14.3%**	**9.1%**	**25.0%**	**0.0%**	**0.0%**	**25.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**8.3%**	**0.0%**
Withdrawal	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	2	0
Withdrawal Rate	**0.0%**	**14.3%**	**0.0%**	**11.1%**	**0.0%**	**25.0%**	**0.0%**	**9.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**8.3%**	**0.0%**
Membership	45,783	47,115	47,408		47,892	48,217	48,323		48,426									**45377**
Appeals - PTMPM	-	0.15	0.04	0.06	-	0.08	0.14	0.08	0.08	-	-	0.03	-	-	-	0.00	0.04	0.14
Grievances - PTMPM	0.28	0.08	0.19	0.19	0.17	0.41	0.35	0.31	0.41	-	-	0.14	-	-	-	0.00	0.16	0.21

CalViva SPD only - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	2	5	7	14	4	4	4	12	4	0	0	4	0	0	0	0	30	25
Standard Grievances Received	30	38	37	105	53	66	57	176	58	0	0	58	0	0	0	0	339	342
Total Grievances Received	**32**	**43**	**44**	119	**57**	**70**	**61**	**188**	**62**	**0**	**0**	**62**	**0**	**0**	**0**	**0**	**369**	**367**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	1	1	2	0	0	0	0	0	0	0	0	2	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.5%**	**98.2%**	**98.9%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.4%**	**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	3	8	13	5	4	4	13	4	0	0	4	0	0	0	0	30	25
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**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	27	38	89	34	57	69	160	51	0	0	51	0	0	0	0	300	356
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**26**	**30**	**46**	**102**	**39**	**61**	**73**	**173**	**55**	**0**	**0**	**55**	**0**	**0**	**0**	**0**	330	**381**
Grievance Descriptions - Resolved Cases	**26**	**30**	**46**	**102**	**39**	**61**	**73**	**173**	**55**	**0**	**0**	**55**	**0**	**0**	**0**	**0**	330	**381**
Access to primary care	0	4	2	6	4	0	8	12	6	0	0	6	0	0	0	0	24	51
Access to specialists	7	10	19	36	15	4	13	32	18	0	0	18	0	0	0	0	86	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	4	13	20	6	17	23	46	15	0	0	15	0	0	0	0	81	89
Out-of-network	0	6	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	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	3	2	11	3	8	10	21	4	0	0	4	0	0	0	0	36	41
QOS Non Access	10	3	10	13	11	32	19	62	12	0	0	12	0	0	0	0	87	118
Exempt Grievances Received	10	15	7	**32**	4	9	4	**17**	0	0	0	**0**	0	0	0	**0**	**49**	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**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	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	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	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	6	3	**9**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**11**	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	1	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	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	3	2	**8**	0	2	2	**4**	0	0	0	**0**	0	0	0	**0**	**12**	58
PCP Assignment/Transfer - HCO Assignment - Change Request	3	5	1	**9**	0	4	0	**4**	0	0	0	**0**	0	0	0	**0**	**13**	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**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	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	1	**1**	0	0	0	**0**	0	0	0	**0**	**1**	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**	2	1	1	**4**	0	0	0	**0**	0	0	0	**0**	**6**	13
Appeals	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2022**
Expedited Appeals Received	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0	2	4
Standard Appeals Received	8	11	5	24	4	5	8	17	4	0	0	4	0	0	0	0	45	76
Total Appeals Received	**8**	**11**	**5**	**24**	**5**	**5**	**8**	**18**	**5**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	47	**80**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**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	1	0	0	1	1	0	0	1	0	0	0	0	2	11
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	7	9	8	24	6	4	6	**16**	5	0	0	**5**	0	0	0	**0**	45	89
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**7**	**9**	**8**	**24**	**7**	**4**	**6**	**17**	**6**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**47**	**93**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**7**	**9**	**8**	**24**	**7**	**4**	**6**	**17**	**6**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**42**	**96**
Continuity of Care	0	5	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	0
Consultation	0	0	1	1	1	1	0	2	0	0	0	0	0	0	0	0	3	1
DME	0	1	4	5	1	0	1	2	1	0	0	1	0	0	0	0	8	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	1	0	3	4	2	0	0	2	0	0	0	0	11	43
Other	0	0	0	0	2	0	1	3	1	0	0	1	0	0	0	0	4	8
Pharmacy/RX Medical Benefit	2	1	1	4	0	0	0	0	1	0	0	1	0	0	0	0	5	6
Surgery	0	2	2	4	2	3	1	6	1	0	0	1	0	0	0	0	11	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	2	4	**9**	4	1	2	**7**	3	0	0	**3**	0	0	0	**0**	19	31
Uphold Rate	**42.9%**	**22.2%**	**50.0%**	**37.5%**	**57.1%**	**25.0%**	**33.3%**	**41.2%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.4%**	**33.3%**
Overturns - Full	4	7	4	**15**	3	3	4	**10**	3	0	0	**3**	0	0	0	**0**	28	65
Overturn Rate - Full	**57.1%**	**77.8%**	**50.0%**	**62.5%**	**42.9%**	**75.0%**	**66.7%**	**58.8%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**59.6%**	**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	49,002	49,750		50,141	50,455	50,626		50,793									**109421**
Appeals - PTMPM	0.18	0.18	0.16	0.00	0.14	0.08	0.12	0.00	0.12	-	-	0.04	-	-	-	0.00	0.01	0.10
Grievances - PTMPM	0.67	0.61	0.92	0.00	0.78	1.21	1.44	0.00	1.08	-	-	0.36	-	-	-	0.00	0.09	0.51

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative Grievance	Balance billing issue, claims delay in processing
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy/RX Medical Benefit	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy/RX Medical Benefit	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist

APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT
Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.

Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

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

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

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

Item #9

Attachment 9.C

Key Indicator Report

Attachment AA

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 7/01/2023 to 7/31/2023

Report created 8/23/2023

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

Key Indicator Report
Auth Based Utilization Metrics for
Report from 7/01/2023 to 7/31/2023
Report created 8/23/2023

ER utilization based on Claims data	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
MEMBERSHIP																Quarterly Averages							Annual Averages		
Expansion Mbr Months	112,057	113,089	114,058	114,706	115,670	116,368		116,424	118,919	119,098	120,345	120,949	121,899	121,577		107,353	109,323	113,068	115,581	118,147	121,064		111,331	119,887	
Family/Adult/Other Mbr Mos	272,745	273,419	274,053	274,444	275,783	276,086		266,305	278,071	270,885	270,388	269,531	270,758	279,015		267,342	269,389	273,406	275,438	271,754	270,226		271,394	272,136	
SPD Mbr Months	36,528	36,696	36,867	37,064	37,288	37,496		39,224	50,115	50,616	51,132	51,364	51,614	51,647		35,754	36,067	36,697	37,283	46,652	51,370		36,450	49,387	
COUNTS																									
Admits - Count	2,292	2,316	2,391	2,296	2,339	2,207		2,283	2,615	2,434	2,328	2,441	2,265	2,303		2,147	2,176	2,333	2,281	2,444	2,345		2,234	2,381	
Expansion	718	689	717	682	649	586		636	617	708	725	759	731	736		627	673	708	639	654	738		662	702	
Family/Adult/Other	1,037	1,120	1,131	1,148	1,214	1,161		1,044	935	1,031	953	1,041	962	1,006		1,024	982	1,096	1,174	1,003	985		1,069	996	
SPD	533	505	533	464	473	458		598	1,061	690	643	636	567	556		492	520	524	465	783	615		500	679	
Admits Acute - Count	1,594	1,568	1,670	1,594	1,684	1,530		1,583	1,488	1,649	1,606	1,721	1,567	1,601		1,542	1,576	1,611	1,603	1,573	1,631		1,583	1,602	
Expansion	596	563	590	570	537	488		527	510	593	604	618	593	610		536	568	583	532	543	605		555	579	
Family/Adult/Other	501	533	588	591	700	608		568	510	559	511	590	498	520		547	524	541	633	546	533		561	537	
SPD	497	472	490	433	446	434		487	468	497	491	512	476	471		459	484	486	438	484	493		467	486	
Readmit 30 Day - Count	240	226	229	238	198	199		253	210	243	226	222	213	203		221	210	232	212	235	220		219	224	
Expansion	97	97	93	89	76	64		100	76	91	87	83	87	90		88	79	96	76	89	86		85	88	
Family/Adult/Other	39	36	45	53	47	32		46	40	59	38	48	36	28		43	39	40	44	48	41		42	42	
SPD	104	93	91	96	75	103		107	94	93	101	91	90	85		91	91	96	91	98	94		92	94	
**ER Visits - Count	14,437	14,275	14,274	14,682	15,477	14,420		12,772	12,965	14,588	14,443	15,548	13,315	7,946		13,177	15,257	14,329	14,860	13,442	14,435		14,406	13,082	
Expansion	4,178	4,019	3,698	3,707	3,653	3,551		3,456	3,380	3,717	3,706	3,929	3,496	2,261		3,513	3,948	3,965	3,637	3,518	3,710		3,766	3,421	
Family/Adult/Other	6,121	6,413	7,156	7,671	8,775	8,413		7,579	7,812	8,574	8,284	8,973	7,603	4,811		4,789	6,330	6,563	8,286	7,988	8,287		6,492	7,662	
SPD	1,463	1,462	1,450	1,582	1,662	1,514		1,507	1,537	1,707	1,753	1,915	1,741	805		1,046	1,375	1,458	1,586	1,584	1,803		1,366	1,566	
PER/K																									
Admits Acute - PTMPY	45.4	44.4	47.1	44.9	47.1	42.7		43.8	39.9	44.0	42.5	45.3	41.1	42.5		45.1	45.5	45.6	44.9	42.6	43.0		45.3	42.7	
Expansion	63.8	59.7	62.1	59.6	55.7	50.3		54.3	51.5	59.7	60.2	61.3	58.4	60.2		60.0	62.4	61.9	55.2	55.2	60.0		59.8	58.0	
Family/Adult/Other	22.0	23.4	25.7	25.8	30.5	26.4		25.6	22.0	24.8	22.7	26.3	22.1	22.4		24.5	23.3	23.7	27.6	24.1	23.7		24.8	23.7	
SPD	163.3	154.3	159.5	140.2	143.5	138.9		149.0	112.1	117.8	115.2	119.6	110.7	109.4		153.9	160.9	159.0	140.9	124.5	115.2		153.6	118.1	
Bed Days Acute - PTMPY	230.4	225.0	238.0	235.3	254.7	237.8		230.1	207.5	232.0	214.3	224.7	211.0	207.6		240.5	238.7	231.1	242.6	223.2	216.6		238.2	218.1	
Expansion	339.4	306.8	356.6	346.3	368.3	345.0		339.5	269.9	323.9	323.4	324.5	313.9	298.0		343.4	333.7	334.3	353.2	310.9	320.6		341.2	313.2	
Family/Adult/Other	78.7	79.0	88.1	89.2	118.1	100.1		87.9	83.0	102.6	84.1	101.4	85.3	86.5		95.0	93.9	81.9	102.5	91.1	90.2		93.3	90.1	
SPD	1,030.6	1,061.5	987.2	974.5	912.0	920.1		937.1	751.2	749.9	694.4	696.4	681.4	649.9		1,020.8	1,038.6	1,026.4	935.4	802.8	690.8		1,004.8	730.0	
ALOS Acute	5.1	5.1	5.1	5.2	5.4	5.6		5.2	5.2	5.3	5.0	5.0	5.1	4.9		5.3	5.2	5.1	5.4	5.2	5.0		5.3	5.1	
Expansion	5.3	5.1	5.7	5.8	6.6	6.9		6.3	5.2	5.4	5.4	5.3	5.4	4.9		5.7	5.3	5.4	6.4	5.6	5.3		5.7	5.4	
Family/Adult/Other	3.6	3.4	3.4	3.5	3.9	3.8		3.4	3.8	4.1	3.7	3.9	3.9	3.9		3.9	4.0	3.5	3.7	3.8	3.8		3.8	3.8	
SPD	6.3	6.9	6.2	7.0	6.4	6.6		6.3	6.7	6.4	6.0	5.8	6.2	5.9		6.6	6.5	6.5	6.6	6.4	6.0		6.5	6.2	
Readmit % 30 Day	10.5%	9.8%	9.6%	10.4%	8.5%	9.0%		11.1%	8.0%	10.0%	9.7%	9.1%	9.4%	8.8%		10.3%	9.6%	9.9%	9.3%	9.6%	9.4%		9.8%	9.4%	
Expansion	13.5%	14.1%	13.0%	13.0%	11.7%	10.9%		15.7%	12.3%	12.9%	12.0%	10.9%	11.9%	12.2%		14.0%	11.8%	13.5%	11.9%	13.6%	11.6%		12.8%	12.5%	
Family/Adult/Other	3.8%	3.2%	4.0%	4.6%	3.9%	2.8%		4.4%	4.3%	5.7%	4.0%	4.6%	3.7%	2.8%		4.2%	4.0%	3.6%	3.7%	4.8%	4.1%		3.9%	4.2%	
SPD	19.5%	18.4%	17.1%	20.7%	15.9%	22.5%		17.9%	8.9%	13.5%	15.7%	14.3%	15.9%	15.3%		18.5%	17.5%	18.3%	19.6%	12.5%	15.3%		18.5%	13.9%	
**ER Visits - PTMPY	411.0	404.5	402.8	413.1	432.9	402.2		353.7	347.8	389.3	382.4	409.4	349.2	210.7		385.1	440.5	406.1	416.1	363.7	380.3		412.0	348.9	
Expansion	447.4	426.5	389.1	387.8	379.0	366.2		356.2	341.1	374.5	369.5	389.8	344.2	223.2		392.6	433.4	420.8	377.6	357.3	367.8		405.9	342.4	
Family/Adult/Other	269.3	281.5	313.3	335.4	381.8	365.7		341.5	337.1	379.8	367.6	399.5	337.0	206.9		215.0	282.0	288.1	361.0	352.7	368.0		287.1	337.9	
SPD	480.6	478.1	472.0	512.2	534.9	484.5		461.0	368.0	404.7	411.4	447.4	404.8	187.0		351.1	457.5	476.9	510.5	407.4	421.2		449.8	380.6	
Services	TAT Compliance Goal: 100%							TAT Compliance Goal: 100%								TAT Compliance Goal: 100%							TAT Compliance Goal: 100%		
Preservice Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Preservice Urgent	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		99.3%	99.1%	99.1%	100.0%	100.0%	99.1%				
Postservice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	N/A	100.0%	100.0%	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%	100.0%	100.0%	100.0%	100.0%		100.0%	99.1%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	95.5%	100.0%	100.0%	93.3%	96.0%	100.0%		100.0%	95.7%	96.0%	100.0%	100.0%	100.0%	96.6%		100.0%	91.5%	98.8%	96.0%	96.9%	100.0%				
Deferrals - Urgent	N/A	100.0%	100.0%	N/A	100.0%	N/A		N/A	100.0%	N/A	100.0%	N/A	N/A	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	NA	NA	NA	NA	NA	NA		null	null	null	null	null	null	null		null	null	null	null	null	null				
	CCS ID RATE							CCS ID RATE								CCS ID RATE							CCS ID RATE		
CCS %	8.36%	8.30%	8.27%	8.21%	8.57%	8.53%		8.50%	8.02%	7.98%	7.94%	7.90%	7.90%	7.90%		8.69%	8.72%	8.31%	8.44%	8.17%	7.91%		8.54%	8.02%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand							Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand								Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand									
Births	16.4	17.7	16.8	16.1	15.0	16.5		14.3	12.1	13.2	12.8	13.0	13.2	14.0		14.3	14.0	17.0	15.8	13.2	-		15.3		
OB % Days	11.8%	12.7%	11.2%	11.2%	10.5%	11.7%		4.7%	1.1%	3.7%	4.3%	6.0%	7.6%	10.4%		10.1%	10.4%	11.9%	11.2%	3.1%	-		17.0%		
OB % Admits	25.2%	27.0%	25.0%	24.9%	22.9%	26.7%		22.6%	17.3%	20.4%	20.8%	20.2%	22.2%	22.9%		22.7%	22.2%	25.7%	24.8%	20.1%	-		30.0%		
	Perinatal Case Management							Perinatal Case Management								Perinatal Case Management							Perinatal Case Management		
Total Number Of Referrals	130	184	162	148	126	112		147	135	160	151	148	151	84		472	598	476	386	442	450		1,932	975	
Pending	0	0	1	0	0	21		5	1	4	28	20	3	2		0	2	1	21	10	51		24	62	
Ineligible	2	5	3	6	7	6		6	1	10	8	5	4	2		18	32	10	19	17	17		79	37	
Total Outreached	128	179	158	142	119	85		136	133	146	115	123	144	80		454	564	465	346	415	382		1,829	876	
Engaged	37	62	84	63	46	28		63	57	54	51	50	62	63		157	224	183	137	174	163		701	399	
Engagement Rate	29%	35%	53%	44%	39%	33%		46%	43%	37%	44%	41%	43%	79%		35%	40%	39%	40%	42%	43%		38%	46%	
New Cases Opened	37	62	84	63	46	28		63	57	54	51	50	62	63		157	224	183	137	174	163		701	399	
Total Cases Managed	313	314	344	337	327	280		291	309	320	313	316	331	320		344	432	496	410	401	425		887	627	
Total Cases Closed	61	52	69	56	73	51		39	41	57	47	47	72	57		136	154	182	180	137	166		652	359	
Cases Remained Open	247	256	263	278	249	224		242	258	261	258	267	251	261		199	263	263	224	261	251		224	261	
	Integrated Case Management							Integrated Case Management								Integrated Case Management							Integrated Case Management		
Total Number Of Referrals	190	223	209	221	158	150		221	211	371	343	242	264	215		288	503	622	529	803	849		1,942	1,866	
Pending	0	0	0	3	1	19		1	2	0	0	2	34	22		1	1	0	23	3	36		25	41	
Ineligible	11	17	14	14	8	10		48	78	68	56	55	48	31		16	26	42	32	194	159		116	387	
Total Outreached	179	206	195	204	149	121		172	131	303	287	185	182	162		271	476	580	474	606	654		1,801	1,438	
Engaged	153	150	142	133	97	98		94	97	159	173	115	127	128		185	341	445	328	350	415		1,299	893	

Key Indicator Report
Auth Based Utilization Metrics for
Report from 7/01/2023 to 7/31/2023
Report created 8/23/2023

ER utilization based on Claims data	2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
Engagement Rate	85%	73%	73%	65%	65%	81%		55%	74%	52%	60%	62%	70%	79%		68%	72%	77%	69%	58%	63%		72%	62%	
Total Screened and Refused/Decline	13	18	23	28	17	15		49	24	96	55	44	30	19		19	46	54	60	169	129		179	323	
Unable to Reach	13	38	30	43	35	8		29	10	48	59	26	25	15		67	89	81	86	87	110		323	222	
New Cases Opened	153	150	142	133	97	98		94	97	159	173	115	127	128		185	341	445	328	350	415		1,299	893	
Total Cases Closed	101	128	104	129	143	123		110	113	102	106	185	123	130		181	238	333	395	325	414		1,147	865	
Cases Remained Open	414	437	471	469	429	411		382	371	399	464	406	418	417		267	368	471	411	399	418		411	417	
Total Cases Managed	535	581	590	616	588	540		505	491	522	609	616	555	556		458	622	900	818	746	851		1579	1298	
Critical-Complex Acuity	42	53	59	61	60	52		43	42	49	68	82	85	86		44	60	73	70	61	94		120	122	
High/Moderate/Low Acuity	493	528	535	555	528	488		462	449	473	541	534	470	470		414	562	827	748	685	757		1459	1176	
	Transitional Case Management							**Transitional Case Management**								**Transitional Case Management**							**Transitional Case Management**		
Total Number Of Referrals	141	115	180	125	133	105		88	97	109	164	300	284	267		252	326	436	363	294	748		1,377	1,309	
Pending	0	0	0	0	0	5		0	0	0	0	0	5	7		0	0	0	5	0	5		5	7	
Ineligible	8	5	8	3	7	8		8	9	16	8	12	3	9		21	24	21	18	33	23		84	65	
Total Outreached	133	110	172	122	126	92		80	88	93	156	288	276	251		231	302	415	340	261	720		1,288	1,237	
Engaged	124	105	146	107	92	65		68	71	75	127	273	269	241		158	213	375	264	214	669		1,010	1,128	
Engagement Rate	93%	95%	85%	88%	73%	71%		85%	81%	81%	81%	95%	97%	96%		68%	71%	90%	78%	82%	93%		78%	91%	
Total Screened and Refused/Decline	3	1	14	5	9	11		1	3	3	4	1	2	6		4	12	18	25	7	7		59	20	
Unable to Reach	6	4	12	10	25	16		11	14	15	25	14	5	4		69	77	22	51	40	44		219	89	
New Cases Opened	124	105	146	107	92	65		68	71	75	127	273	269	241		158	213	375	264	214	669		1,010	1,128	
Total Cases Closed	82	120	136	113	106	82		70	55	70	62	145	267	185		138	220	338	301	195	474		997	854	
Cases Remained Open	100	83	87	75	55	45		30	29	19	59	96	73	80		71	56	87	45	19	73		45	80	
Total Cases Managed	200	217	245	206	180	135		113	107	112	147	336	439	356		214	297	579	372	265	689		1127	1179	
High/Moderate/Low Acuity	200	217	245	206	180	135		113	107	112	147	336	439	356		214	297	579	372	265	689		1127	1179	
	Palliative Care							**Palliative Care**								**Palliative Care**							**Palliative Care**		
Total Number Of Referrals	9	21	21	17	7	15		11	10	12	15	15	10	9		24	32	51	39	33	40		146	81	
Pending	0	0	0	0	0	3		0	0	0	0	1	3	1		0	0	0	3	0	4		3	1	
Ineligible	1	8	8	5	0	6		6	3	5	1	1	1	1		11	7	17	11	14	3		46	18	
Total Outreached	8	13	13	12	7	6		5	7	7	14	13	6	7		13	25	34	25	19	33		97	62	
Engaged	5	11	7	7	6	6		5	6	5	9	9	5	2		9	19	23	19	16	23		70	42	
Engagement Rate	63%	85%	54%	58%	86%	100%		100%	86%	71%	64%	69%	83%	29%		69%	76%	68%	76%	84%	70%		72%	68%	
Total Screened and Refused/Decline	1	0	4	4	0	0		0	1	2	2	3	1	3		2	2	5	4	3	6		13	14	
Unable to Reach	2	2	2	1	1	0		0	0	0	3	1	0	2		2	4	6	2	0	4		14	6	
New Cases Opened	5	11	7	7	6	6		5	6	5	9	9	5	2		9	19	23	19	16	23		70	42	
Total Cases Closed	4	7	4	7	9	3		7	4	8	4	4	3	4		23	12	15	19	19	11		69	34	
Cases Remained Open	83	86	92	87	86	92		88	91	88	89	95	98	101		73	82	92	92	88	98		92	101	
Total Cases Managed	89	96	97	99	96	95		99	97	98	99	104	105	105		99	97	114	111	109	113		167	135	
	Behavioral Health Case Management							**Behavioral Health Case Management**								**Behavioral Health Case Management**							**ehavioral Health Case Managemer**		
Total Number Of Referrals	90	111	69	70	65	79		70	76	89	46	60	61	38		295	318	270	214	235	167		1,097	439	
Pending	0	0	0	0	0	8		0	0	0	0	0	0	1		0	0	0	8	0	0		8	1	
Ineligible	4	8	1	0	2	4		4	6	11	5	4	3	3		25	18	13	6	21	12		62	36	
Total Outreached	86	103	68	70	63	67		66	70	78	41	56	58	34		270	300	257	200	214	155		1,027	402	
Engaged	56	74	45	46	43	51		47	49	43	28	35	50	27		164	203	175	140	139	113		682	277	
Engagement Rate	65%	72%	66%	66%	68%	76%		71.0%	70.0%	55.0%	68.0%	63.0%	86%	79%		61%	68%	68%	70%	65%	73%		66%	69%	
Total Screened and Refused/Decline	7	4	2	4	4	1		1	2	3	4	6	1	1		11	12	13	9	6	11		45	19	
Unable to Reach	23	25	21	20	16	15		18	19	32	9	15	7	6		95	85	69	51	69	31		300	106	
New Cases Opened	56	74	45	46	43	51		47	49	43	28	35	50	27		164	203	175	140	139	113		682	277	
Total Cases Closed	73	73	71	61	55	32		43	61	50	30	48	43	41		134	142	217	148	154	121		641	316	
Cases Remained Open	171	193	171	151	145	160		167	154	149	146	131	138	126		149	212	171	160	149	138		160	126	
Total Cases Managed	273	276	248	222	202	199		215	221	203	179	183	185	166		293	359	444	316	307	264		809	443	
Critical-Complex Acuity	12	7	9	9	11	7		7	9	11	16	16	13	14		18	15	17	12	13	17		30	21	
High/Moderate/Low Acuity	261	269	239	213	191	192		208	212	192	163	167	172	152		275	344	427	304	294	247		779	422	

Item #9

Attachment 9.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: September 28th, 2023

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 3 2023

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 3rd Quarter 2023 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on July 20th, 2023. At the July meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the first quarter for 2023 were reviewed for delegated entities and second quarter 2023 for Health Net and MHN. A summary of the first quarter data is included in the table below.

III. Table 1. Quarter 1 2023 Credentialing/Recredentialing

	Sante	ChildNet	MHN	HN	LaSalle	ASH	Envolve	IMG	CVMP	Adventist	Totals
Initial credentialing	34	14	24	6	50	0	2	21	23	28	**202**
Recredentialing	67	23	32	43	22	1	4	11	66	7	**276**
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	**101**	**37**	**56**	**49**	**72**	**1**	**6**	**32**	**89**	**35**	**478**

IV. Credentialing Adverse Actions for Q2 for CalViva from Health Net Credentialing Committee was presented. There were no (0) cases for April 2023, one (1) case in May and three (3) cases presented in June 2023. Outcomes include in two (2) cases the provider was placed on annual monitoring for compliance with the Board's orders; one (1) case the provider was placed on semi-annual monitoring for compliance with the Medical Board's order; one case was pended awaiting the Medical Board's decision and actions.

V. The 2023 Adverse Events Report is a new report for the Credentialing Sub-Committee this year. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were two (2) cases identified for Q2 2023 with adverse outcomes associated with a contracted practitioner. One (1) case was placed on annual monitoring and one case remained open for Board decision. There were no incidents or patterns of non-compliance resulting in substantial harm to a member or members as a result of access to care issues in Q2. There were no (0) cases identified outside of the ongoing monitoring process in which an adverse injury occurred during a procedure by a contracted practitioner in Q2. (NCQA CR.5.A.4)

Item #9

Attachment 9.E

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	September 28th, 2023
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 3 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 July 20th, 2023. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 2023 were reviewed for approval. There were no significant cases to report.

II. The 2023 Adverse Events Report is a new report for the Peer Review Sub-Committee in 2023. This report provides a summary of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period.

- There were five (5) cases identified for Q2 2023 with adverse outcomes. Three (3) cases involved a practitioner, and two (2) cases involved a provider.
- Outcomes included: Two (2) cases were tabled, three (3) were closed to track and trend.
- There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members as a result of access to care issues in Q2.
- There were no (0) cases that met the pattern of non-compliance for access to care in Q2.
- There were three (3) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q2. (NCQA CR.5.A.4)
- There were 34 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management.

III. Quarter 2, 2023 Peer Count Report was presented at the meeting with a total of ten (10) cases reviewed. The outcomes for these cases are as follows:

- There were five (5) cases closed and cleared. There were two (2) cases pending closure for Corrective Action Plan compliance. There were three (3) cases 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 #9

Attachment 9.F

Executive Dashboard

	2022	2022	2022	2022	2022	2022	2023	2023	2023	2023	2023	2023	2023
Month	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**
CVH Members													
Fresno	330,629	331,857	333,152	334,058	335,572	336,359	338,835	349,660	351,313	353,806	355,821	357,098	355,405
Kings	35,216	35,453	35,619	35,804	36,051	36,208	36,388	38,617	38,772	39,184	39,372	39,665	39,611
Madera	44,285	44,542	44,805	44,997	45,377	45,484	45,783	47,115	47,408	47,892	48,217	48,323	48,426
Total	410,130	411,852	413,576	414,859	417,000	418,051	421,006	435,392	437,493	440,882	443,410	445,086	443,442
SPD	35,896	36,079	36,243	36,409	36,589	36,848	38,875	49,002	49,750	50,141	50,455	50,626	50,793
CVH Mrkt Share	68.41%	68.39%	68.38%	68.34%	68.29%	68.23%	68.10%	67.08%	67.14%	67.21%	67.26%	67.28%	67.36%
ABC Members													
Fresno	139,004	139,689	140,370	141,093	142,029	142,820	144,993	157,415	157,746	158,447	158,902	159,464	158,068
Kings	23,622	23,735	23,794	23,857	24,011	24,185	24,323	25,683	25,797	25,854	25,987	26,085	25,976
Madera	26,745	26,935	27,089	27,242	27,552	27,692	27,897	30,593	30,579	30,831	30,902	30,915	30,793
Total	189,371	190,359	191,253	192,192	193,592	194,697	197,213	213,691	214,122	215,132	215,791	216,464	214,837
Default													
Fresno	566	693	630										
Kings	133	159	144										
Madera	101	128	90										
County Share of Choice as %													
Fresno	65.10%	64.80%	62.60%										
Kings	47.90%	58.90%	55.40%										
Madera	61.60%	73.30%	72.40%										
Voluntary Disenrollment's													
Fresno	389	448	414										
Kings	48	46	63										
Madera	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	**3 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 Communication and Systems.		

Member Call Center CalViva Health Website		**Year**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**
		Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	(Main) Member Call Center	**# of Calls Received**	**31,993**	**26,858**	**26,747**	**24,875**	**35,660**	**34,897**
		# of Calls Answered	**31,509**	**26,465**	**26,495**	**24,707**	**35,418**	**34,625**
		Abandonment Level (Goal < 5%)	**1.50%**	**1.50%**	**0.90%**	**0.70%**	**0.70%**	**0.80%**
		Service Level (Goal 80%)	**95%**	**94%**	**88%**	**96%**	**94%**	**87%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,365**	**1,511**	**1,082**	**602**	**813**	**940**
		# of Calls Answered	**1,352**	**1,490**	**1,066**	**596**	**808**	**930**
		Abandonment Level (Goal < 5%)	**1.00%**	**1.40%**	**1.50%**	**1.00%**	**0.60%**	**1.10%**
		Service Level (Goal 80%)	**89%**	**88%**	**86%**	**92%**	**91%**	**89%**
	Transportation Call Center	**# of Calls Received**	**6,737**	**8,470**	**8,062**	**9,278**	**12,407**	**12,107**
		# of Calls Answered	**6,663**	**8,411**	**8,014**	**9,241**	**12,394**	**12,083**
		Abandonment Level (Goal < 5%)	**0.80%**	**0.40%**	**0.50%**	**0.20%**	**0.10%**	**0.00%**
		Service Level (Goal 80%)	**75%**	**85%**	**85%**	**88%**	**94%**	**93%**
	CalViva Health Website	**# of Users**	**28,000**	**25,000**	**32,000**	**27,000**	**54,000**	**42,000**
		Top Page	**Provider Search**	**Provider Search**	**Provider Search**	**Do You Qualify?**	**Main Page**	**Main Page**
		Top Device	**Mobile (62%)**	**Mobile (59%)**	**Mobile (60%)**	**Mobile (57%)**	**Mobile (60%)**	**Mobile (60%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 1 minute**	**~ 2 minutes**	**~ 1 minute**
Message from the CEO	Q2 2023 data is available. At present time, there are no significant issues or concerns as it pertains to the Plan's Member Call Center and Website Activities. The Plan is looking at some enhancements to their website in the future.							

Provider Network & Engagement Activities	**Year**	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**
	Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**154**	**155**	**155**	**155**	**155**	**155**	**156**
	PCP	**378**	**382**	**383**	**385**	**387**	**387**	**393**
	PCP Extender	**284**	**305**	**310**	**314**	**318**	**318**	**324**
	Specialist	**1194**	**1277**	**1291**	**1346**	**1401**	**1431**	**1451**
	Ancillary	**240**	**239**	**240**	**238**	**236**	**236**	**238**
	Year	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Behavioral Health	**447**	**472**	**497**	**530**	**472**	**507**	**593**
	Vision	**43**	**39**	**39**	**25**	**30**	**37**	**104**
	Urgent Care	**13**	**14**	**10**	**11**	**11**	**12**	**14**
	Acupuncture	**5**	**5**	**6**	**4**	**4**	**4**	**4**
	Year	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	% of PCPs Accepting New Patients - Goal (85%)	**95%**	**95%**	**95%**	**92%**	**97%**	**97%**	**97%**
	% Of Specialists Accepting New Patients - Goal (85%)	**96%**	**97%**	**98%**	**97%**	**97%**	**98%**	**98%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**97%**	**97%**	**97%**	**97%**	**96%**	**96%**	**97%**
	Year	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**
	Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
	Providers Touched by Provider Relations	**282**	**307**	**326**	**421**	**461**	**704**	**550**
	Provider Trainings by Provider Relations	**281**	**219**	**426**	**351**	**642**	**1,185**	**1,492**
	Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
	Total Providers Touched	**2,786**	**2,552**	**1,932**	**3,354**	**1,952**	**1,530**	**3,051**
	Total Trainings Conducted	**762**	**808**	**1,353**	**257**	**3,376**	**5,754**	**4,596**
Message From the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network & Engagement Activities.							

Claims Processing	**Year**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	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	95% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% N/A	96% / 99% N/A	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	94% / 95% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / NA NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	99% / 99% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	97% / 99% YES	97% / 99% YES	99% / 100% YES	96% / 99% NO	99% / 100% NO	99% / 99% NO	100% / 100% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	88% / 95% NO	80% / 95% NO	78% / 87% YES	81% / 89% YES	90% / 94% YES	82% / 91% YES	91% / 97% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	63% / 99% YES	95% / 99% YES	79% / 95% YES	55% / 89% NO	95% / 100% YES	90% / 100% YES	83% / 98% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 99% YES	97% / 100% NO	88 / 100% YES	98% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	97% / 97% NO	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% YES	84% / 89% NO	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	95% / 100% NO	91% / 96% NO	94% / 100% YES	99% / 99% NO	99%/100% NO	99%/100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	73% / 98% NO	89% / 96% NO	99% / 99% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q2 2023 numbers are available. All areas met performance and goal with the exception of PPG 3. Management is working with PPG 3 on improving performance.							

Provider Disputes	**Year**	**2021**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	99%	98%	97%	96%	98%	99%
	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%	N/A	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	94%	97%	100%	100%	100%	100%	100%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	84%	11%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	97%	97%	45%	85%	71%	40%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	99%	41%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	97%	97%	86%	98%	100%	43%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	N/A	100%	100%	47%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	39%	91%	43%	96%	98%	N/A	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	100%	100%	100%	100%	100%
Message from the CEO	Q2 2023 numbers are available. Several PPGs encountered performance issues. PPGs 2-6. Management is working with the PPGs to improve performance.							