DATE: May 10, 2024

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, May 16, 2024
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 **13** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
May 16, 2024
1:30pm - 3:30pm
<mark>**Meeting Location(s):**</mark>

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		**FKM RHA Appointment/Reappointments**	D. Hodge, MD; Chair
		• Fresno County At-Large BOS Reappointed Commissioner	
	Attachment 3.A	➢ *Soyla Reyna-Griffin*	
		• CRMC Reappointed Commissioner:	
	Attachment 3.B	➢ *Aldo De La Torre*	
		• Department of Public Health	
	Attachment 3.C	➢ *David Luchini, Fresno County*	
	Attachment 3.D	➢ *Rose Mary Rahn, Kings County*	
		• Valley Children's Hospital	
	Attachment 3.E	➢ *Jennifer Armendariz*	
		Action: Ratify appointments/reappointments	
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C	**Consent Agenda:** • Commission Minutes dated 3/21/23 • Finance Committee Minutes dated 2/15/24 • QIUM Committee Minutes dated 2/15/24 *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)**	
Information	No attachment	A. **Public Employee Appointment, Employment, Evaluation, or Discipline:** Title: Equity Officer Per Government Code Section 54957(b)(1)	
Information	No attachment	B. **Conference Report Involving Trade Secret – Discussion of service, program, or facility:**	

Estimated Date of Public Disclosure: January 2028
Government Code section 54954.5

6 Action	No attachment	**Chair and Co-Chair Nominations for Fiscal Year 2025:** *Action: Nominate and Approve Appointments*	J. Nkansah, CEO
7 Action	No Attachment	**CEO Annual Review -Ad-Hoc Committee Selection** • Select ad-hoc Committee *Recommended Action: Selection of Ad-Hoc Committee*	D. Hodge, MD, Chair
8 Information	Attachment 8.A	**Sub-Committee Members for Fiscal Year 2025:** • BL 24-004 Sub-Committee Members	D. Hodge, MD, Chair
9 Action	Attachment 9.A Attachment 9.B Attachment 9.C	**Community Support Funding** • BL 24-005 Community Support Program • Proposed Grant Recommendations 2024-2025 • Ad-Hoc Committee Meeting Minutes *Action: Approve Community Funding Grant Recommendations*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for item 10 - 12* ***One vote will be taken for combined items 10 - 12***	
10 Action	Attachment 10.A Attachment 10.B Attachment 10.C	**Health Equity Program Description and Work Plan Evaluation** • 2023 Executive Summary and *Annual Evaluation* • 2024 Change Summary and *Program Description* • 2024 Executive Summary and *Work Plan Summary*	P. Marabella, MD, CMO
11 Action	Attachment 11.A Attachment 11.B	**Health Education Work Plan Evaluation** • Executive Summary • 2023 Annual Evaluation	P. Marabella, MD, CMO
12 Action	Attachment 12.A	**Population Health Management** • **PHM 2024 Strategy Program Description & Change Summary** *Action: Approve Health Equity 2023 Annual Evaluation, 2024 Program Description, and 2024 Work Plan, and the Health Education 2023 Annual Evaluation, and PHM 2024 Strategy Program Description.*	P. Marabella, MD, CMO

13 Action		**Standing Reports**	
		Finance Report	
	Attachment 13.A	• Financials as of March 31, 2024	D. Maychen, CFO
	Attachment 13.B	• FY 2025 Proposed Budget	
		Compliance	
	Attachment 13.C	• Compliance Report	M.L. Leone, CCO
		Medical Management	
	Attachment 13.D	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 13.E	• Key Indicator Report	
	Attachment 13.F	• Quarterly Summary Report	
		Executive Report	
	Attachment 13.G	• Executive Dashboard	J. Nkansah, CEO
		Action: Accept Standing Reports	

14		**Final Comments from Commission Members and Staff**	D. Hodge, MD, Chair
15		**Announcements**	D. Hodge, MD, Chair
16		**Public Comment**	D. Hodge, MD, Chair
		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.	
17		**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 July 18, 2024 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-E

FKM RHA Appointment/Reappointments

- 3.A   Soyla Reyna-Griffin reappointment
- 3.B   Aldo De La Torre reappointment
- 3.C   David Luchini official appointment
- 3.D   Rose Mary Rahn official appointment
- 3.E   Jennifer Armendariz appointment

County of Fresno

BOARD OF SUPERVISORS

Chairman	Vice Chairman				
Nathan Magsig	**Buddy Mendes**	**Brian Pacheco**	**Steve Brandau**	**Sal Quintero**	**Bernice E. Seidel**
District Five	District Four	District One	District Two	District Three	Clerk

May 8, 2024

Soyla A. Reyna-Griffin
917 E Windsor Circle
Fresno CA 93720

Subject: Appointment to Fresno-Kings-Madera Regional Health Authority

Dear Ms. Reyna-Griffin,

We are pleased to inform you that on May 7, 2024, under Supervisor Quintero's nomination, you were reappointed by the Board of Supervisors to serve on the **Fresno-Kings-Madera Regional Health Authority** (hereinafter referred to as "authority") for a term expiring on **May 3, 2027**. We thank you for your interest in serving our County.

Statement of Economic Interests (Form 700): You are required to file a Form 700 for your appointed position. Please contact Cheryl Hurley at (559) 540-7842 for information regarding the Form 700.

Brown Act Requirements

Newly elected and appointed members of a "legislative body" who have not yet assumed office must conform to the requirements of the Brown Act as if already in office (California Government Code Section 54952.1). Until you hear otherwise, you should immediately begin to refrain from any discussions of authority business, with a quorum of the authority, outside a formal authority meeting. If you have any questions about the Brown Act or your responsibilities and duties under it, please consult your authority's legal counsel.

State Mandated Ethics Training

California Government Code Section 53235 provides that if a local agency (which includes special districts) provides any type of compensation, salary, or stipend to a member of a legislative body, or provides for reimbursement for actual and necessary expenses incurred by a member of a legislative body in the performance of official duties, then all local agency officials shall receive training in ethics. Such local agency officials must receive **two hours** of ethics training within one year of commencing service with the local agency and once every two years thereafter. Please consult your committee's staff or legal counsel with questions relating to this requirement.

Should you be required to comply with the ethics training requirement, the Fair Political Practices Commission (FPPC) offers **free** online training at http://localethics.fppc.ca.gov/login.aspx. This course requires that you log onto the FPPC's website, review the course content materials, and take periodic tests to assure retention of the information. For those who choose this option, please be aware that the certificate will record how much time an individual spends to complete the online training. You must

complete **at least 2 hours** of training time in order to be compliant with the training requirement. <u>If an individual completes the online training in less than two hours, the certificate will reflect this, indicating that the individual has not completed the required amount of training.</u>

When you complete the training, you will receive a Proof of Participation certificate to sign and submit to whoever maintains the training compliance records for your authority (e.g., the clerk or secretary for the authority). You should keep a copy of the certificate for your records. The authority is required to retain the certificates as public records for at least five years.

On behalf of the Fresno County Board of Supervisors, we wish to extend sincere appreciation for the time and effort you are giving in service to your community and Fresno County.

Sincerely,

Bernice E. Seidel
Clerk of the Board

cc: **Fresno-Kings-Madera Regional Health Authority**

April 1, 2024

Fresno-Kings-Madera Regional Health Authority Commissioners
7625 North Palm Avenue #109
Fresno, CA 93711

Dear Commissioners,

Aldo De La Torre has been serving the Fresno-Kings-Madera Regional Health Authority Commissioners as a representative of Community Regional Medical Center since 2015.

Mr. De La Torre's three-year term on the Commission comes up for reappointment in May 2024. We would respectfully request that Mr. De La Torre continue on as the Community Regional Medical Center representative for another three-year term.

We look forward to receiving confirmation of the reappointment.

Sincerely,

Craig S. Castro
President & Chief Executive Officer

cc: Cheryl Hurley, Director, Human Resources / Office
     Aldo De La Torre, Senior Vice President, Payer Strategy, Managed Care and
        Insurance Services

County of Fresno

Board of Supervisors

Minute Order

Hall of Records, Room 301
2281 Tulare Street
Fresno, California
93721-2198
Telephone: (559) 600-3529
Toll Free: 1-800-742-1011
www.co.fresno.ca.us

April 9, 2024

Present: 5 - Supervisor Steve Brandau, Chairman Nathan Magsig, Vice Chairman Buddy Mendes, Supervisor Brian Pacheco, and Supervisor Sal Quintero

Agenda No. 25.   **Board of Supervisors**   File ID: 24-0328

Re: Appoint the Director of the Department of Public Health, David Luchini, to the Fresno-Kings-Madera Regional Health Authority Commission, in the position previously held by former Director David Pomaville, nunc pro tunc, for a term coterminous with his position as the County's DPH Director; and Designate the Director of DPH to serve ex officio on the Commission

APPROVED AS RECOMMENDED

Ayes: 5 - Brandau, Magsig, Mendes, Pacheco, and Quintero

Intra-Office Memo

TO: **CALVIVA/TRI-COUNTY HEALTH AUTHORITY COMMISSION**
Cheryl Hurley, Committee Coordinator
c/o email at: CHurley@calvivahealth.org

FROM: Catherine Venturella - Clerk of the Board

DATE: April 16, 2024

SUBJECT: **Appointment to the CalViva/Tri-County Health Authority Commission**

On April 16, 2024, the Board of Supervisors appointed the following member to the above named committee: Rose Mary Rahn as the Director of the Department of Public Health primary representative. I have attached a copy of the appointment letter and a new roster for your files. Please call if you have any questions at 559-852-2362.

JOE NEVES – DISTRICT 1
LEMOORE & STRATFORD

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

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

RUSTY ROBINSON – DISTRICT 4
ARMONA & HANFORD

RICHARD FAGUNDES – DISTRICT 5
HANFORD & BURRIS PARK

COUNTY OF KINGS
BOARD OF SUPERVISORS

MAILING ADDRESS: KINGS COUNTY GOVERNMENT CENTER, HANFORD, CA 93230
OFFICES AT: 1400 W. LACEY BLVD., ADMINISTRATION BUILDING # 1, HANFORD
(559) 852-2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

April 16, 2024

Rose Mary Rahn
c/o Public Health Department

Subject: **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission**

Dear Rose Mary;

It is a pleasure to inform you that on April 16, 2024 the Kings County Board of Supervisors appointed you to serve on the **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission** as the Director of the Department of Public Health primary position.

Congratulations on your appointment and thank you for your interest in serving Kings County in this capacity. A copy of this letter is being sent to the Committee to inform them of your appointment. I have enclosed a copy of the oath of office which will need to be completed in the presence of a notary public and sent to me or you may come by our office and have the oath completed for free. Please call if you have any questions concerning the above.

Sincerely,

Catherine Venturella
Clerk to the Board of Supervisors

H:\BOS\Brdcomm\Ag Advisory appt.doc
cc: Committee Coordinator

CALVIVA-TRI-COUNTY HEALTH AUTHORITY COMMISSION

TERM	LAST	FRST	STREET	CITY	PH	REP	EXPIRATION
Open	Hurley	Cheryl	7625 N Palm Ave, Ste 109	Fresno, CA 93711	540-7842	Commission Clerk/Coordinator	Open
Open	Neves	Joe	Government Center	Hanford	2368	Board of Supervisors/primary	Open
Open	Verboon	Doug	Government Center	Hanford	2366	Board of Supervisors/alt	Open
Open	Rahn	RoseMary	Government Center	Hanford	2625	Dept of Public Health/primary	Open
3 years	Lewis	Lisa	Government Center	Hanford	362-0051	At Large/Primary member	3/1/2026

Membership composition = 17 members:
Six members appointed by Fresno County Board of Supervisors
Three members appointed by Kings County Board of Supervisors
Three members appointed by Madera County Board of Supervisors
Five appointed by the Commission
Kings County appointees:
One member of the Board of Supervisors and his alternate
The Director of Public Health or Director of Social Services
One member at large/representing interests of physician providers
of Medi-Cal covered health care services, health care consumers,
community representatives or community clinics

This roster will only show Kings County appointees

4/11/2024

May 6, 2024

David Hodge, MD
Chairperson
Fresno-Kings-Madera Regional Health Authority Commission
7625 N. Palm Avenue, #109
Fresno, CA 93711

Dear Chairperson Hodge,

By this letter, Valley Children's Hospital nominates Jennifer Armendariz, Vice President, Revenue Cycle and Managed Care, to replace Michael Goldring as Valley Children's Hospital's representative to the Fresno-Kings-Madera Regional Authority Commission.

Sincerely,

Todd A. Suntrapak,
President & Chief Executive Officer

Item #4
Attachment 4.A-C

Consent Agenda

- 4.A   Commission Minutes dated 3/21/23
- 4.B   Finance Minutes dated 2/15/24
- 4.C   QIUM Minutes dated 2/15/24

| | Fresno-Kings-Madera Regional Health Authority | | **CalViva Health** **Commission** Meeting Minutes March 21, 2024 | **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, Director Office/HR
	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.		*A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#3 Reappointment of Madera County At-large Commission Seat Action D. Hodge, MD, Chair	The Commission voted unanimously to reappoint Paulo Soares for an additional three-year term for the Madera County At-Large Commission seat.		*Motion: Reappointed Paulo Soares to Commission for Madera County At-Large* *11 – 0 – 1 – 5* *(Frye / Bosse)*
#4 Consent Agenda • *Commission Minutes dated 2/15/24* • *Finance Committee Minutes dated 10/19/23* • *QI/UM Committee Minutes dated 11/16/23* • *Public Policy Committee Minutes dated 9/6/23* • *Public Policy Committee Minutes dated 9/27/23* • *Public Policy Committee Minutes dated 12/6/23* Action D. Hodge, MD, Chair	All consent items were presented and accepted as read.		*Motion: Consent Agenda was approved.* *12 – 0 – 0 – 5* *(Neves / Naz)*
#5 Community Support Program Ad-Hoc Committee Selection Action D. Hodge, MD, Chair	A new ad-hoc committee is needed for the Community Support Program. Dr. Hodge polled Commissioners and no volunteers responded. Dr. Hodge will select and appoint ad-hoc committee members, and those members will be contacted at a later date.		*No Motion - No Committee members selected*
#6 Population Health • Segmentation Report • Assessment Report	Dr. Marabella presented the 2024 Population Health Segmentation Report and the Assessment Report.		*Motion: See item #7 for motion.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The Segmentation Report looks at the Plan's population and matches that population to the Plan's programs. It is part of the Plan's ongoing programs and specific activities aimed at targeting specific subpopulations. The Population Segmentation is recorded to understand the portions of the population targeted by each Population Health Management program. The programs and criteria for eligibility and the number of those potentially eligible as of December 2023 are as follows: • Eligible members with no risk factors = 132,944 • Eligible members with no claims = 109,239 • Improve Preventive Health – FluVaccinations: all members six (6) months and older = 429,206 • Improve Preventive Health – Breast Cancer Screening: women ages 50-74 = 69,411 • 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 = 695 • CalViva Pregnancy Program: pregnant members at risk for complications of pregnancy as detemined by having an NOP score greater than 34 and/or provider determination = 22 • 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 = 20,136 • Palliative Care: members with chronic, severe, progressive or terminal illness = 4,826 • 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	*Commissioner Sara Bosse asked on the 40 items, from the start date how long did most of them run? Was it a period of time? Are they ongoing?* *Dr. Marabella responded that it's variable. Some items are ongoing; some items were for a specific time; there is overlap of multiple items; and they are grouped into segments. In the actual report there is a list of all items with a timeline for each. There's a summary for the past three years.* *Commissioner Sara Bosse asked what is the intersection between this and the Population Needs Assessment in which health plans need to work with Health Departments?* *Dr. Marabella responded that the Population Needs Assessment is a snapshot in time and is done every 3 years The reports for the Population Health Management (PHM) Assessment will be done annually.* *Commissioner Sara Bosse asked about the tool*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	issues, psychosocial issues/barriers impacting access to care and/or services, history of non-compliance and/or complexity of anticipated discharge = 1,059 • Chronic Condition Disease Management: Members with Asthma, COPD, Diabetes, Cardiovascular Conditions, and Heart Failure = 72,496 • Chronic Condition Management – Substance Use Disorder-Opiod (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 = 1,241 • Tobacco Cessation – Kick it California: members 13 years and older = 308,521 • Diabetes Prevention Program: members 18 years and older with pre-diabetes and/or abnormal glucose = 19,741 • Diabetes Management Program: Members 18-75 years of age with diabetes (type 1 and 2) with care gaps = 26,002 • Cardiac and Diabetes: members that have diabetes with hypertension and/or cardiovascular disease = 9,630 • Fit Families for Life – Home Edition: adults and children = 431,152 • Health Information Form: all members = 431,152 • Health Risk Questionnaire: members 18 years and older = 256,918 • 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 = 308,521 • Behavioral Health Care Management: all members = 431,152 • 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 = 1,868 • Emergency Room Diversion Program: members visiting the ER for avoidable chief complaints = 25,277 • 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 = 80 • Telemedicine: all members = 431,152	*FindHelp.org and stated it has issues. Her main concern with the tool is that it puts the onus entirely on the participant. They have to know what to search, how to search it, how to find it, know what it is they are looking for, have a grasp of what their needs are, and proactively reach out to the resource themselves, as opposed to it being more customer service oriented towards the participant with a closed-loop referral system. She inquired as to whether there has been any thought to upgrading from something that checks the box to meet the requirement versus something that would be more effective?* *Dr. Marabella responded that findhelp.org was previously AuntBertha when CalAIM was created. Findhelp.org was determined to be the best tool given the breadth of what needed to be covered.* *Mary Lourdes Leone added that Findhelp.org is not the Plan's application, it is more of a national tool. She also stated it is used by the Plan more specifically to help the members connect with*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The purpose of the Population Health Management Assessment Report is to: • Assess the needs and characteristics of the enrolled population, including review of the impact of Social Determinants/Drivers of Health (SDoH). • Identify key sub-populations and determine their needs. • Assess the needs of child and adolescent members. • Assess the needs of members with disabilities. • Assess the needs of members with serious persistent mental illness (SPMI). • Evaluate the extent to which current organization-wide population health management activities and resources address the needs identified and determine if modifications are needed to better serve the enrolled population. • Evaluate the integration of community resources into population health management activities to address member needs not covered by the benefit plan and make recommendations if changes are needed. The methodology and time period: Data is combined from multiple sources and is stored in data warehouses. Data from the warehouse is extracted into a predictive modeling tool. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: 1. medical and behavioral claims/encounters 2. pharmacy claims 3. laboratory results 4. health appraisal results 5. electronic health records 6. data from health plan UM and/or CM programs 7. advanced data sources such as all-payer claims databases or regional health information 8. Timeframe: January through December 2023 Race and Ethnicity: • Race and ethnicity vary by region in California, with Hispanic/Latino comprising 40% of the state population. • CalViva counties serve 55-60% Hispanic population.	*Community Supports and the Community Supports Providers.* *Dr. Marabella added that it was determined by Health Net and other health plans that this was a useful tool to support CalAIM efforts, but not the only tool.* *Mary Lourdes Leone added that for the Plan to be able to use FindHelp.org to connect Community Supports providers for CalAIM we had to obtain State approval.* *Amy Schneider added that staff do assist members with using FindHelp.org. The staff use it to connect members as well.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• In Fresno, nearly 11% of the population is Asian with the White population representing 27% (lowest in F, K, M). • Kings County has a Black/AA population of 6% (highest). • Madera has highest Hispanic (60.3%) and White (31.7%). Per the county Health Rankings and Roadmaps, CalViva counties experience higher rates compared to California of the following social economic contributing factors: • Premature death • Percentages of adult smoking • Adult obesity • Physical inactivity • Excessive drinking • Teen births children in poverty • Injury deaths • Air pollution • Ratio of population to primary care physicians and mental health providers (limited access) • Fresno and Kings counties experience higher sexually transmitted infections. CalViva counties compared to California overall have lower rates of: • Access to exercise opportunities • Kings and Madera counties experience lower percentage of flu vaccination completion. • Education; high school and college completion • Social Associations The Population Analysis reflects the following key findings **(Purposes 1-5):** • Top social determinants/drivers of health (SDoH) factors impacting CalViva Health: Smoking, Teen Birth, Air Pollution • Top needs of child and adolescent members: Pulmonary conditions • Top needs of members with disabilities: Cardiovascular and Pulmonary conditions		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Top needs of members with serious and persistent mental illness (SPMI): Anxiety and Mood disorders • Top Race/Ethnicity: Hispanic, White, Black, Asian • Top language groups with Limited English Proficiency: Hispanic, Asian (SE Asian/Laotian Other) • Top Health Conditions: Pulmonary, Cardiac and Pregnancy **Purpose #6** is to Evaluate the extent to which current PHM activities and resources address the needs identified in this analysis and determine if modifications are needed. • Actions taken since 2021 to address identified gaps were considered as part of this analysis. • Almost 40 actions were identified that address opportunities for improvement. Additional examples of actions taken include: • Heart Health: Cardiac + Diabetes Social media post to create awareness to members and the community for heart health, diabetes & medication adherence. • Pregnancy and Birth: Outreach to newly delivered moms to address post-partum needs including encouraging follow up visits with OB, screening for depression and referral to BH. Explore timely treatment options for pregnant mothers with substance use disorder. • Pulmonary – related admits: Enrollment of members who are active smokers to Smoking/Vaping Cessation app via Clinical Pharmacist outreach. • Healthy or At-Risk behavioral health: Calls to adult members diagnosed with major depression and demonstrating refill gaps, to improve medication adherence. • Pulmonary – adults, children and disabled: Partner with school districts to hold vaccination clinics for school-age youth focusing on low vaccination regions. **Purpose #7** is to evaluate the integration of community resources into PHM activities to address member needs not covered by the benefit plan and make recommended changes.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• CalViva connects members with community resources and also promotes community programs. We actively respond to members' assessed needs. • All Care Managers have access to and utilize a central directory for local community resources (*FindHelp*) for this purpose and educate members on available resources. • A community resources link by county is available on our website for staff and members. Jeff Nkansah announced this is the first time the Population Segmentation and Assessment Reports have been brought to the Commission and questioned the Commissioners if these reports were something that they would like to see on an annual basis? These reports are also presented at the Quality Improvement Utilization Management meetings prior to the Commission. *Alde De La Torre arrived at 1:36 pm* *Kerry Hydash connected in at 1:43 pm*	*Dr. Naz stated its good information to know. He added that annual reporting is good, with additional reporting as needed.* *John Frye added that if there are any concerns from the QIUM committee, the Commission would want to know that.*	
#7 2024 Quality Improvement • Program Description & Change Summary • Work Plan **Action** P. Marabella, MD, CMO	Dr. Marabella presented the 2024 Quality Improvement and Health Education Annual Program Description & Change Summary, and the 2024 Work Plan. Quality Improvement and Health Education have now merged into one set of program documents. The two components for the QI and Health Ed Program consist of: • 2024 QI & Health Ed Program Description: This is a roadmap for structure, resources and monitoring and we combined QI and Health Ed this year. • 2024 QI & Health Ed Work plan: The plan for quality improvement activities throughout the year combined with Health education activities. The highlights of changes for 2024 include: • Updated QI Program and QI Work Plan to QIHEd Program and QIHEd Work Plan throughout.		***Motion:*** *Approve 2024 QI & HE Program Description and Work Plan* *14 – 0 – 0 – 3* *(Neves / Naz)* *(Naz / Frye)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Updated social determinates of health to social drivers of health (SDoH) throughout. • Information Systems and Analysis: added ECHO behavioral health survey and provider satisfaction survey to scope of analytics. • Health Promotion Programs: added use of QR codes to promote HEd programs. Revised the CalViva Pregnancy Program, Health Promotion Incentive Program and Member Newsletter descriptions. • MemberConnections® Program: added clinical pharmacy to the scope of the program. Added HEDIS Care Gap Reports as a tool used to engage members. • Health Management Programs: Added social needs data to data sources used for PHM assessments. Added additional details on risk stratification, segmentation, and tiering methodologies to identify changes in member's health status and connecting them to health management programs. • Health Plan Performance: Revised description to include additional details of performance metrics and standards that are monitored by the plan to improve health outcomes. Also, details were added on how performance data and ratings are shared with members and providers. • Delegation: Added statement regarding QI functions that are delegated. • QI Process: Replaced SWBHC with CAHPS/ECHO Surveys. Added REL, SOGI, and social needs status under demographics with risks. Moved information regarding communication to members and providers into its own section. • Behavioral Health Medical Director: Removed MHN reference. Clarified role of the BH Medical Director who functions as an advisor to the QI/UM Committee. • Health Education: Revised the population needs assessment from conducted annually to every three years. • Corrective Actions: New section added for corrective actions taken for problems identified. • QIHEd Program Information Availability: New section added regarding how QIHEd program is communicated to members and/or providers. • Other minor edits Activities for QI, Health Ed, and Wellness Work Plan for 2024 focus on: • Work Plan Initiatives: Implement activities to improve performance measures.	*Amy Schneider added that the MemberConnections team are also doing bedside enrollment for hospitalized members.* *Commissioner Soyla Reyna-Griffin asked what led to the Health Education program being integrated into QI?* *Dr. Marabella stated it's an integration of a natural fit to bring QI and the educational aspect together.* *Commissioner Dr. Naz asked if the Director of Behavioral Health will be able to help with finding a Provider, as this is a problem.* *Dr. Marabella stated that Medical Management is meeting with BH on a regular*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Ongoing Work Plan Activities There are eight (8) sections for the QI Work Plan that are more comprehensive and inclusive of key areas for QI Work: 1. Behavioral Health – Improving Behavioral Health (Mental Health and Substance Use) Outcomes: objective is to meet directional improvement of 1-5% from prior year or greater than or equal to the 50th percentile. 2. Chronic Conditions: objective is to meet directional improvement of 1-5% from prior year or greater than or equal to the 50th percentile. 3. Hospital Quality/ Patient Safety: monitoring for hospital acquired conditions. 4. Member Engagement and Experience: Improve New Member completion of IHA in under 120 days. 5. Pediatric and Maternal Health Programs: Well-Child visits; Childhood Immunization; Prenatal and Postpartum Care; and Lead Screenings. 6. Pharmacy: Pharmacy Medical Drug Benefit 7. Preventive Health: Cancer Screening (MCAS). Breast Cancer Screening and Cervical Cancer Screening 8. Provider Engagement: Improving Member Experience (CAHPS) – Provider and Plan Focus; and Improving Provider Survey Results. Quality Improvement Tracking System Activities include: 1. Behavioral Health: Conduct live outreach to Medi-Cal members that had an ED visit for MH, SUD, or Drug Overdose. Uses ADT reports to conduct member outreach calls to close gaps. 2. Chronic Conditions: Diabetes Prevention Program (DPP) Vendor Onboarding. Multiconditions: KED Tip Sheets. 3. Hospital Quality/ Patient Safety: Hospital outreach about patient safety, C-section overuse and maternal health issues, Hospital Quality Scorecard program, Participation on Leapfrog Partners Advisory Committee and Engagement with external collaboratives to promote hospital quality. 4. Member Engagement and Experience: Annual Member Newsletter- CalViva, IHA Quarterly Reporting and focus on Low Performing Providers. 5. Pediatric/ Adolescents: First Year of Life Program – FYOL, QI Referrals to the CalViva Health Pregnancy Program, Peds+ POD Action Plan Reviews,	*basis now, they have a network and a list of all the providers who provide mental health services. Now that the Plan is closer to the issue, access will be a priority area of focus.* *Dr. Naz added that we lack an adequate number of psychiatrists to treat serious mental illness. It was noted that serious mental illness services are the responsibility of the counties.* *Commissioner Sara Bosse added that behavioral health staffing is an issue. She stated Madera County has a program, but the issue is staffing.* *Commissioner Michael Goldring asked what SIR stands for in relation to #3 Hospital Quality / Patient Safety.* *Dr. Marabella stated it stands for Systemic Inflammatory Response-evidence of infection.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Pediatric/Perinatal/ Dental Provider HEDIS Tip Sheets, Provider Engagement and CPM Training on Pediatric MCAS measures for MY 2024. 6. Pharmacy: Multi-Gap Family Unit (MCL) Live Call Outreach, KIC Smoking Cessation Newsletter, Community Supports Asthma Remediation Email Campaign, Provider flyer. 7. Preventive Health: PARS for High Volume Specialists, Ancillary, CBAS, and Behavioral Health providers. 8. Provider Engagement: IHQC – Project Management Training and Fundamentals of QI Training.		

#8 HEDIS® Report Update
 	
Information
P. Marabella, MD, CMO
	Dr. Marabella presented the 2023-2024 HEDIS® Update.
	
	Recent changes to quality measures by Quality Domain for MY2024 are as follows:
	1. Child & Adolescent Preventative Health Domain:
	    a. Child and Adolescent Well-Care Visits
	    b. Childhood Immunization Status: Combination 10
	    c. Developmental Screening in the First Three Years of Life
	    d. Immunizations for Adolescents: Combination 2
	    e. Lead screening in Children
	    f. Topical Fluoride for Children
	    g. Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months
	    h. Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30 Months
	
	2. Reproductive Health Domain:
	    a. Chlamydia Screening in Women
	    b. Prenatal and Postpartum Care: Postpartum Care
	    c. Prenatal and Postpartum Care: Timeliness of Prenatal Care
	    d. Postpartum Depression Screening and Follow Up (new measure)
	    e. Prenatal Depression Screening and Follow Up *(new measure)*
	    f. Prenatal Immunization Status (new measure)
	
	3. Behavioral Health Domain:
	    a. Follow-Up After Emergency Department (ED) Visit for Mental Illness –30 days.
			No Motion

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN

	b. Follow-Up After ED Visit for Substance Abuse – 30 days
	c. Depression Remission or Response for Adolescents & Adults *(new measure)*
	d. Depression Screening and Follow-Up for Adolescents & Adults (new measure)
	e. Pharmacotherapy for Opioid Use Disorder *(new measure)*
	
	4. Chronic Diseases Domain:
	  a. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
	  b. Controlling High Blood Pressure
	  c. Asthma Medication Ratio
	
	5. Cancer Prevention Domain:
	  a. Breast Cancer Screening (BCS)
	  b. Cervical Cancer Screening (CCS)
	  c. Colorectal Cancer Screening (COL) *(new measure)*
	
	The QI Accountability Tier Updates are:
	1. Red Tier (systemic QI challenges): County is below the State AND Region median or average in 3 or more domains.
	2. Orange Tier (QI sporadic): County is below the State or region median or average in 2 domains.
	3. Green Tier (QI integrated): County is below the State median or average within a region in any 1 domain.
	
	CalViva Health tier status shows that no service counties are in the red. Fresno County is in the orange tier, and Kings and Madera counties are both in the green tier.
	
	Orange Tier County Activities include:
	1. County is below the State or Region median or average in 2 domains. (RY 2023):
	  Accountability Project:
	  a. SWOT process with modification of SWOT analysis to be replaced by fishbone for each domain triggered by the RU (reporting unit or county).
		Commissioner Sara Bosse asked what counties are in the San Joaquin region.
		
		Dr. Marabella stated the counties in the San Joaquin region are Fresno, Kings Madera, Tulare, Kern, San Joaquin, Merced and Stanislaus.	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN

	b. The fishbone should include disparity barriers for the disparate group compared to the well- performing group within the triggered domain.
	Advantage:
	1. Allows peer comparison in performance within a region.
	2. Allows accountability for performance that is consistently low compared to the Plans within the region
	3. Allows domain-focused interventions that could potentially impact multiple measures within a domain
	4. Allows improvement in rates for disparate groups
	within the region for multiple measures within a domain.
	
	Green Tier County Activities include:
	2. County is below the State median or average within a region in one (1) of the domains.
	      Accountability Project:
	      a. Improve Disparity population in a region with measure(s) within a triggered domain by using A3 and a summary of Aims. (Improvement ideas & measures/progress, results & impact, then next steps).
	      Advantage:
	      a. Allows peer comparison in performance within a region.
	      b. Allows accountability within a domain performance.
	      c. Allows potential for sustainability.
	      d. Allows improvement in rates for disparate groups.
	
	Improvement Opportunities for CalViva in 2023-2024 consist of:
	• Clinical PIP: Well Child Visits in AA/Black population in Fresno County
	• Non-clinical PIP: Follow up after ED Visit for MH/SUD in Fresno & Madera Counties
	• SWOT: Well Child & CIS-10 Project in all three service counties. (closed December 2023)
	• 2024: Anticipate A3 Projects in Madera & Kings Counties. SWOT Project in Fresno County.
	• IHI Collaborative: DHCS Child Health Sprint Collaborative. Focus on Well Child Visits in Fresno County.
		Commissioner Rose Mary Rahn asked if the Health Departments will be a part of helping with the A3 projects?	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		Dr. Marabella responded, for Kings County, it is unknown at this time.	
#14 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** Financials as of January 31, 2024: Total current assets recorded were approximately $711.2M; total current liabilities were approximately $570.1M. Current ratio is approximately 1.25. Current assets and liabilities are higher due to accruing for the new MCO taxes which are substantially higher than in the past. Total net equity was approximately $151M, which is approximately 847% above the minimum DMHC required TNE amount. For the first seven months of the current fiscal year, interest income actual recorded was approximately $4.5M, which is approximately $2.4M more than budgeted due to interest rates on our money market funds being higher than projected. Premium capitation income actual recorded was approximately $1.2B which is approximately $209.6M more than budgeted due to accounting for MCO taxes that are applicable to fiscal year 2024 with $125M related to FY 2023, and enrollment and rates being higher than projected. Total cost of medical care expense actual recorded is approximately $765.4M which is approximately $80.9M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $33.6M, which is approximately $2.4M more than budgeted due to enrollment being higher than projected. Taxes were approximately $423.4M, which is approximately $125.5M more than budgeted due to that portion of MCO taxes relating to FY 2023 (April 2023 – June 2023 quarter). Net income through January 31, 2024, was approximately $9.6M, which is approximately $4.5M more than budgeted primarily due to interest income being approximately $2.4M higher than projected, and rates and enrollment being higher than projected.	*Commissioner Soyla Reyna-Griffin asked if the MCO taxes are a part of premium capitation.* *Daniel Maychen responded, yes.*	*Motion: Standing Reports Approved* *14 – 0 – 0 – 3* *(Naz / Frye)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Compliance** Mary Lourdes Leone, CCO	**Compliance** Compliance Report Year to date there have been 112 Administrative & Operational regulatory filings for 2024; 5 Member Materials filed for approval; 26 Provider Materials reviewed and distributed, and 16 DMHC filings. There have been 10 potential Privacy & Security breach cases reported since year to date. One of the four cases reported in February involved a cybersecurity incident at Change Healthcare that caused widespread product outages affecting many plans nationally. CalViva does not have a contractual relationship with Change Healthcare but CalViva's Plan Administrator, Health Net, does. Although Health Net submitted a Privacy Incident Report to DHCS on 2/28/24 no member PHI was impacted and DHCS closed the case as a non-breach. There have been six (6) Fraud, Waste & Abuse cases filed with DHCS year to date. The Annual Oversight Audits currently in progress since last reported include Credentialing, UMCM, and Behavioral Health. Audits completed since last reported consist of Emergency Room (CAP), and Quality Improvement (CAP). The Plan is currently awaiting response from DMHC relating to the CAP response submitted on 12/15/23 in reference to the 2022 Medical Audit. With regard to the DHCS 2023 Medical Audit, the Plan submitted its March CAP update on 2/26/24. DHCS has requested the Plan's final CAP response by 3/20/24. The Plan received notice from DHCS for this years' 2024 Medical Audit. It will take place May 20th – 31st covering the review period of 4/1/23 – 3/31/24. The audit will be virtual. Regarding Enhanced Care Management, the Plan submitted an updated Justice Involved ECM network and capacity report on 1/19/24.	*Commissioner Aldo De La Torre asked if this is the Routine Medical Survey?* *Mary Lourdes Leone responded, it's routine in that it's done every year, but not as in depth as it was last year.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding Community Supports, the Plan submitted an updated 2024 Community Supports MOC on 1/29/24 for those services going live 7/1/24; Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties; and Recuperative Care (Madera County.)		
	Effective 1/1/2024, LTC-ICF/DD and Subacute Care services were carved into MCPs statewide. The Plan submitted deliverables associated with APL 23-004 ("Intermediate Care Facilities for Individuals with Developmental Disabilities"), and APL 23-027 ("Subacute Care Facilities") to DHCS on 11/27/23 and 1/29/24. The Plan is still working to complete Phase I of the ICF/DD network readiness requirements regarding contracting efforts.		
	DHCS requires Plans and Third-Party Entities to submit updated MOU templates and to specify responsibilities under those MOUs. DHCS has provided base templates that the Plan must execute starting January 1, 2024, through January 1, 2025. DHCS will require quarterly status updates on the execution of those MOUs. Q1 2024 is due 4/30/2024.		
	Regarding the Annual Subnetwork Certification (SNC), the Plan filed all the required documentation on 1/5/24 and is awaiting DHCS determination.		
	Regarding the 2023 Annual Network Certification (ANC), the Plan is scheduled to file the required documentation by 3/25/24. Regarding the 2022 Annual Network Certification (ANC), the Plan was informed on 3/13/24 it's Alternate Access Standard (AAS) requests were approved by DHCS and have been posted as required on the CalViva Health website.		
	The Public Policy Committee met on March 6, 2024, at 7625 N. Palm Ave Suite 109, Fresno, CA 93711. The following programs and reports were presented: 2024 Annual Compliance Report; Q4 2023 Grievance & Appeals Report; and the Semi-Annual (Q3 and Q4 2023) Member Incentive Programs Report. Additionally, CalViva Health's 2023 Annual Report was presented and was posted on the Plan's website. Next Public Policy Committee meeting will be June 5, 2024, 11:30 am-1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	**Medical Management** Appeals and Grievances Dashboard Dr. Marabella presented the Appeals & Grievances Dashboard through January 31, 2024. • The total number of grievances remains consistent compared to previous months. • For the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Access (Prior Authorizations, Availability of Providers, DME delays), Administrative (member material requests), and Transportation. • The volume of Quality of Care (QOC) cases remains consistent with recent months. • The volume of Exempt Grievances remains consistent. Exempt Transportation Grievances have improved when compared to previous months. Balanced Billing Grievances have improved. • Total Appeals remain in line with previous data reported, while the uphold and overturn rates remain consistent. Advanced imaging and Cardiovascular imaging volume of cases has improved (declined). Key Indicator Report Dr. Marabella presented the Key Indicator Report (KIR) through January 31, 2024. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through January 2024, which demonstrates that most rates have decreased. • Membership continues to show a decrease for Expansion, TANF, and the SPD populations. This is related to redetermination activities.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Acute Admissions, Bed Days, and Acute Length of Stay (adjusted PTMPY), for SPDs continues to decrease. • For Acute Admissions (adjusted PTMPY), SPDs continues to decrease. • Acute Length of Stay (adjusted PTMPY) continues to decrease. • Turn-around time compliance remains at 100%. Care Management (CM) results have fluctuated within the various programs; Perinatal CM increased significantly with good engagement rates, Integrated Case Management has decreased, Transitional Case Management (Transitions of Care) continues to increase with recent modifications to the program processes. Palliative Care has trended down the past couple of months, and Behavioral Health CM increased substantially in January. First Year of Life is a new program recently added and has shown an increase in engagement rates. Credentialing Sub-Committee Quarterly Report The Credentialing Sub-Committee met on February 15, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering the third quarter for 2023 were reviewed for delegated entities and fourth quarter 2023 for Health Net and MHN. Credentialing Adverse Actions for Q4 for CalViva from Health Net Credentialing Committee was presented. There were no (0) cases for October, November, or December for CalViva Health. The Q4 2023 Adverse Events Report is a new report for the Credentialing Sub-Committee in 2023. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were no (0) cases identified in Q4 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no reconsiderations or fair hearings during the fourth quarter of 2023. There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	access to care issues. There were no (0) cases identified outside of the ongoing monitoring process this quarter. There were six Credentialing Policies reviewed by the committee with edits, Policy CR-101 Delegation Evaluation; Policy CR-109 Ongoing Monitoring of Sanctions-Complaints; Policy CR-110 Credentialing and Recredentialing; Policy CR-120 Organizational Providers; Policy CR-140 Adverse Action; and Policy CR-160 Appeal Process. NCQA System Controls Oversight Report is to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe 1) How primary source verification information is received, dated, and stored; 2) How modified information is tracked and dated from its initial verification; 3) Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate; 4) Security controls that are in place to protect the information from unauthorized modification; 5) How the organization monitors its compliance with the policies and procedures in factors 1–4 at least annually and takes appropriate action when applicable. Quarterly audits were performed with no modifications to CalViva provider records during 2023, therefore no cases to audit. The Health Net audit results provided to CalViva reflect 100% compliance with audit criteria. Peer Review Sub-Committee Quarterly Report The Peer Review Sub-Committee met on February 15, 2024. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2023 were reviewed for approval. There were no significant cases to report. The Q4 2023 Adverse Events Report was presented. This 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 nine (9) cases identified in Q4 that met the criteria for reporting and were submitted to the Peer Review Committee.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Three (3) of these cases involved a practitioner and six (6) cases involved organizational providers (facilities). Of the nine (9) cases, three (3) were tabled, one (1) was tabled with a letter of education, zero (0) were placed on a CAP, three (3) were closed with a letter of education, and two (2) 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. There was one (1) case identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. There were 37 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.

The Peer Review Policies presented to the committee for review, discussion, and approval include the PR-001 Peer Review Protected Information, PR-100 Peer Review Committee Policy.

The Access & Availability Substantial Harm Report Q4 2023 identifies incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability issues and are ranked by severity level. Sixteen (16) cases were submitted to the Peer Review Committee in Q4 2023. There were zero (0) incidents found involving appointment availability issues resulting in substantial harm to a member or members.   One (1) case was associated with significant harm without appointment availability issues.

The Quarter 4, 2023 Peer Count Report was presented at the meeting with a total of sixteen (16) cases reviewed. The outcomes for these cases consist of ten (10) cases closed and cleared. There were five (5) cases tabled for further information. There was one (1) case with CAP outstanding and none (0) were pending closure for CAP compliance.

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** Data from the State was unavailable at the time packets were distributed and numbers reported were from December 2023. Updated data has been received and total membership for CalViva as of January 2024 is 428,442. Kaiser numbers are now included in the report and show their MC membership at 4,100 for January 2024. There are no significant issues or concerns to report at this time as it pertains to IT, Member Services, CVH Website, Provider Network, Claims, and Provider Disputes.		
#10 Final Comments from Commission Members and Staff	None.		
#11 Announcements	None.		
#12 Public Comment	None.		
#13 Adjourn	The meeting adjourned at 2:58 pm. The next Commission meeting is scheduled for May 16, 2024, in Fresno County.		

Submitted this Day: _____

Submitted by: _____

      Cheryl Hurley
      Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

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

February 15, 2024

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Director, HR/Office
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
✓	Paulo Soares		
✓	Joe Neves		
	David Rogers		
	John Frye		
	Rose Mary Rahn		
		✓	Present
		*	Arrived late/Left Early
		●	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:42 am, a quorum was present.		
#2 Finance Committee Minutes dated October 19, 2023 Attachment 2.A Action, D. Maychen, Chair	The minutes from the October 19, 2023, Finance meeting were approved as read.		Motion: *Minutes were approved* *4 – 0 – 0 – 3* *(Soares / Nkansah)*
#3 Financials – as of December 31, 2023 Action D. Maychen, Chair	Total current assets recorded were approximately $300.7M; total current liabilities were approximately $160.7M. Current ratio is approximately 1.87. Total net equity was approximately $149.8M, which is approximately 868% above the minimum DMHC required TNE amount.		Motion: *Financials as of December 31, 2023, were approved* *4 – 0 – 0 – 3* *(Neves / Soares)*

Finance Committee

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#4 Fiscal Year 2024 – Revised Budget	For the first six months of the current fiscal year, interest income actual recorded was approximately $4M which is approximately $2.2M more than budgeted due to interest rates on our money market funds being higher than projected. Premium capitation income actual recorded was approximately $705.8M which is approximately $66.5M more than budgeted due to enrollment and rates being higher than projected. Total cost of medical care expense actual recorded is approximately $666.7M which is approximately $64M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $28.8M, which is approximately $1.9M more than budgeted due to enrollment being higher than budgeted. Disenrollment was projected to be higher; however, the Plan retained more membership during the redetermination process than what was projected. Net income for the first six months of FY 2024 actual recorded was approximately $8.5M, which is approximately $4M more than budgeted primarily due to interest income being approximately $2.2M higher than projected, and rates and enrollment being higher than projected. When the fiscal year 2024 budget was presented to the Commission in May 2023, DHCS was looking to renew the MCO taxes, noting a substantial increase to the MCO taxes from prior periods. For some plans, the increase in MCO taxes would increase by over 400%. Due to the uncertainty of approval by the federal government of the new MCO tax proposal, CalViva did not budget for the new MCO taxes in the initial fiscal year 2024 budget. However, if the federal government were to approve the new MCO tax proposal, CalViva would bring a revised budget to the Commission for review and approval. On December 19, 2023, CMS approved the MCO taxes as proposed which prompted the Fiscal Year 2024 Revised Budget. The calculation used for MCO tax revenue and expenses is based off a revised MCO tax proposal from what was just approved in December. The State of California is projecting a $38B budget deficit and the State is looking to revise the recently approved MCO tax to obtain an additional $1.5B in funding to help cover the budget deficit. DHCS feels confident that the revised MCO tax proposal will be approved by CMS, which is why CalViva is using the revised MCO tax numbers.		Motion: FY 2024 Revised Budget was approved to move to Commission 4 – 0 – 0 – 3 (Neves / Soares)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	The revision will increase CalViva's MCO tax revenue and expense by approximately $144M over the term of the MCO tax which has a term of April 2023 – December 2026. For the actual revised budget for FY 2024, the only change made was to Medical Revenue, increasing by approximately $466.3M, and correspondingly, MCO tax expense increasing by the exact same amount. Net income remains the same as previously approved. The Plan budgeted the new MCO taxes with no gain or loss; in actuality, there could be a gain or loss but at this point in time, it is difficult to determine if there will be a gain or loss, and at what amount of gain or loss.		
#5 Fiscal Year 2025 Review and Discuss Budget	The basic assumptions being used to create the FY 2025 budget was presented to the Committee. An official proposed FY 2025 budget is planned for presentation at the March 2024 Finance meeting with intent to accept and forward to the Commission. Any changes requested as a result of the March 2024 meeting will carry on to an April 2024 meeting, if necessary. The Finance Committee reviewed and approved budget will then be presented at the May 2024 Commission meeting. FY 2025 enrollment projected to gradually decline throughout the fiscal year as we project our enrollment to trend closer to our pre-COVID membership, net of membership gains from new membership such as but not limited to dual Medi-Cal/Medicare members moving from voluntary to mandatory Medi-Cal managed care and undocumented adults ages 26-49 receiving full scope Medi-Cal benefits in 2024. By the end of next fiscal year, June 2025, membership is projected to be approximately 375,000. Revenues projected based on enrollment breakdown by aid category, using current aid code category specific rates as a benchmark known at time of budget preparation. Overall, revenues are projected to increase in comparison to prior year budget primarily due to three factors, 1) MCO tax revenue is projected to substantially increase; a projected increase of approximately $497M, 2) increase in capitation rates paid by DHCS to the Plan as a result of the additional funds generated by the new MCO tax which will be used to increase the Medi-Cal fee schedule for primary care, maternity care, and non-specialty mental health services, and 3) increase in membership from prior year FY 2024 budgeted amounts as there have been lower actual disenrollments vs previously projected	*Supervisor Neves asked if the accreditation expenses previously discussed are still accounted for.* *Jeff Nkansah confirmed it's still programmed in and still on track.* *Daniel Maychen confirmed the consulting expense is still in place in the case it is needed.* *Paulo Soares questioned the community investments and meeting the new requirement.* *Jeff Nkansah explained that the funding bucket may look different if the State says what the*	Motion: *FY 2025 Budget Timetable, Assumptions, and Preliminary Draft were approved* 4 – 0 – 0 – 3 (Soares / Neves)

Finance Committee

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	disenrollments as a high number of individuals remain eligible for Medi-Cal after eligibility redeterminations. The Plan is projecting FY 2025 staffing at 21 full-time employees. The Plan is currently at 18. One of the additional positions is for the Equity Officer. Projected wage increases of up to 5% based on employee performance at anniversary date, 8% increase in health insurance premiums based on January renewal, current deferral rate and employer contribution/match into the 457b-retirement program. The increase is primarily due to the potential addition of staff to support the new DHCS 2024 contractual requirements (e.g., NCQA, D-SNP, Long-Term Care, etc.) and potential succession planning efforts for key management positions near retirement age. Projected increase in Dues & Subscriptions expense as a result of increase in dues from trade organizations who have added additional staff to better represent health plans in relation to numerous changes affecting Medi-Cal managed care such as but not limited to the MCO tax targeted rate increases (i.e., increase to Medi-Cal fee schedule), and long-term care moving into Medi-Cal managed care. Community Support/Grants expense based on continuation of providing grants to community-based organizations, scholarship funding to various local colleges, physician recruitment grants, and quality score incentive grants to providers. Increase to account for DHCS 2024 contractual requirement which requires Plans to submit a Community Reinvestment Plan for DHCS' approval in a form and manner to be specified by DHCS through a future document. Per DHCS 2024 contract, Plans must contribute 5% of annual net income to community reinvestment initiatives. The Community Reinvestment also includes a mandated amount if Plans do not meet certain quality metrics. Therefore, in addition to the 5%, Plans may have to contribute an additional 7.5% of the Plan's net income to community reinvestment initiatives, for a total of 12.5% of net income. Projected increase to Legal & Professional expense to account for CalViva utilizing a vendor to add CalViva Health member ID option on our website where members can access their member ID online. Projected increase to Recruitment expense to fill additional positions during FY 2025.	Plan is doing for community investment is not aligning with new guidelines.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	MCO tax expense calculated per recently revised MCO tax structure for FY 2025, noting a substantial increase from FY 2024. MCO tax is projected to be budget neutral (i.e., no gain or loss). Per preliminary FY 2025 budget, medical revenue is projected to be $1.78B, which is $515.4M more than previously budgeted mainly due to the MCO tax increase and capitation rate increases from DHCS. Net income is projected to be approximately $8.1M, which is approximately $744K less than budgeted for FY 2024 primarily due to an increase in Admin expenses net of increase in revenues.		
#6 Moss Adams, LLP Audit Proposal	The fee proposal was approved to forward to Commission for final approval of reappointment of Moss Adams as independent auditors for an additional three years.	*Paul Soares asked if there's any requirement for an RFP for health plans by the State.* *Daniel Maychen stated there is no requirement that he is aware of. In addition, there are other local health plans that have used Moss Adams for 10+ years.*	Motion: *Moss Adams, LLP Audit Proposal was approved.* 4 – 0 – 0 – 3 (Neves / Soares)
#7 Announcements	None.		
#8 Adjourn	Meeting was adjourned at 12:02 pm		

Submitted by: _Cheryl Hurley_

Cheryl Hurley, Clerk to the Commission

Dated: _March 21, 2024_

Approved by Committee: _Daniel Maychen_

Daniel Maychen, Committee Chairperson

Dated: _3/21/24_

Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	**Patrick Marabella, M.D.,** Emergency Medicine, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Director of Medical Management Services
✓	**David Cardona, M.D.,** Family Medicine, Fresno County At-large Appointee, Family Care Providers	✓**	**Iris Poveda,** Senior Medical Management Specialist
	Fenglaly Lee, M.D., Obstetrics/Gynecology, Central California Faculty Medical Group	✓	**Mary Lourdes Leone,** Chief Compliance Officer
✓	**Carolina Quezada, M.D.,** Internal Medicine/Pediatrics, Family Health Care Network	✓	**Maria Sanchez,** Compliance Manager
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**Joel Ramirez, M.D.,** Family Medicine/Sports Medicine, Camarena Health Madera County (arrived at 10:35 AM)	✓	**Zaman Jennaty,** Medical Management Nurse Analyst
	Rajeev Verma, M.D., Pediatrics, UCSF Fresno Medical Center	✓	**Norell Naoe,** Medical Management Administrative Coordinator
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
Guests/Speakers			
	None were in attendance.		

✓ = In attendance
* = Arrived late/left early
** = Attended virtually

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D Chair	The meeting was called to order at 10:32 am. A quorum was present.	
#2 Approve Consent Agenda Committee Minutes:	November 16th, 2023, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Dr. Marabella reminded the committee that any item on the	Motion: *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
November 16th, 2023 - Member Incentive Programs Semi-Annual Report (Q4) - California Children's Service Report (CCS) (Q4) - Concurrent Review IRR Report (Q4) - Appeals & Grievances Inter-Rater Reliability Report (IRR) (Q4) - Provider Preventable Conditions (PPC) (Q4) - Provider Office Wait Time Report (Q4) - County Relations Quarterly Report (Q4) - Customer Contact Center (CCC) DMHC Expedited Grievance Report (Q4) - SPD HRA Outreach (Q3) - Enhanced Care Management and Community Supports Performance Report (Q3) - TurningPoint Musculoskeletal Utilization Review (Q3) - MedZed Integrated Care Management Report (Q3) (Attachments A-M)	consent agenda may be pulled out for further discussion at the request of any committee member. A link for the Medi-Cal Rx Contract Drug List was available for reference.	(Quezada/Waugh) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair		
#3 QI Business - Appeals & Grievances Dashboard and Turnaround Time Report (December) - Appeals & Grievances Executive Summary (Q4) - Appeals & Grievances Quarterly Member Report (Q4) - Appeals & Grievances Classification Audit Report (Q4) - Quarterly Appeals & Grievances Member Letter Monitoring Report (Q4) (Attachments N-R) **Action** Patrick Marabella, M.D Chair	**Appeals & Grievances Dashboard and Turnaround Time Report** through December 2023 were presented noting the following trends: ● The total number of grievances through December 2023 has increased compared to previous years. Trends associated with this increase are being addressed. ● The increase noted can be attributed to the Quality of Service (QOS) category of grievances since Quality of Care, Exempt, and Appeals have all declined compared to previous years. ● With the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Access (Prior Authorizations), Administrative, Other (Balanced Billing), and Transportation. ● Transportation grievances have demonstrated variation over time, however, at the Plan's request the transportation vendor has focused in recent months on high-risk transports such as dialysis, assigning their most reliable transportation providers to these trips, and conducting root cause analysis to identify and address core issues. Improvement is noted in Q4 for missed/late appointments for this sub-group. ● The volume of Quality of Care (QOC) and Quality of Service (QOS) grievances have decreased in Q4 compared to Q3. ● Exempt Grievances have decreased compared to last year. Both the Availability of Appointments with PCP and Exempt Transportation Grievances have improved when compared to last year. Balanced Billing Grievances have increased. Total Appeals received through Q4 2023 have decreased, while the uphold and overturn rates remain consistent. Advanced imaging cases represent the highest volume of appeal type and almost all appeals are pre-service. *Discussion:* *Dr. Cardona asked if a "Transportation – Provider Late" affected the ability of the member to see their provider.* *Dr. Marabella clarified the difference between the categories of no-show, late, and missed appointments. A no-show would affect the members' ability to see their provider and late may or may not depending on whether the office can fit the member in. A missed appointment due to inadequate transportation is tracked.* **Appeals & Grievances Executive Summary (Q4)** through December 2023 was presented noting	Motion: *Approve* - Appeals & Grievances Dashboard and Turnaround Time Report (December) - Appeals & Grievances Executive Summary (Q4) - Appeals & Grievances Quarterly Member Report (Q4) - Appeals & Grievances Classification Audit Report (Q4) - Quarterly Appeals & Grievances Member Letter Monitoring Report (Q4) (Ramirez/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	the following trends: • Total Appeals have decreased when Q4 2022 is compared to Q4 2023, but the Total Grievances in these same periods have increased. • For Q4 2023, there were 80 Total Appeals & 453 Total Grievances reported. • Total Exempt Grievances, particularly Member Billing, have increased when Q4 2022 is compared to Q4 2023, but Exempt Transportation grievances have decreased. • In Q4, 70 formal and 34 exempt grievances were transportation-related, 14 were access-related (missed appointment/provider no-show), and 56 were related to behavioral issues (for example, late, general vendor complaint, reimbursement). • Top Access Grievances were Prior Authorization Delay, PCP, and Specialist availability. • The Turnaround Time Resolution letter compliance rate across all categories ranged from 98.7-100%. **Appeals & Grievances Quarterly Member Report (Q4)** through December 2023 was presented noting the following trends: • The Overall grievance rate on a PTMPY basis is higher in 2023 compared to 2022. While the PTMPY rate for appeals is lower. • There were seventy-nine (79) pre-service appeals and one post-service. Pre-service appeals were mainly related to Diagnostic MRIs, Self-Injectable Medication, and CAT Scans. • Quality of Care (QOC) Grievances: Delay in referral by PCP, Inadequate Care, and Delay in RX Refill were the top grievances in all three counties. • Quality of Service (QOS) Grievances and QOS Access Grievances: Balance Billing, Prior Authorization, and Transportation remain top grievances in all three counties. • Exempt Grievances: Sixty-seven (67) were Balanced Billing, thirty-four (34) for Transportation. **Appeals & Grievances Classification Audit Report (Q4)** is a review of a random sample of grievance logs and grievance classification while the case is still open to ensure appropriate disposition of grievances. • Six (6) cases were misclassified as QOS instead of QOC, six (6) cases were misclassified as appeals instead of QOS, and four (4) cases were identified as duplicates. These cases were misclassified due to one new rep learning the triaging process.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o A QOS Grievance goes to the State for a Fair Hearing decision versus appealing a decision that the member disagrees with. • Triagers received feedback/reteaching regarding processing errors. **Quarterly A & G Member Letter Monitoring Report** provides a summary of the daily audits of acknowledgment and resolution letters to ensure: • Required bolding of DMHC and Plan Phone numbers. • 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. o This metric has continued to show improvement quarter over quarter throughout 2023. All errors identified by the A & G team in Table 1 were corrected prior to mailing. The clinical team will continue to monitor and track acknowledgment and resolution letters.	
#3 QI Business - Potential Quality Issues Report (Q4) (Attachment S) **Action** Patrick Marabella, M.D Chair	**Potential Quality Issues (PQI) Report (Q4)** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or peer-review activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data was reviewed for all case types including the follow-up actions taken when indicated. Beginning in 2023, peer review results reported for cases with severity code levels 0, I, or II include reporting on further actions taken to address identified issues, such as practitioner/provider education, case management, health equity review, and network management involvement. PQI and PPC cases will continue to be tracked, monitored, and reported. • There were six (6) non-member PQIs in Q4; one (1) Practitioner PQI, and five (5) Provider PQI. One case scored a level zero, and five (5) at level two. • There were seventy-five (75) member-generated PQIs in Q4. Most of these cases were scored a level zero, followed by level one and then level two. Two (2) cases were at level three and sent to Peer Review. • Sixteen (16) cases were sent to Peer Review in Q4; with eleven (11) cases closed and five (5) remaining open.	Motion: *Approve* - Potential Quality Issues Report (Q4) (Ramirez/Waugh) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Forty-three (43) cases required further action with peer review in Q4. The cases are closed to track and trend. *Discussion:* *Dr. Cardona asked if grievances can be coded more specifically designating whether a family member filed the grievance versus the actual member to help PCPs provide better care and resolve issues.* *Dr. Marabella will follow up to see if a check box can be added to the grievance documentation.*	
#3 QI Business - NCQA System Controls Oversight Report (Attachment T) **Action** Patrick Marabella, M.D Chair	**NCQA System Controls CR Oversight Report 2023** identifies any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe: • How primary source verification information is received, dated, and stored. • How modified information is tracked and dated from its initial verification. • Titles or roles of staff who are authorized to review, modify, and delete information, and • Circumstances when modification or deletion is appropriate. • Security controls in place to protect the information from unauthorized modification. • How the organization monitors its compliance with the policies and procedures in factors 1–4 at least annually and takes appropriate action when applicable. Quarterly audits were performed with no modifications to CalViva provider records during 2023, there were no cases to audit. The Health Net audit results provided to CalViva reflect 100% compliance with audit criteria therefore monitoring was determined to be adequate with full compliance with policy and procedure. No recommendations for improvement, continue to monitor and report.	Motion: *Approve* - NCQA System Controls Oversight Report (Quezada/Ramirez) 5-0-0-2
#4 QI/UM/CM Business-Key Presentation - 2023 QI Work Plan End of Year Evaluation & Executive Summary (Attachment U) (PowerPoint)	**2023 Quality Improvement Work Plan End of Year Evaluation and Executive Summary** were presented and reviewed. The Quality Improvement (QI) Program Evaluation 2023 Year-End includes: tion 2023 Year-End includes: 1. Summary of Overall effectiveness of QI Program 2. Goals and Quality Indicators 3. Overall Effectiveness of QI Work Plan Initiatives 4. QI Reporting	Motion: *Approve* - 2023 QI Work Plan End of Year Evaluation & Executive Summary (Quezada/Ramirez) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Action
Patrick Marabella, M.D Chair
	5. Summary of Key Accomplishments
	6. Annual QI Program Changes
	CalViva's Quality Improvement Committee Organizational Chart was presented and reviewed.
	Planned activities and Quality Improvement focus for 2023 were:
	Overall Goals and Quality Indicators for 2023, 46/67 Objectives Met with a completion rate of 68.66%.
	• Behavioral Health: focus on improving follow-up after E.D. visits for substance use or mental health disorder, measured by the HEDIS® metric FUA-30 and FUM-30. Thirty-three percent (33.3%) of the behavioral health objectives were met with one of three counties meeting or exceeding the minimum performance level (MPL). Overall, CalViva did not meet the 50th Percentile Quality Compass performance goal (MPL). Kings County did meet the MPL for both measures.
	  o Initiated Non-clinical PIP to focus on Fresno and Madera Counties.
	  o PIP topic is focused on improving provider notifications.
	  o Working with CRMC and HSAG to work out data-sharing issues.
	  o Project is ongoing through the end of 2025 with 90% of activities planned for 2023 completed.
	• Chronic Conditions: Implement strategies to improve performance in Asthma Medication Ratio (AMR), Blood Pressure Control (CBP), and Diabetes (CDC >9): 100% of activities completed and objectives met (MPL met or exceeded in all three counties).
	  o ECHO Program – 12 Weeks for PCP had positive results for satisfaction and increased confidence in diabetes management.
	  o Tip Sheets for Diabetes & Controlling Blood Pressure
	• Member Engagement and Experience: CAHPS Survey: 5/8 measures met the Outcome Quality Compass (QC) 25th percentile goal.
	  o The following three (3) outcomes were not met:
	    ▪ Getting Needed Care 76.7%
	    ▪ Customer Service 86.3%
	    ▪ Rating of Health Plan 55.4%
	  o The following 5 (5) outcomes were met:
	    ▪ Getting Care Quickly 81.8%
	    ▪ How Well Doctors Communicate 93.5%	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Rating of All Health Care 53.2% - Rating of Personal Doctor 64.8% - Rating of Specialist 69.6% ○ 100% of activities completed and objectives met. ● Hospital Quality/Patient Safety: CVH has five (5) facilities participating in this project in total. Work to ensure hospitals are providing appropriate, safe care to patients that avoid preventable harm, and provide guidance to members about informed choice when selecting a site. 100% of activities completed and 75% of objectives met. ○ All hospitals submitted sufficient data to develop a scorecard. ○ Improvement is still needed in hospital-acquired infections (MRSA & SSI Colon did not improve). All hospitals continued to meet the goal for Clostridioides difficile (C. Diff). ○ Most hospitals did not meet the goal for C-section rate (<23.6%) however, most did show directional improvement. ● Pediatric/Children's Health Program: Completed SWOT Project focused on increasing Well Child Visits and Childhood Immunizations. 33.3% of activities completed. ○ Initiated PIP for Well-Child Visits in the First 30 Months of Life – 0 – 15 months – Six or More Well-Child Visits (W30-6+) - Target Population: Black or African American members in Fresno County - PIP Submission: Steps 1-6 approved with 100% validation in January 2024. - Key Informant Interviews/Focus Group completed. - Process Map & GIS Map in development. - Next steps are to identify interventions based on failures in the process and key drivers and begin intervention implementation in 2024. ● Perinatal Health: All CalViva Health Counties exceed the 50th percentile for timely prenatal care, postpartum care, and Chlamydia screening; the 90th percentile for PPC-post. Fresno and Madera counties exceeded the 75th percentile for PPC-Pre. 80% of activities completed. ● Pharmacy: Asthma Medication Ratio (AMR) is a new MCAS measure for MY 2023. 100% of activities completed with 66.6% of objectives met. ○ In 2023 members with a gap were outreached and instructed to review their action plan with their MD. ○ In 2024, an assessment of the effectiveness of these strategies will be made as well as modifications/additions to address the desired outcomes.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Preventive Health: Cancer Screening: Breast Cancer, Cervical Cancer & Chlamydia Screening had 100% of activities completed with 92.31% of objectives met. - Two mobile mammography vendors contracted: Alinea and Pacific Coast. 20 Pacific Coast mobile mammography events that were completed for CalViva. - A Mammography Incentive Program was also offered, and in 2023, eight provider groups opted into the radiology incentive program. - A Mammography Incentive Program was also offered, and in 2023, eight provider groups opted into the radiology incentive program. - Provider Engagement: 75% of activities completed with 54.55% of objectives met. - Quality EDGE: Evaluating Data to Generate Excellence (EDGE) - Provider Engagement action planning with Priority Providers– adult and pediatric measures to improve HEDIS® measure compliance. - Cozeva adoption for priority providers. - Focus on PARS assessment to identify office equipment needs. - Provider Access, Availability, and Service Results: - PAHAS: - Appropriate Emergency Instructions: 98.3% - Ability to Contact On-Call Physicians: 91.6% - 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% - Continuity/Coordination of Care: CalViva utilizes NCQA as a roadmap for improvement and how an organization can deliver high-quality care. Organizations use NCQA standards to perform a care gap analysis and align improvement activities with areas that are most important to the State and employers. - Access, Availability, and Service and Satisfaction: - PAAS (DMHC + Non-DMHC Medi-Cal) Access Measure and Standard (Performance Goal = 70%) - Urgent care Appointment within 48 hours of request (PCP) MY22: Fresno 50.2%, Kings	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	62.7%, Madera 90.9%, Telehealth 42.2%, Total 49.0%
	  ▪ Non-Urgent Appointment within 10 business days of request (PCP) MY22: Fresno 76.8%, Kings 77.2%, Madera 73.2%, Telehealth 70.3%, Total 74.4%
	  ▪ Access to Preventative Health Check-Up/Well-Child Appointment within 10 business days of request (PCP) MY22: Fresno 62.9%, Kings 69.8%, Madera 68.6%, Telehealth 56.7%, Total6 1.8%
	  ▪ Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP) MY22: Fresno 81.7%, Kings 84.6%, Madera 84.8%, Telehealth 76%, Total 80.3%
	  ▪ Access to First Prenatal Appointment within 2 weeks of request (PCP) MY22: Fresno 71.9%, Kings 82.1%, Madera 90%, Telehealth 66.7%, Total 72.6%
	  o Provider Access, Availability, and Satisfaction Survey Measures met the following goals:
	  ▪ 100% of PAAS (DMHC) - Access to Ancillary measures.
	  ▪ 100% of Provider After-Hours Survey measures.
	  ▪ 50.82% of PAAS measures.
	  ▪ 50% of the Telephone Access Survey measures.
	  ▪ 44% of Provider Satisfaction Survey (PSS) measures and 50% of BH PSS measures.
	  ▪ 100% of Behavioral Health PAAS by Risk Rating measures.
	• Final HEDIS Results RY2023:
	  o Quality and Safety of Care: Overall, CalViva achieved 64% of MCAS measures above the MPL for MY 2022. With Fresno County at 47%, Kings County at 60%, and Madera County at 87%.
	  o HEDIS Default Measures Rates for MY 2022 MPL:
	  ▪ Breast Cancer Screening: All three counties exceeded the MPL of 50.95%.
	  ▪ Cervical Cancer Screening: Kings and Madera counties exceeded the MPL of 57.64%, and Fresno almost met the MPL with 57.08%.
	  ▪ Childhood Immunization Combo 10: Madera exceeded MPL of 34.79%; Kings and Fresno counties fell below the MPL.
	  ▪ Follow-up After ED Visit for Mental Health Illness (54.51%)/Substance Use Disorder - 30 Days (21.24%): Both Fresno and Madera fell below the MPLs, Kings exceeded the MPL.
	  ▪ Lead Screening in Children: Fresno and Kings did not meet the MPL of 63.99%, Madera met the MPL.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Immunizations for adolescents: Fresno County met the MPL of 35.04%; Kings County fell below the MPL and Madera County exceeded the MPL. ▪ Well-Child Visits in the first 15 months of Life: Madera County exceeded the MPL of 55.72%; Fresno and Kings counties fell below the MPL. ▪ Well-Child visits for ages 15 months to 30 months: Madera County exceeded the MPL of 65.83%; Fresno and Kings counties fell below the MPL. Committee members agreed that Health Net met expectations as described above regarding the performance of delegated functions and in support of CalViva's Quality Improvement efforts recommends continuing the relationship as currently established.	

#4 QI/UM/CM Business-Key Presentation
- 2023 UM/CM Work Plan End of Year Evaluation & Executive Summary (Attachment V) (PowerPoint)
 	
Action
Patrick Marabella, M.D Chair
	2023 Utilization Management/Care Management Work Plan End of Year Evaluation and Executive Summary were presented and the planned activities and focus for 2023 included the following:
	• Compliance with Regulatory & Accreditation Requirements:
	  o All compliance activities met objectives for this end-of-year evaluation except for 1.4 periodic audits for compliance with regulatory standards-Member Letters.
	    ▪ Additional training and coaching were completed regarding the use of clear and concise language.
	    ▪ Incorporated sample cases for denial letter language in group meetings to critique denial verbiage used and provided job aids to streamline the process.
	    ▪ The A&G letter template correction was submitted to compliance for approval and subsequently moved to production in January 2024.
	• Monitoring the UM Process:
	  o TAT was met with 99% or better in all areas and quarters except for Pre-Service Routine Deferrals.
	  o One deficiency in January 2023 resulting in a 96.85% TAT for the quarter but met the threshold for action of 95%.
	• Monitoring Utilization Metrics:
	  o Objectives met except 3.3 PPG Profile.
	    ▪ 2023 Goals: 2% reduction in admissions and length of stay compared to 2022.
	  o Annual audit reviews resulted in corrective action plans (CAPs) for PPGs due to falling below turnaround time targets, denials, access to staff, appropriate professionals, and delegations.
		Motion: *Approve*
		- 2023 UM/CM Work Plan End of Year Evaluation & Executive Summary (Quezada/Ramirez)
		5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Monitoring Coordination with Other Programs and Vendor Oversight:
	  ○ All metrics for this section met the objectives.
	• Monitoring Activities for Special Populations:
	  ○ All monitoring activities for this section met the goals.
	    ▪ CCS Tracking ongoing.
	    ▪ SPD Tracking ongoing.
	    ▪ CBAS Tracking ongoing.
	    ▪ Mental Health Tracking ongoing.
	• Adequacy of UMCM Program Resources:
	  ○ Utilization metrics met the goal of a 2% decrease in bed days, acute admissions, length of stay, and readmissions.
	  ○ Satisfaction data reports noted consistent results with previous years with some improvements and some opportunities identified.
	  ○ Improvement in the timeliness of referrals was identified as an opportunity and determined to be consistent with grievance data when analysis was performed.
	• Program Scope, Processes, Information Sources:
	  ○ Annual DHCS survey (2023) which had only one deficiency identified, classifying grievances.
	  ○ Ongoing outreach and monitoring.
	  ○ Criteria used for decision-making were updated and approved.
	• Practitioner Participation and Leadership Involvement in the UM Program:
	  ○ Contracted network providers participated in the QI/UM Committee and Credentialing and Peer Review Sub-Committees.
	  ○ Weekly Multi-disciplinary Care Rounds.
	  ○ Leadership and staff provided reports, participated in improvement activities, and attended monthly meetings.
	Committee members agreed that Health Net met expectations as described above regarding the performance of delegated UMCM functions and recommended continuing the relationship as currently established.	

#4 QI/UM/CM Business- Key Presentation - 2024 UM Program	**2024 Utilization Management Program Description & Change Summary** were presented and changes for this year include: • Clarified HN mission and updated value statements on page 6.	Motion: *Approve* - 2024 UM Program Description & Change

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Description & Change Summary (Attachments W) (PowerPoint) **Action** Patrick Marabella, M.D Chair	• Changed "preauthorization" to "prior authorization" and "Policy" Letters to "All Plan" Letters on page 9. • Changed "Physician" to "Provider" and Added "Post Service" to section title and section, added "or retrospective" on page 13. • Removed "Change Healthcare's InterQual Level of Care Criteria" on page 15. • Added Population Health Management key performance indicator metrics and Provider prescribing patterns including medication utilization metrics on page 21. • Added "and Health Equity" to the HN Quality Improvement on page 32. o CalViva will be hiring a Health Equity Officer who will report to the CEO and will be included in this Committee meeting as CalViva staff. • Added "PMH and Health Equity" on page 34.	Summary (Waugh/Ramirez) 5-0-0-2
#4 QI/UM/CM Business - Key Presentation - 2024 CM Program Description & Change Summary - 2024 UM/CM Work Plan (Attachment X, Y) (PowerPoint) **Action** Patrick Marabella, M.D Chair	**2024 Case Management Program Description & Change Summary** were presented and changes for this year include: • Added CalViva QI/UM Committee information and organization, updated Health Net job titles (removed VP PHCO and added CM Director, VPMM changed to CMO), removed Member Connections. Added CVH Medical Management roles. Pages 7-10. • Updated Transitions of Care program section to reflect requirements for 2024. Page 24. • Palliative Care has changed to a prior auth benefit and has been updated to reflect this change. Page 26. **2024 Utilization Management/Case Management Work Plan** was presented, and areas of focus include: • Compliance with Regulatory & Accreditation Requirements • Monitoring the UM Process • Monitoring Utilization Metrics • Monitoring Coordination with Other Programs and Vendor Oversight • Monitoring Activities for Special Populations Major changes to the Work Plan include: • Additions to simplify documentation of compliance with NCQA standards. • Added Section 1.6 Review, revisions, and updates to program documents and policies and procedures at least annually.	Motion: *Approve* - 2024 CM Program Description & Change Summary - 2024 UMCM Work Plan (Ramirez/Quezada) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Added Section 1.7 Annually review, approve, and update clinical criteria and clinical practice guidelines. • Added Section 1.8 Evaluate inclusion of new technologies into benefits including medical, behavioral, and devices. • Added Section 2.5 Review annual member and practitioner satisfaction surveys for UM processes and address areas of dissatisfaction.	
#5 Access Business - Access Work Group Minutes from 11/28/2023 - Access Work Group Quarterly Report (Q4) (Attachment Z-AA) **Action** Patrick Marabella, M.D Chair	**Access Work Group Minutes from 11/28/2023** were presented and reviewed. The list of HN-generated reports that the Access Work Group routinely reviews at their meeting was discussed. • New this year is the *New Member Understanding Report*, (part of NCQA Accreditation) to ensure that new members understand their coverage and can access information with ease within a timely manner. Mary Lourdes Leone, CCO indicated that we must now report contracting agreements relating to Telehealth to the DMHC, whereas historically, we have not had to submit delegated agreements with HN. *Discussion:* *On the meeting roster, Amy Schneider would like to have the HN Departments listed next to their attendees going forward as it would be helpful to show the representation of all the different departments covered at this meeting.* **Access Work Group Quarterly Report (Q4)** provides an update on the CalViva Health Access Workgroup activities in Quarter 4 of 2023. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. The following reports were reviewed (and approved on 11/28/23): • 274 Monthly Data Quality Check – September and October • Q3 2023 Behavioral Health Performance Indicator • 2022 C&L Geo Access Report • Q3 2023 Member Services Call Center Metrics Reports (HN and MHN) • Q3 2023 Specialty Referrals Report • Q3 2023 Telehealth Program • MY 2022 Access & After-Hours CAP Evaluation – The status of the corrective action plans	Motion: *Approve* - Access Work Group Minutes from 11/28/2023 - Access Work Group Quarterly Report (Q4) (Quezada/Ramirez) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(CAPs) was reported. CAPS were issued to 21 PPGs and direct network providers. Educational Packets were issued to a total of 54 PPGs and direct network providers. • Q3 2023 Network Adequacy Report • Q3 2023 Open Practice Report • Q3 2023 Provider Office Wait Times • Q3 2023 Long-Term Support Services (LTSS) • Q3 2023 Transportation Oversight Report • New Member Understanding Report – This is an NCQA-required report that was first presented at the 11/28/23 work group meeting. The Member Services Call Center routinely collects information from newly enrolled members within the first 3 months of their active policy. The goal is to improve communications and member satisfaction through continuous quality review and analysis. APL 23-020 – Amendments to Rule 1300.67.2.2, and updates to Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2024 were discussed. *Dr. Cardona left the meeting from 11:37 – 11:44. A quorum was maintained.	
#6 UM/CM Business - Key Indicator Report (December) - Utilization Management Concurrent Review Report (Q4) (Attachments BB-CC) **Action** Patrick Marabella, M.D Chair	**Key Indicator Report (December)** provides the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through December 2023. • Membership has decreased from the beginning of the year due to the redetermination process. It is expected that we will see an increasing trend again beginning in 2024 with the addition of the Adult Expansion and undocumented members. • Acute Admissions, Bed Days, and Acute Length of Stay (adjusted PTMPY), for SPDs have decreased. • Turnaround Time (TAT) rates are in compliance with two (2) months in a row at 100%. • Perinatal Case Management referrals have increased as well as the Inpatient Maternity Utilization. • Transition Care Services (TCS) (formerly Transitional Care Management) has seen an increase in referrals due to a program change so all hospitalized members begin with TCS at discharge, which has also affected the regular Care Management referrals. • Palliative Care shows a decrease in referrals and the program has closed as previously discussed however, the benefit remains.	Motion: *Approve* - Key Indicator Report (December) - Utilization Management Concurrent Review Report (Q4) (Ramirez/Quezada) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Behavioral Health has fluctuated but we anticipate it stabilizing in conjunction with the additional care coordination.
	• A new program called the *First Year of Life* has been added to ensure this population goes to their well-child visits and receives their immunizations. Since the launch in July, there has been a steady increase in referrals and increasing engagement rates.
	
	Utilization Management Concurrent Review Report presents inpatient utilization data and clinical concurrent review activities for Q4 2023. The emphasis of the UM team is on improving member healthcare outcomes, minimizing readmission risk, and reducing post-acute gaps in care delivery via proactive discharge planning and expeditious linkages to medically necessary health and support services. Data trends are consistent with those described above for KIR.
	• The average acute monthly admits for 2023 have been steady for TANF and SPDs. The MCE admits have decreased at year-end.
	• Utilization on a Per Thousand Members Per Year (PTMPY) basis, can be measured by reviewing the goals:
	    ○ Admits: TANF went over goal by 7.04%.
	    ○ Bed Days: SPD went over goal by 26.7%.
	    ○ Average Length of Stay: SPD went over goal by 29.2%, and MCE went over goal by 16.9%.
	• Year-to-date readmission rates for all populations have stabilized.
	• In response to increased bed days and ALOS, refined Clinical Rounds to include Transition of Care (now referred to as "Transition Care Services" (TCS) to align with DHCS), Care Management (CM), MemberConnections, Public Programs, Medical Directors, and Clinical Pharmacy
	• Initiated CM and TCS referrals during Rounds to improve discharge planning and successful transitions.
	• The CalAIM team joined Clinical Rounds to facilitate appropriate ECM and Community Support referrals.
	Next Steps include:
	• Integrate the MemberConnections team into TCS.
	• Beginning Q1 2024, 100% of IP members will receive TCS outreach while in the hospital.
	• Beginning Q1 2024, place TCS staff in target hospitals to do bedside outreach and enrollment	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	in TCS, and better coordinate with hospital discharge planning/care management.	
#6 UM/CM Business - Medical Policies Update (Q4) (Attachment DD) **Action** Patrick Marabella, M.D Chair	**Medical Policies Provider Updates (Q4)** were presented to the committee. The Provider Update Newsletter is compiled based on a national review by physicians and distributed monthly to providers via facsimile featuring new, updated, or retired medical policies for the Plan. Updated policies for Q4 include but are not limited to the following: • CP.MP.186 Burn Surgery • CP.MP.145 Electric Tumor Treating Fields • CP.MP.180 Implantable Hypoglossal Nerve Stimulation • CP.MP.144 Mechanical Stretching Devices for Joint Stiffness and Contracture • CP.MP.181 Polymerase Chain Reaction Respiratory Viral Panel Testing • CP.MP.70 Proton and Neutron Beam Therapy • CP.MP.247 Transplant Service Documentation Requirements • CP.MP.142 Urinary Incontinence Devices and Treatments • CP.MP.108 Allogeneic Hematopoietic Cell Transplant for Sickle Cell Disease • CP.MP.101 Donor Lymphocyte Infusion • CP.MP.107 Durable Medical Equipment and Orthotics and Prosthetic Guidelines • CP.MP.53 Ferriscan R2-MRI • CP.MP.138 Pediatric Heart Transplantation • CP.MP.38 Ultrasound in Pregnancy The following policies have been retired: • HNCA.CP.MP.517 Implantable Miniature Telescope Screening for Age-Related Macular Degeneration • HNCA.CP.MP.203 Cardiac Risk Lab Tests • HNCA.CP.MP.432 Occipital Nerve Stimulation for Headache	Motion: *Adopt* - Medical Policies Update (Q4) (Ramirez/Quezada) 5-0-0-2
#7 Compliance Update - Compliance Regulatory Report (Attachment EE)	Mary Lourdes presented the **Compliance Regulatory Report.** **CalViva Health Oversight Activities. HealthNet.** 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,	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc. **Oversight Audits.** The following annual audits are in progress: Credentialing, Emergency Room, UMCM, and Quality Improvement. The following audits have been completed since the last Commission report: Appeals and Grievances (No CAP), Continuity of Care (No CAP), Health Education (No CAP), Privacy and Security (No CAP). Due to NCQA requirements regarding oversight audits, starting this year, we're going to be implementing annual calendar year oversight audits of Health Net for all categories that we oversee. There will no longer be a "lookback" period to ensure more timely oversight of the previous calendar year. **Fraud, Waste & Abuse Activity.** Since the 10/19/23 Compliance Regulatory Report to the Committee, no new MC609 cases were filed by the close of CY 2023. **Department of Managed Health Care ("DMHC") 2022 Medical Audit.** The Plan received the 2022 DMHC Preliminary Audit Report on 11/1/2023 which included a CAP request covering 11 deficiencies. Some were minor and some were more significant like post-stabilization where they found that claims were being inappropriately denied based on medical necessity and had to be re-adjudicated. The Plan submitted a response on 12/15/2023 and is awaiting DMHC's response. **Department of Health Care Services ("DHCS") 2023 Medical Audit.** The Plan received the 2023 DHCS Final Report on 9/20/23. DHCS has issued a final CAP because the Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances. The Plan submitted its initial response on 10/20/23 and has been submitting monthly updates until the CAP is closed. **DMHC Enforcement Matter (22-724).** On 8/10/23, the Plan received a DMHC Subpoena requesting documents related to a member's appeal for services. The Plan complied with the subpoena and submitted all documents on 10/4/23. The Plan has not heard back from the DMHC on this matter. **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 and 2024 as of February 2024. **California Advancing and Innovating Medi-Cal (CalAIM).** • **Enhanced Care Management (ECM):** The DHCS approved the Plan's Birth Equity POF MOC on 11/7/23 and the Birth Equity Provider Capacity on 11/27/23 in preparation for the 1/1/24 effective date.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	On 10/16/23, the Plan submitted the Justice-Involved ("JI") MOC. On 10/20/23, the DHCS announced it moved the JI initiative from 4/1/24 to 10/1/24. On 2/2/24, the Plan received a "Pre-Corrective Action Plan ("Pre-CAP") letter from DHCS regarding its JI ECM provider capacity submission. The letter indicates that the Plan's JI provider network capacity was inadequate and will need to address all inadequate benchmarks. **Note that all Local Health Plan Initiatives also received DHCS Pre-CAP letters.** A response is due on 3/22/24. • **Community Supports (CS):** On 12/27/23, DHCS approved the Plan's January 2024 Community Supports MOC update, which included updated Community Supports Provider Capacity and Community Supports Final Elections. **Long-Term Care (LTC) Carve-In Deliverable List – Phase II (ICF/DD and Subacute Care facilities).** Effective 1/1/2024, LTC-ICF/DD and Subacute Care services were carved into MCPs statewide. The Plan submitted deliverables associated with APL 23-004 ("Intermediate Care Facilities for Individuals with Developmental Disabilities"), and APL 23-027 ("Subacute Care Facilities") to DHCS on 11/27/2023 and 1/29/24. The Plan is still working to complete Phase I of the ICF/DD network readiness requirements regarding contracting efforts. On 12/7/23, the DHCS approved Phase I of the Subacute Care Network Readiness requirements. Through post-transitional monitoring starting on 1/1/24, DHCS will evaluate plans for meeting Phase II of the Subacute Care Network Readiness which requires plans to attempt to contract with all Subacute Care facilities where their members reside. **Memorandum of Understanding (MOU)** DHCS requires Plans and Third-Party Entities to submit updated MOU templates and to specify responsibilities under those MOUs. DHCS has provided base templates that the Plan must execute starting January 1, 2024, through January 1, 2025. **Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP** Effective 1/1/24, CalViva and Health Net went live with an Exclusively Aligned Enrollment, Dual Eligible Special Needs Plan ("EAE-DSNP") named, "WellCare CalViva Health Dual Align (HMO D-SNP)". Health Net will be providing CalViva with high-level reports on oversight and utilization. **Adult Expansion 26-49** Effective 1/1/24, DHCS expanded Medi-Cal eligibility to individuals who are 26 through 49 years of age. The Plan will be working with providers to maintain PCP assignments. **Member Handbook/Evidence of Coverage.** The Plan's 2024 Member Handbook/Evidence of Coverage was posted to the CalViva Health website on 1/1/24 as required. **DHCS 2024 Operational Readiness("OR") Work Plan & Contract.** The Plan has completed the	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	required OR Workplan filings to DHCS. The only remaining documents to be submitted are the DHCS "bespoke" MOU templates that must be sent to the various Local Health Departments, LEAs, Regional Centers, WIC Agencies, County Behavioral Health Departments, etc., for their review and execution. In 2024, DHCS will require quarterly status updates on the execution of those MOUs. The 2024 DHCS Medi-Cal Managed Care Contract ("Primary Contract") was executed on December 20, 2023, and the 2024 DHCS State Supported Services Contract ("Secondary Contract") was executed on December 16, 2023. **Public Policy Committee.** The PPC met on December 6, 2023, at 7625 N. Palm Ave Suite 109, Fresno, CA 93711. The following programs and reports were presented: 2023 Health Education Executive Summary and Work Plan Mid-Year Evaluation; 2023 Health Equity Executive Summary and Work Plan Mid-Year Evaluation; 2023 Language Assistance Program Mid-Year Report; 2022 Geo Access Executive Summary and Assessment Report; Quality Improvement & HEDIS Update MY2022; Q3 2023 Grievance & Appeals Report; 2023 DHCS Audit CAP Update; 2022 DMHC Audit Final Report and CAP. Additionally, Dr. Marabella reviewed in detail where the Plan met and did not meet the minimum performance levels for specific HEDIS measures and identified opportunities for improvement. The next Public Policy Committee meeting will be March 6, 2024, 11:30 am-1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.	
#11 Old Business	None.	
#12 Announcements	Dr. Marabella informed the Committee that Dr. Verma has retired from the QIUM, Peer Review and Credentialing Committees and he will be looking for a replacement with a pediatric focus.	
#13 Public Comment	None.	
#14 Adjourn	The meeting was adjourned at 12:06 pm	

NEXT MEETING: March 21st, 2024

Submitted this Day: ___March 21, 2024___

Submitted by: ___Amy Schneider RN___

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #8
Attachment 8.A

BL 24-004
Sub-Committee Members for FY 2025

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

Sal Quintero
Board of Supervisors

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn
Public Health Department

Lisa Lewis- At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: May 16, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Committee Appointments—Commissioner Representation

BL #: **BL 24-004**
Agenda Item **8**
Attachment **8.A**

DISCUSSION:

In accordance with the Committee Charters, Commissioner representation on committees will be established by the RHA Commission Chairperson on an annual basis at the start of each fiscal year except for the "Public Policy Committee". The Public Policy Committee Commission members will serve coterminous terms with their Commission appointment. Chairperson Hodge has approved the following appointments for the Commissioners listed below.

FINANCE:
The **Finance Committee** meets at 11:30 am prior to the Commission meeting.
Commission members: Supervisor Neves, Supervisor Rogers, John Frye, Rose Mary Rahn, and Paulo Soares

QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT:
The **Quality Improvement/Utilization Management (QI/UM) Committee** meets at 10:30am prior to the Commission meeting. This committee must consist of participating providers.
Commission members: David Cardona, MD, and five participating providers; David Hodge, MD is an alternate.

CREDENTIALING
The **Credentialing Sub-Committee** meets at 12:00 pm following the QI/UM Committee and prior to the Commission meeting. This committee must consist of participating providers.
Commission members: David Cardona, MD, and five participating providers; David Hodge, MD is an alternate.

PEER REVIEW
The **Peer Review Sub-Committee** meets following the Credentialing Sub-Committee and prior to the Commission meeting. This committee must consist of participating providers.
Commission members: David Cardona, MD, and five participating providers; David Hodge, MD is an alternate.

PUBLIC POLICY:
The **Public Policy Committee** meets the first Wednesday of every quarter.
Commission member: Supervisor Neves serves as Chair. His seat is coterminous with his Commission seat.

Item #9
Attachment 9.A-C

Community Support Funding

- BL 24-005 Community Support Program
- Proposed Grant Recommendations 2024-2025
- Ad-Hoc Committee Meeting Minutes (2)

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

Sal Quintero
Board of Supervisors

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
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Chief Executive Officer

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

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

DATE: May 16, 2024

TO: Fresno-Kings-Madera Regional Health Authority
               Commission

FROM: Jeffrey Nkansah, CEO

RE: CalViva Health Community Support Program

BL #:   **24-005**
Agenda Item   **9**
Attachment   **9.A**

In May 2017, the Fresno-Kings-Madera Regional Health Authority established a process to review and consider funding for Community Support programs/initiatives in excess of twenty thousand dollars ($20,000) or more per fiscal year.

Guidelines and review process were established and approved during this time. As a reminder, the Commission has approved funds over the past six years to support our community programs.

The current fund request is intended for Provider Network and Member Support, Education Scholarships and Community Workforce Support, Community Infrastructure and Community Program Support as well as Community Based Organization support. Additional funds were also allocated in preparation for the new Department of Health Care Services ("DHCS") 2024 contractual requirements pertaining to Community Reinvestments.

The Ad-hoc committee reviewed the funding recommendations (attachment 9.C and 9.C.1) on April 16, 2024 and an online vote on April 29, 2024 and voted to bring them to the full commission.

Community Support

Community Support Grant Recommendations 2024-2025

	Fresno County	Madera County	Kings County	2024-2025 Proposed Funding
Provider Network Support				
Funding for PCPs/Extenders	x	x	x	$600,000
Funding for Specialists, Behavioral Health, Ancillary Providers	x	x	x	$120,000
Provider Incentive Quality Bonus (Top Performer(s))	x	x	x	$1,000,000
Provider Infrastructure, Supplies & Equipment	x	x	x	$100,000
Tzu Chi-See 2 Succeed Vision Program (Mobile Clinic)	x			$100,000
Member Support				
Enrollment Support	x	x	x	$125,000
Education Scholarships & Community Workforce Support				
California State University Fresno	x	x	x	$100,000
Community Colleges	x	x	x	$100,000
Community Regional Medical Centers Nursing Scholarships	x	x	x	$50,000
Image Church Certified Nursing Assistant Program	x			$25,000
Community Infrastructure Support				
Food Bank Funding	x	x	x	$100,000
Outdoor Play and Green Space	x	x	x	$200,000
Community Program Support				
Generation Changers Youth and Family Engagement Initiative	x			$30,000
Community Based Organizations				
CBO Support (Big Brothers Big Sisters Fresno and Madera Counties, Break the Barriers, CASA Fresno and Madera Counties, Every Neighborhood Partnership, Exceptional Parents Unlimited, Habitat for Humanity, Kings Community Action Organization, Marjaree Mason Center, Reading Heart, The Children's Movement of Fresno, Fresno Cradle 2 Career)	x	x	x	$750,000
DHCS Community Reinvestment				
Community Reinvestment Categories To Be Determined	x	x	x	$400,000
Other				
Recreation Sports	x	x	x	$100,000
Contingency				$425,000
				$4,325,000

Ad-Hoc Committee
Meeting Minutes
April 16, 2024

Ad-Hoc Committee Members	
✓	**David Hodge,** M.D., Chair, Fresno County At-large Appointee
✓	**David Luchini,** Director, Fresno County Dept. of Public Health
✓	**Sara Bosse**, Director, Madera Co. Dept. of Public Health
✓	**Rose Mary Rahn,** Kings County Director, Department of Public Health
✓	**John Frye,** Commission At-large Appointee, Fresno
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)
✓	**Daniel Maychen,** Chief Finance Officer (CFO)
✓	**Courtney Shapiro**, Director, Community Relations and Marketing

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Jeff Nkansah	The meeting was called to order at 2:00 pm. A quorum was present.	
#2 Summary of Past Community Support Program Funding Jeff Nkansah	Jeff Nkansah and Courtney Shapiro reviewed the history of the past community support funding.	**No motion**
#4 Community Support Grant Recommendations Jeff Nkansah and Courtney Shapiro	Jeff Nkansah and Courtney Shapiro presented a funding matrix with potential grantees listed on it. They provided a background on how staff evaluated current funded partners and how they determined services of greatest need to our members. The committee reviewed each organization and staff answered questions when needed.	*Motion: Approve Recommendations and bring to full Commission for approval* *5-0-0-0* *(Frye / Hodge)*

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	After reviewing all organizations, the committee made a motion and second to move this to the full Commission in May.	

Ad-Hoc Committee
Meeting Minutes
Online Vote
April 29, 2024

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

Ad-Hoc Committee Members	
✓	**David Hodge,** M.D., Chair, Fresno County At-large Appointee
✓	**David Luchini,** Director, Fresno County Dept. of Public Health
✓	**Sara Bosse**, Director, Madera Co. Dept. of Public Health
✓	**Rose Mary Rahn,** Kings County Director, Department of Public Health
✓	**John Frye,** Commission At-large Appointee, Fresno
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)
	Daniel Maychen, Chief Finance Officer (CFO)
✓	**Courtney Shapiro**, Director, Community Relations and Marketing

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Community Support Grant Recommendations Update (EPU) Jeff Nkansah	Jeff Nkansah emailed the Ad-Hoc committee with an update to the Community Supports grant proposals. The online vote requested $100,000 be added to the Community Supports budget (from contingency) for Exceptional Parents Unlimited (EPU). He explained that EPU updated their proposal and it aligned with CalViva Health's funding goals. A write up was shared with a timeline and outcomes. Members emailed their votes in.	*Motion: Approve Recommendations and bring to full Commission for approval* *Roll Call:* *David Hodge Yes* *David Luchini Abstained (Conflict)* *Sara Bosse Abstained (Conflict)* *RoseMary Rahn Yes* *John Frye Yes*

Item #10
Attachment 10.A

Health Equity Program Description
and Work Plan Evaluation

2023 Executive Summary
and Annual Evaluation

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist
COMMITTEE DATE:	May 16, 2024
SUBJECT:	Health Equity 2023 Work Plan End of Year Evaluation – Executive Summary Report

Summary:

This report provides information on the Health Equity Department work plan activities, which are based on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. The Health Equity Work Plan is broken down into the following four sections: 1) Language Assistance Services (LAP), 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. As of December 31, 2023, all work plan activities have been completed.

Purpose of Activity:

To provide a summary report of the Health Equity Work Plan End of Year Evaluation. CalViva Health (CVH) has delegated all language services to Health Net's Health Equity Department.

Data/Results (include applicable benchmarks/thresholds):

Below is a high-level summary of the activities completed during 2023. For a complete report and details per activity, please refer to the attached 2023 Health Equity Work Plan End of Year Evaluation Report.

1) *Language Assistance Services*
   a. Updated / amended contracts with 3 vendors. Amendments included contract extensions, new rates, new service, and updates to the Business Associate Agreement which included the Medi-Cal Addendum.
   b. Newsletter informing members on how to access language services completed and disseminated.
   c. Eighty-six staff completed their bilingual assessment / re-assessment.
   d. Four quarterly LAP and Health Literacy meetings conducted.
   e. Completed annual report of the LAP assessment results for the Timely Access Reporting.
   f. Twenty-eight translation reviews were completed in 2023.
   g. Successfully integrated sexual orientation gender identity (SOGI) and preferred pronouns and name into OMNI.

2) *Compliance Monitoring*
   a. HEQ reviewed 4 interpreter complaints and 45 grievance cases with 3 interventions identified.

b. 2022 grievance trending report was completed in Q3.
c. 2023 Mid-Year Work Plan was approved by committee.
d. Attended QI/UM Workgroup, weekly and PPC meetings, quarterly.
e. Two findhelp trainings were completed with 753 overall new programs added to the platform.
f. All HEQ Policy & Procedures reviewed and updated.

3) *Communication, Training and Education*
a. One A&G trainings completed on coding and resolution of grievances.
b. Nine call center trainings conducted, and training decks updated.
c. Providers were updated on cultural practices, LAP services, health literacy, and on-line cultural competency/OMH training.
d. Language identification poster for provider office was remediated and posted in provider library.

4) *Health Literacy, Cultural Competency and Health Equity*
a. English material review completed for a total of 56 materials.
b. Revised Plain Language training; posted updated version online.
c. Completed 6 cultural competency trainings for 350 providers. Trainings includes (2) Healthcare Barriers for Gender Diverse Populations, (2) Implicit Bias, (2) Special Needs and Cultural Competency.
d. Conducted annual Heritage/CLAS Month with 14 live attendees and 4,300 staff who read the newsletter.
e. Completed 3 live cultural competency trainings for staff; 191 staff attended live trainings. Trainings includes LGBTQ+ 101 for Medical Professionals and Support Staff, Implicit Bias, and Healthcare Barriers for Gender Diverse Populations.
f. Deploy online cultural competency trainings for staff with 6,755 who completed trainings. Training topics are Cultural Sensitivity 101 and Bridging Cultural Gaps for Equitable Healthcare.
g. Successfully co-led and supported the completion of quality projects. Projects targets HEDIS measure: CIS-10, WCV, and CDC.
h. Supported work plan development, updated, and extended the Scope of Work for community partners.

Analysis/Findings/Outcomes:

All work plan activities in 2023 were completed.

Next Steps:

Obtain approval on the 2023 End of Year Work Plan evaluation report and proceed to implement the 2024 Work Plan upon committee approval.

2023
Health Equity
End of Year Work Plan

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

Mission:

CalViva Health's Health Equity mission is to be an industry leader in ensuring health equity for all members and their communities.

Goals:

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:
1. To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
2. To promote for members and potential enrollees to be active participants in their own health and health care through clear and effective communication.
3. To advance and sustain cultural and linguistic innovations.

Objectives:

To meet these goals, the following objectives have been developed:
A. To ensure compliance with applicable Medi-Cal contractual requirements, state and federal regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).
B. To ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members.
C. To be champions of cultural and linguistic services in the communities CalViva Health serves.
D. To promote and be champions for diversity of CalViva Health members, providers and Plan staff.

Selection of the Cultural and Linguistics Activities and Projects:

The Cultural and Linguistics Work Plan activities and projects are selected based on the results from the CalViva 2022 Population Needs Assessment Report (PNA) (i.e., demographics, health status, risk factors, and surveys), regulatory requirements, department evaluation report from the previous year, HEDIS results, contractual requirements, and strategic corporate goals and objectives. After review and input from senior management staff, projects and new departmental activities are identified and incorporated into this work plan. Programs and services are developed with special attention to the cultural and linguistic needs of our membership. This work plan addresses the needs of our Medi-Cal (MC) members.

Strategies:

The Health Equity Work Plan supports and maintains excellence in the cultural and linguistics activities through the following strategies:

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A. Goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all members and their communities;
B. Work plan objectives and activities reflect the Office of Minority Health's national Culturally and Linguistically Service (CLAS) standards, and directly address various contractual and regulatory requirements;
C. Support information-gathering and addressing needs through Population Needs Assessment (PNA), data analysis, and participation in the CalViva Health Public Policy Committee (PPC);
D. Interacting with community-based organizations, advocacy groups, community clinics and human service agencies to identify the cultural and linguistic-related concerns of the community.

The Health Equity Work plan is divided into the following areas in support of the Principal CLAS Standard (To provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs): 1) Language Assistance Program Activities, 2) Compliance Monitoring, 3) Communication, Training and Education and 4) Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity.

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Main Area and Sub-Area	Activity	Measurable Objective	Due Dates	Mid-Year Update (1/1/23 - 6/30/23)	Year-End Update (7/1/23 - 12/31/23)
		Language Assistance Program Activities			
1 Rationale	**The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members.[1]**				
2 Responsible Staff:	**Primary: P. Lee, I. Diaz**	**Secondary: D. Fang, L. Espinoza**			
3 Audit	Assure C&L audit readiness to support DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: collecting requested documentation, submitting documents as requested, participate in on-site interviews as requested	Annual	Ongoing. No audits at the moment.	Ongoing. No audits at the moment.
4 Contracted Vendors	Conduct language assistance vendor management oversight	Review and update vendor contracts to ensure alignment with requirements	Ongoing	Ongoing. Continue to support internal team with language vendors' services. Renew contracts to 3 language vendors.	Amend contracts to 3 vendors. Amendment includes updating rates and renewing contracts. Amend and update vendors' BAA. Add another vendor to provide onsite and ASL interpretation service.
5 Interpreter	Monthly collection of language utilization data for CalViva	Updated LAP utilization report to contain: monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log	Semi-annual	Ongoing. Monthly reports are generated and saved to Health Equity shared drive. On track to completing 2023 Mid-Year LAP report.	Ongoing. 2023 Mid-Year LAP report completed and approved by committee. 2023 EOY LAP report is on track to be completed.

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6	Data	Conduct membership data pulls	Validated membership reports	Monthly	Ongoing. Monthly reports are generated and saved to Health Equity shared drive.	Completed. Monthly reports have been collected for 2023.
7	Operational	Create language and alternate format standing request report	Number of reports generated and posted	Weekly	Ongoing. Weekly and monthly reports generated and disseminated to stakeholders.	Ongoing. Weekly and monthly reports generated and disseminated to stakeholders.
8	Compliance	Coordinate and support operationalizing 508 remediation plan inclusive of providing SME consultation to workgroups and identification of process risks	Number of PDFs remediated/total PDFs	Ongoing	1 PDF coordinated; ongoing support provided	3 PDF coordinated
9	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing	LAP Provider Update prepared in June for distribution in July. Provider Ops Manual review on track for Q3.	LAP Provider Update were distributed in Q3.
10	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint	June and December	Updated tagline to remove traditional Chinese to simplify Chinese. Developed 2 taglines.	Ongoing.
11	Member Communication	Annual mailing to members advising how to access language assistance services	Write or revise annual language assistance article distributed to CalViva members	Annual	On track. Member newsletters to be scheduled and delivered by Q3.	Member newsletter was mailed to members in September.
12	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified annually	Annual	39 staff were assess and reasess for their bilingual skills.	47 staff were assess and reasess for their bilingual skills.

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13	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis	Report to summarize utilization of LAP services, number of bilingual staff and provide year over year trends for the utilization of LAP services	Q2	Completed. 2022 CVH EOY LAP report completed and accepted May 2023.	Completed Q2. 2023 CVH EOY LAP trend report is on track to be completed next year.
14	Operational	Oversight of interpreter and translation operations. Review of metrics for interpreter/translation coordination	Conduct oversight meetings to review metrics for timeliness. Hold quarterly meetings with Centralized Unit and escalate when metrics are not being met	Quarterly	Conducted quarterly meetings (1/23; 4/24) with one ad hoc meeting (3/1)	Conducted quarterly meetings (07/26 and 11/28) of 2023.
15	Operational	Review interpreter service complaints (exempt grievance) reports and conduct trend analysis. Provide complaint information to impacted area for resolution, e.g., vendor, internal process	Monitor interpreter service vendors through service complaints	Annual (trend)	Interpreter service complaint logs are being received and monitored on a monthly basis.	Interpreter service Call Center complaint logs are being received and monitored on a monthly basis. Developed exepmt grievance log. Also identified new contacts for reporting and Sharepoint sites to pull exempt data.
16	Operational	Coordinate and deliver Health Equity Department Quarterly meetings to review requirements and department procedures for language and health literacy services	Minutes of meetings	Quarterly	Conducted quarterly meetings (3/8; 6/27)	Conducted quarterly meetings (9/15,12/12)
17	Operational	Complete Population Needs Assessment (PNA) in collaboration with Health Education. Review new PNA requirement and participate in PNA Workgroup to complete assessment report.	Support PNA data collection, interpretation for member demographics, disparity analysis and development of an action plan that addresses identified member needs	June	Ongoing VRI quarterly meetings. No report to provide this year, next PNA report to be due in 2025.	Provided any requested information to the PHM team for action plan update in Q4.
18	Operational	Develop, update and maintain translation, alternate formats, interpreter services and bilingual assessment policies and procedures (P&Ps)	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps	Annual	Extensive and ongoing update to P&P throughout Q1 and Q2 for annual updates.	Updated all P&Ps for Medi-Cal to meet the new Medi-Cal 2024 contract.

19	Operational	Collect and review LAP P&Ps from other departments to assure compliance with use of tagline, NDN, translation process and interpreter coordination	P&Ps will be reviewed and placed in Health Equity LAP compliance folder	Annual	Annual tracking and updating of vital documents to be completed in Q3 from 9 business units.	Annual tracking and updating of vital documents completed.
20	Operational	Complete Health Equity Geo Access report documenting Provider Network Management (PNM) findings every two years	Data collection and data analysis for Health Equity GeoAccess report, production of HEQ Geo Access report.	Q3 2023	On track to be completed in Q3.	Completed in Q4. Presented and accepted by committee in Q4.
21	Operational	Complete annual Timely Access Reporting on the Language Assistance Program Assessment	LAP Assessment Timely Access Report	Annually	Submitted report on March 2023. Presented report to committee on July 2023.	Completed in Q1.
22	Operational	Coordinate and provide oversight to translation review process	Number of translation reviews completed	Ongoing	There were a total of 15 translation reviews. 10 in Q1 and 5 in Q2.	There were a total of 13 translation reviews, 9 in Q3 and 4 in Q4.
23	Training	Review, update and/or assign LAP online Training	Number of staff who are assigned training and percentage of completion	Annual	On track to complete in Q3.	1,848 staff completed the LAP online training.
24	Information Technology	Participate in information technology projects related to language assistance services to ensure C&L requirements are represented through various projects	Successful implementation of information technology projects	Ongoing	Go-live of "Sexual Orientation and Gender Identity (SOGI)" data fields in OMNI. Extensive and ongoing support for additional SOGI data. IT infrastructure on-track to deploy in late Q3 or early Q4. Overseeing REL/Language updates through the Program Management project	REAL and SOGI integration and enchancement for OMNI, TruCare, and Prime went live in December 2023.

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25	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Request information from specialty plans and strategic partners (e.g., MHN, VSP, etc.) semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing	Ongoing. Completed in Q1 of 2023	Completed in Q1 of 2023. Ensured regular data collection for different vendors contracted within 2023.
26	Translation and Alternate Format Management	Develop and maintain Translation and Alternate Format Tracking (TAFT) database with comprehensive list of member informing materials available and department responsible. Database will help support prompt identification of document and department responsible. Ongoing updating with bi-annual requests to all departments to review/update their list. Oversee implementation, management and updating of TAFT database	List of available materials	Ongoing	Migrated documents in Q2 with 100% response rate from document owners.	Completed in Q2.
		Compliance Monitoring				
27	Rationale	**Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.**				
28	Responsible Staff:	**Primary: P. Lee**	**Secondary: I. Diaz, N. Buller**			

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| 29 | Complaints and Grievances | Oversight of complaints and grievances related to LAP or C&L services, including monitoring and responding to all C&L related grievances. Collect grievance and call center reports. Maintain contact with the call center to ensure C&L complaints are monitored. Grievance reports include grievances coded to C&L codes (including discrimination due to language or culture). Maintain grievance response log and list of materials, develop and document interventions when indicated | Report on grievance cases and interventions | Ongoing | On track. Investigated and responded to 2 interpreter complaints.

There were a total of 20 cases sent to C&L. The cases were coded to C&L with the following codes:
1) Cultural [C] code and 2) Linguistic [L] code.

1 case required a corrective action plan and/or a provider intervention. | Ongoing. Investigated and responded to 2 interpreter complaints.

There were a total of 25 cases sent to C&L. The cases were coded to C&L with the following codes:
1) Cultural [C] code and 2) Linguistic [L] code.

1 case required a corrective action plan. |
|----|---------------------------|------------|------------|----------|------------|------------|
| 30 | Complaints and Grievances | Conduct a trend analysis of C&L grievances and complaints by providers | Production of trend analysis report | August | On track to complete in Q3. | 2022 trend report completed and submitted to Committee in Q3. |
| 31 | Complaints and Grievances | Review and update desktop procedure for grievance resolution process | Revised desktop procedure | December | Completed. | Completed. |
| 32 | Oversight | Complete all CalViva required Health Equity/C&L reports | Develop Health Equity CalViva work plan, write/revise and submit Health Equity CalViva Program Description. Prepare and submit work plan, LAP mid year and end of year reports | Ongoing | Completed and approved in Q2. | 2024 work plan and program description are on track to be completed in Q2. |
| 33 | Oversight | Participate in CalViva required work groups and committees | Participate in the ACCESS workgroup, QI/UM workgroup, QI/UM committee, monthly operations management meetings. Provide support for Regional Health Authority meetings as needed or requested. | Ongoing | Ongoing. Attend QI/UM weekly meetings and ACCESS workgroup meetings. | Ongoing. Continue to attend QI/UM meetings and Access Workgroup meetings. |
| 34 | Oversight | Support Public Policy Committee meetings for Fresno, Kings and Madera Counties | Assist at Public Policy Committee meetings as required. | Quarterly | Completed and attended quarterly meetings. | Completed and attend one PPC meeting per quarter. |

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35	Oversight	Develop, update and/or maintain all Health Equity related P&Ps.	Updated P&Ps submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps.	Annually	Several P&Ps were updated throughout the mid-year period.	Updated all P&Ps for Medi-Cal to meet the new MediCal 2024 contract.
36	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide training on findhelp to internal deparments, members, and providers on to promote the Social Needs Self-Assessment. Produce analytics and segmented utilization reports to ensure social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 75% of qualifying members are referred to an appropriate internal program. Add social need programs within Findhelp to address social risks within each month.	Ongoing	Completed 1 training for staff and 1 for providers. 201/270 referrals were referred to a program (74%). 410 programs added.	400 referrals made, 143 loops were closed. 343 programs were added.

<table>
<tr><td colspan="7" align="center">Communication, Training and Education</td></tr>
<tr><td>37</td><td>Rationale</td><td colspan="5">To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.</td></tr>
<tr><td>38</td><td>Responsible Staff:</td><td>Primary: P. Lee, S. Rushing</td><td colspan="4">Secondary: L. Espinoza, N. Buller</td></tr>
<tr><td>39</td><td>Training and Support</td><td>Provide support and training to A&G on coding and resolution of grievances; re-align coding per 1557 non-discrimination reporting</td><td>Revised/updated Quick Reference Guide (QRG) for A&G staff regarding grievance responses, coding and process on sending to Health Equity, etc.</td><td>Ongoing</td><td>Completed the Yearly A&G Department training in July.</td><td>No training during this period as the yearly training was completed in July.</td></tr>
<tr><td>40</td><td>Staff Training</td><td>Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations).</td><td>Curriculum/power point, name of department and total number of participants who attended the in-service</td><td>Ongoing</td><td>Ongoing. Completed 4 trainings throughout Q1 and Q2 of 2023.</td><td>In Q3 and Q4, completed 5 trainings with a total of 60 new hires were trained on HEQ Core areas, LAP program, Cultural Competency and Implicit Bias.</td></tr>
</table>

41	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g., vendor attestation forms, threshold languages list, etc.	Ongoing	Ongoing- On Track	On going. Site was promoted to associates in the 1st and 2nd bi-annual Health Equity Newsletters.
42	Provider Communication	Prepare and submit articles for publication to providers. Potential topics: LAP services, culture and health care, and promotion of on-line cultural competence/Office of Minority Health (OMH) training	Copies of articles and publication dates	Ongoing	LAP Provider Update developed in Q2. Distribution on track for July 2023.	LAP Provider Update were distributed in Q3.
43	Provider Communication and Training	Promote C&L flyer and provider material request form about Health Equity department consultation and resources available, inclusive of LAP program and interpreter services	Provider material request forms received by Health Equity Department	Ongoing	LAP Provider Update developed in Q2. Distribution on track for July 2023.	LAP Provider Update were distributed in Q3.
	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity					
	Health Literacy					
44	Rationale	**To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.**				
45	Responsible Staff:	**Primary: A. Kelechian**	**Secondary: A. Schoepf**			
46	English Material Review	Conduct English Material Review (EMR) per end-end document production guidelines (review of content and layout of materials for C&L appropriateness and low literacy)	Completion of all EMRs as tracked through the C&L database	Ongoing	There were a total of 34 EMRs. 19 in Q1 and 15 in Q2.	There were a total of 22 EMRs. 12 in Q3 and 10 in Q4.
47	Operational	Review and update Health Literacy materials as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials	Update and post materials on Health Literacy SharePoint Explore new system platform to host EMR data	Ongoing	On track to completing in Q3.	On track to complete in 2024.

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48	Training	Quarterly training for staff on how to use the C&L database and write in plain language	Quarterly training	Quarterly	Completed 2 quarterly Readability and EMR Database trainings.	During this period, 2 quarterly trainings were offered, 1 was completed in Q3 as there were no staff registered in Q4.
49	Training	Conduct activities and promotion of national health literacy month (NHLM)	Production and tracking of action plan for NHLM and summary of activities	October	On track to complete in Q4.	Completed in October. During health literacy month, we urged staff including providers to put health literacy awareness into action! Training and activities included topics such as: Use of Appropriate Language to Communicate with People with Disabilities Helping our members overcome challenges with Digital Health Literacy Ensuring the Use of Gender-Neutral Language
	Cultural Competency					
50	**Rationale**	**To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.**				
51	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, I. Diaz**			

52	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) for Health external workgroup	Minutes of meetings that reflect consultation and shared learning	Ongoing	Attended 3 C&L Workgroup meetings. Participated in Health Equity Accreditation Workgroup. Led revision of Provider Toolkit	Attended 3 C&L Workgroup meetings. Serve as chair for SB923 training attestation workgroup Participated in review of Cultural Competency Training
53	Provider Training	Conduct cultural competency, implicit bias, and gender identity training/workshops for contracted providers and provider groups upon request. Training content to include access to care needs for all members from various cultural and ethnic backgrounds, with limited English proficiency, disabilities, and regardless of their gender, sexual orientation or gender identity. Work with provider communication to implement ICE for Health computer based training through provider update and/or provider newsletters and/or medical directors, promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates	Output number of providers who received cultural competency training by type of training received	Annual	On track to complete in Q3 & Q4.	A total of 350 providers received trainings in Q3 and Q4 2023. 7/26/2023: Healthcare Barriers for Gender Diverse Populations- 26 attendees; 8/4/23 Implicit Bias 134 attendeees; 9/29/2023: Special Needs and Cultural Competency-10 attendees; 11/3/2023: Implicit Bias Training Q4- 87 attendees; 12/8/2023: Healthcare Barriers for Gender Diverse Populations- 90 attendees; 12/13/2023: Special Needs and Cultural Competency-3 attendees

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| 54 | Staff Training | Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles / webinars that educate staff on culture, linguistics and the needs of special populations | Online tracking. Event summary and activity specific participation totals | Q3 | Ongoing. Will deploy in Q3 of 2023 | Completed annual CLAS month celebration in August 2023. This year's theme was Gender Affirming Care. We partnered with the Sacramento LGBT Community Center to provide a training on how health professsionals can be advocates of LGBTQ- affirming care (14 attendees). CLAS month was featured in our newsletters, each with over 1,800 unique opens and over 2,500 opens. Staff participated in a virtual "Cultral Vision Board" activity, where they displayed photographs- some personal photographs- displaying cultural practices with their co-workers. These displays were posted in our Health Equity Sharepoint. Moreover, staff who participated in these activities were put into a raffle to win CLAS-theme merchandise. |

55	Online Training	Review online content for cultural competency training and update as needed annually	Annual online training and number of staff trained	Annual	Completed review of tranings: Cultural Humility & Health Equity and Health Equity 101	3 live trainings were contducted in Q3 and Q4 of 2023: 8/23/23 LGBTQ+ 101 for Medical Professionals and Support Staff (14 attendees); 11/3/2023: Implicit Bias Training Q4- 87 attendees; 12/8/2023: Healthcare Barriers for Gender Diverse Populations-90 attendees. More over 6,755 total staff participated in online deployed trainings. 3,491 participated in Cultural Sensitivity 101 and 3,264 participated in Bridging Cultural Gaps for Equitable Healthcare
		Health Equity				
56	Rationale	**To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.**				
57	Responsible Staff:	**Primary: P. Lee, D. Fang,**	**Secondary: A. Schoepf**			
58	Operational	Increase interdepartmental alignment on disparity reduction efforts. Facilitate quarterly meetings	Facilitation of health disparity collaborative meetings	Quarterly	Ongoing. Completed-facilitate quarterly meetings.	Ongoing. Completed-facilitate quarterly meetings.
59	Operational	Align population health and disparity initiatives across departments	Develop Health Disparity e-newsletter and listserv for internal staff. Facilitate communication on health disparities and newsletter development and distribution	Ongoing	Produced and distributed the 1st newsletter in June. The second newsletter is scheduled for December.	Produced and distributed the 2nd Newsletter December 1st.

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60	Operational	Implement disparity model for PIP projects (CIS-10 and WCV) include formative research, community, member and provider interventions	Development of modules; meet PIP disparity reduction targets	Ongoing	Ongoing. Support QI with reviewing materials to be submitted to DHCS.	Ongoing. Conducted 1 focus group and 8 KII with community members and 2 KII with CBOs. Attend bi-weekly meetings.
61	Operational	Support in SWOT analysis project (CIS-10 and W6+)	Disparity reduction project work plan; evaluation, documentation of process outcomes	Ongoing	Ongoing. Support QI with reviewing materials to be submitted to DHCS.	Completed.
62	Operational	Improve food security among Black and Latino residing in Fresno County. Targeting members with diabetes A1c >9%	Report on Disparity Leadership Program (DLP) project	Quarterly	6 healthy cooking sessions to begin Aug. 2023.	21 members successfully completed 4 or more healthy cooking sessions.
63	Operational	Provide consultation to departments on cultural competency and improving health care outcomes (including enrollment) for key demographics and key metrics to support health equity	Consultation and /or trainings provided	Ongoing	Ongoing, on track.	Ongoing. Attend and provide consultation as needed in meetings.

[1] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

^ Indicates revision.

* Indicates new.

04.22.2024

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   Date
Regional Health Authority Commission Chairperson

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

Item #10
Attachment 10.B

Health Equity Program Description
and Work Plan Evaluation

2024 Change Summary
and Program Description

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist
COMMITTEE DATE:	May 16, 2024
SUBJECT:	Health Equity Program Description 2024 CalViva Health – Change Summary

Program Description Change Summary:

The primary changes made to the 2024 Health Equity Program Description are to meet the Health Equity Accreditation requirements.

Redline Page #	Section/Paragraph Name	Description of Change	New Page #
Page 4	Mission, Goals, and Objective	Expanded and added introduction to the Mission, Goals, and Objective section to align with the Health Equity Accreditation requirements.	Page 4
Page 4	Mission, Goals, and Objective	Added vision to section. Edited heading to include "vision".	Page 4
Page 5	Goals	Removed and enhanced mission and replaced with the following bullets: 1. Ensure language services meet regulatory requirements and achieve metric goals. 2. Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels. 3. Complete staff and provider trainings for required topics. 4. Address health disparities through targeted cross-collaborative projects. 5. Implement social needs assistance strategies with integrated approaches for mitigating social risks.	Page 5
Page 8	Health Equity Work Plan	Expanded on CLAS standards and the requirements it meets.	Page 8
Page 8	Health Equity Work Plan	Removed the following sentence from this section. The mid-year review allows for modifications to	Page 8

		be taken if necessary, and ensures progress is on course.	
Page 16	Health Equity Interventions	Edited the formatting on this section and added the following bullet of the disparity reduction model: "Social needs and social risks all play into determining appropriate partners, selecting, engaging and taking initiatives with partners."	Page 16
Page 17-18	Public Policy Committee	Expanded on the roles and objectives of the Public Policy Committee. Include language regarding committee selection.	Page 17-18
Page 19	CalViva Health Monitoring and Evaluation	Expanded on the roles and objectives of the Governing Body and QI/UM Committee.	Page 19
Page 22	Data Collection	Broaden how data will be collected including SOGI data.	Page 21
Page 24	CalViva Health Staff Roles and Responsibilities	Added Equity Officer's role and responsibilities.	Page 24

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Health Equity
Program Description

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1.0 <u>EXECUTIVE SUMMARY</u>

The Fresno-Kings-Madera Regional Health Authority (RHA) is a local public agency, created through a joint exercise of powers agreement by the Counties of Fresno, Kings, and Madera in California. Under California's Medi-Cal Managed care program, the RHA dba CalViva Health is designated as the Local Initiative. CalViva Health is contracting with Health Net Community Solutions (HNCS) to provide cultural and linguistic services and programs for the CalViva Health's membership. CalViva Health ("CalViva" or "Plan") may also contract with other entities or health plans to provide or arrange cultural and linguistic services and programs for members enrolled with CalViva Health. CalViva Health, in collaboration with Health Net Community Solutions (HNCS), is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, provider networks, and CalViva Health and HNCS.

The HNCS Health Equity Department develops programs and services to facilitate understanding, communication and cultural responsiveness between members, providers, and Plan staff.

The Health Equity Department, on behalf of CalViva Health, utilizes the Cultural and Linguistic Appropriate Services (CLAS) Standards, developed by the Office of Minority Health, as a guide for provision of culturally and linguistically appropriate services. CLAS Standards assure that services comply with the Office of Civil Rights Guidelines for culturally and linguistically appropriate access to health care services. Health Equity's objective is to promote effective communication with limited English proficient members by assuring access to culturally appropriate materials, print translations of member informing materials, telephonic and in-person interpreter services, and through trainings, and in-services on a wide range of health equity and cultural and linguistic (C&L) topics that impact health and health care.

Services offered include cultural and language information for providers and their staff, as well as for Plan staff; trainings on language assistance requirements imposed by state and federal regulatory agencies; interpreter support for members and providers; culturally appropriate translation and review of member materials; and cultural responsiveness education.

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

2.0   Staff Resources and Accountability

2.1   Staff Roles and Responsibilities

A detailed description of staff roles and responsibilities is included in Appendix 1.

3.0   VISION, MISSION, GOALS AND OBJECTIVES

3.1   The organization's health equity mission and vision are led by the Chief Health Equity Officer and are implemented through cross-functional collaboration and partnership. The mission and vision are aligned with regulatory requirements and implemented across products and lines of business.the plan.

The Health Equity program structures are organized to meet program goals and objectives through formal processes that objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety and effectiveness of care and services to meet the needs of multicultural populations, reduce social risks in the community, and address social needs of individuals. The program's multidimensional approach enables the organization to focus on opportunities for improving operational processes, services, health outcomes, experiences, and community partnerships. The Health Equity Accreditation program is formulated and operated based on foundational structures that include the program description, an annual work plan, and an annual evaluation. Programming focus and initiative development is based on assessment of the population and individuals' personal characteristics (race/ethnicity, preferred languages, gender identity, sexual orientation, age, socio-economic status, geographic location), social risks, and social needs through community-level and individual-level data collection to determine high volume, high risk, and problem-prone clinical and service bias and discrimination issues leading to uneven care outcomes. Performance goals and thresholds are established for all measures and are trended over time. At a minimum, the HEA program monitors and evaluates CLAS, individual demographic/personal characteristic data, network responsiveness, individual experience, practitioner experience, staff feedback, service performance, stratified clinical performance measures (i.e., HEDIS), and stratified individual experience measure (i.e., CAHPS).

3.1 Vision

To help all the people and communities we serve achieve the highest level of health by advancing equity in health and health care.

This vision aligns with and helps advance Health Net's enterprise-wide purpose – "Transforming the health of the community, one person at a time."

The organization implements an overarching vision of diversity, equity, and inclusion that works to:

- Eliminate disparities and improve quality of care and health outcomes.
- Eliminate systemic organizational marginalization.
- Promotes inclusion and anti-racist practices, that will be evidenced through our structures, customs, and leadership.
- Driving systemic strategy to ensure all of our members have access to equitable health outcomes.
- Expanding current and develop new community partnerships to elevate the health of the communities we serve.
- Informing policy discussion as well as investments to close the gap in equity.
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3.2 Mission

CalViva Health's Health Equity mission is to:

- 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

3.3 Goals

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:

1. Ensure language services meet regulatory requirements and achieve metric goals.
2. Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.
3. Complete staff and provider trainings for required topics.
4. Address health disparities through targeted cross-collaborative projects.
5. Implement social needs assistance strategies with integrated approaches for mitigating social risks.

- To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
- To promote for members and potential enrollees to be active participants in their own health and health care through clear and effective communication.
- To advance and sustain cultural and linguistic innovations.

3.43 Objectives

To meet these goals, the following objectives have been developed:

A. To ensure compliance with applicable Medi-Cal contractual requirements, state and federal regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).

- Develop and implement Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services.
- Utilize and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities.
- Collect and analyze health equity and C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities.
- Adhere and implement HHS guidelines for Section 1557 of the ACA for C&L services and requirement for non-discrimination based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.
- Collect, analyze and report membership language, race and ethnicity data.
- Inform members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually.
- Maintain information links with the community through Public Policy Committee (PPC) meetings, Population Needs Assessment (PNA) and other methods.
- Inform contracted providers annually of the health equity and C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources.
- Monitor the use of taglines and Non-Discrimination notices in all required communications.

B. To ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members.

- Provide C&L information and support for HNCS and CalViva Health staff in their efforts to provide excellent customer relations and services.

- Collaborate with other departments, where appropriate, to further the mutual attainment of culturally and linguistically appropriate healthcare services received by members.
- Support efforts of contracted providers to deliver culturally and linguistically appropriate health care services by providing informative materials, cultural competency workshops, and in-services.
- Promote effective communication by staff and contracted providers with LEP members by providing them with easy access to culturally and linguistically appropriate materials, quality translations of member-informing materials, high quality interpreter services, and culturally responsive staff and health care providers.
- Address health equity through development and implementation of an organizational and member level strategic plan to improve health disparities.
- Sustain efforts to address health literacy in support of CalViva Health members.
- Provide oversight for the assessment of bilingual capabilities of bilingual staff and provide ongoing education and support.

C. To be champions of cultural and linguistic services in the communities CalViva Health serves.

- Continue involvement with local community-based organizations, coalitions, and collaborative efforts in counties where CalViva Health members reside and to be a resource for them on C&L issues.
- Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (HICE), and America's Health Insurance Plans (AHIP).
- Participate in employee inclusion groups (EIG) for veterans, military families, women, LGBTQ community, MOSAIC (multicultural network), and people with disabilities. The EIG's help expand sharing of knowledge and resources.

D. To promote and be champions for diversity of CalViva Health members, providers, and Plan staff. This includes:

- Provide C&L services that support member satisfaction, retention, and growth.
- Provide subject matter expertise and training resources to meet the needs of seniors and persons with disabilities (SPD) and other population groups.
- Increase cultural awareness of Plan staff through trainings, newsletter articles, annual "Heritage / CLAS Month", and other venues.

4.0 HEALTH EQUITY WORK PLAN

The goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all

members and their communities. The work plan objectives and activities reflect the Office of Minority Health's national Culturally and Linguistically Service (CLAS) standards, and directly address various contractual and regulatory requirements. The CLAS standards represent 15 different standards that serve as the foundation for the development of the Health Equity Department strategic plans. CLAS standards are "intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States" (Think Cultural Health).

CLAS Standards ensure that services comply with the Office of Civil Rights Guidelines and Section 1557 of the Affordable Care Act (ACA) for culturally and linguistically appropriate access to health care services (Title VI of the Civil Rights Act), which cover three major areas: 1) Culturally Competent Care; 2) Language Access Services; and 3) Organizational Supports. In addition to CLAS, Health Net on behalf of CalViva Health, ensures implementation activities and compliance with National Council on Quality Assurance (NCQA) Health Equity (HE) Accreditation guidelines and multiple requirements from the state and federal government, including 2 CFR section 438.10, Exhibit A, Attachment III, Section 5.2.10 (Access Rights) of our contract with the State of California, and DHCS APL 21-004.

The work plan also supports information-gathering through PNA updates, data analysis, and participation in the CalViva Health Public Policy Committee (PPC). In addition, the Plan interacts with community-based organizations, advocacy groups, community clinics and human service agencies to identify the cultural and linguistic-related concerns of the community.

The work plan is divided into the following areas:
- Operational Areas Subject Matter Experts
- Language Assistance Program
- Health Literacy
- Cultural Competency
- Health Equity, Social Determinants of Health, & Social Needs
- General Compliance Activities

The work plan activities are evaluated twice a year by CalViva Health's QI/UM committee. The work plan activities are also shared as information to CalViva Health's PPC. The mid-year review monitors the progress of each activity and assesses if it is meeting the established objective. The mid-year review allows for modifications to be taken if necessary, and ensures progress is on course. The end of year evaluation assesses if the activity has met the objective, its successes, identifies the challenges and barriers encountered and how they were addressed, and is also an assessment for the future direction of health equity and C&L services. This work plan review and approval process assures that a standard of excellence is maintained in the delivery of cultural and linguistic

and health equity services. The work plan has more detailed information and activities in these areas.

5.0 <u>SCOPE OF PROGRAMS AND SERVICES</u>

The Plan is committed to ensuring quality care and services that meet the needs of diverse communities within the CalViva Health service area. CalViva Health, in collaboration with the Health Net Community Solutions (HNCS), ensures that all services provided to members are culturally and linguistically appropriate. There are some aspects of language assistance services that are delegated to HNCS with oversight by CalViva Health. The collaboration and coordination between both plans ensure that there is dedicated staff providing overall support and guidance to health equity and C&L program and services.

5.1 Language Assistance Program

The Plan established and monitors the Language Assistance Program (LAP) for members and providers. The LAP is a comprehensive program that ensures language assistance services are provided for all members and that there are processes in place for training and education of Plan staff and providers. The LAP ensures equal access to quality health care and services for all members. Health Equity provides oversight for LAP operational activities and directly provides LAP services related to member and provider communication.

The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. The mandated standards (4, 5, 6, and 7) provide the basics for language support services for CalViva Health members.

The LAP main elements include:

▪ **Demographic Data Collection for Members**

The standards for direct collection of members' race, ethnicity, alternate format, spoken and written language needs consist of informing members of the need to collect information, requesting information from members, capturing the information accurately in the membership databases and monitoring the information collected. Members are informed of the need to collect this information through a variety of methods such as the member newsletter. Providers may request the information collected for lawful purposes.

▪ **Interpreter Services**

Interpreter services range from ensuring contracted vendors are in place, monitoring the provision of services and annual communication with members and providers on how to access these services. Interpreter services are available in over 150 languages supported by the contracted vendors and bilingual staff. Interpreter services are guided by the Interpreter Services and Assessment of Bilingual Staff policies and procedures and meet the national quality standards for interpreter support. Interpreter services facilitate communication with members with limited English proficiency (LEP) to speak with Plan staff and/or its contracted providers. Bilingual staff and contracted telephone interpreter services vendors are used to assist members with LEP.

Providers and members may request an interpreter 24 hours a day, 7 days a week at no cost. Interpretation services may be delivered either through telephone, face-to-face, video remote interpreting, closed caption services or sign language (SL) depending on the nature of the appointment and need. As a result of COVID-19 changes in patient care delivery, the Plan continues to provide direct access to telephone interpreters for pre-scheduled interpreter requests and video remote interpreting services are available on the same day of the appointment. Interpreter services also include oral translation services of print documents upon request from a member, which may be provided by either a bilingual staff or contracted interpreter vendor. Quality standards for contracted interpreter services are incorporated into the vendor scope of work agreements and include demonstrating that the interpreter is versed in health care and medical terminology as demonstrated by a validated test instrument, familiarity with interpreter ethics, and verification process for basic interpreter skills such as sigh translation, listening and memory skills, commitment, confidentiality, and punctuality. Interpreter quality standards are fully compliant with the interpreter quality definitions from the federal requirements in Section 1557 of the ACA and with CA SB223, Language Assistance Services.

The Plan also supports provider groups and individual providers' efforts to supply interpreter services for CalViva Health's members with LEP. Providers may call the Provider Services toll free number and request interpreter assistance. Updates on Health Equity and C&L services available are sent regularly to all contracted providers.

- **Translation Services**

Translation services are guided by the Translation of Written Member Informing Materials P&P and are based on industry translation standards. Translation services includes quality standards for translators, a style guide to promote consistent translation quality, a glossary of common terms in each threshold language, provision of materials in Alternate Formats, a review process to prepare English documents for translation, and a process to monitor translations for quality, timely delivery, and accuracy. Translation services ensure that member informing documents are provided in the threshold languages of English, Spanish and Hmong and that a tagline and Non-Discrimination Notice (NDN) are included in member mailing when required. The translation program includes oversight of

the use of the Non-Discrimination Notices and taglines with English and translated documents as required by federal rules (Section 1557, 45 CFR 155.205).

- **Alternate Formats** – CalViva Health provides alternate formats of member informing documents to members as required by regulation, law, and upon member request. Alternate formats include but are not limited to Braille, large print, and accessible PDF documents. The quality of the documents and the time to fulfill member requests for these documents are monitored to assure timely access of benefit information to CalViva Health members. The provision of alternate formats is compliant with Section 1557 of the ACA and DHCS All Plan Letters 21-004 and 22-002. This consists of informing members of the need to collect information on their preferred alternate format, requesting the information, capturing the information accurately in the membership databases and monitoring the information collected. For example, if a member states their preferred alternate format is Braille, CalViva Health will provide all required member information material to this member in this format moving forward.

- **Oversight of Contracted Specialty Plans and Health Care Service Vendors**

The Health Equity Department is responsible for monitoring its Language Assistance Program (LAP), including plan partners, specialty plans and delegated health care service vendors, and to make modifications as necessary to ensure full compliance. Monitoring includes assurance that all language assistance regulations are adhered to for members at all points of contact.

- **Staff Training on LAP**

All Plan staff who have direct routine contact with members with LEP and whose duties may include elements of CalViva Health's language services must be trained on the LAP and on the P&Ps specific to their duties. Training is conducted annually and is done on-line.

- **Monitoring for LAP Quality**

The quality of the LAP is assured through quarterly monitoring of the utilization of language services such as interpreter requests by language, telephone interpreter utilization by language, and the number of members requested translations. All translation vendors are provided with a translation and alternate format style guide and a glossary of preferred terms in each of the threshold languages. The quality of Spanish, Hmong, Armenian, and Chinese translations are monitored by reviewing translated documents. Quality of translations and interpreters is monitored through quarterly review of linguistic grievances and member complaints that are related to language.

The Health Equity Department also oversees and monitors the delegation of LAP services with our specialty plans and ancillary vendors. The Health Equity Department in collaboration with other departments ensures LAP services are available to all members at all points of contact and that the specialty plans and ancillary vendors have processes in place to adhere to the regulations. To assure that all language assistance regulations are adhered to members at all points of contact, Health Equity requests/obtains a semi-annual report from each specialty plan or health care service vendor. The Health Equity Department provides consultation services to these plans and vendors as necessary.

- **Communication for LAP**

The Plan has implemented processes to assure routine member and provider communication promoting the LAP. The Plan advises members annually of no-cost language services (inclusive of interpreter and translation support) that are available to them. Methods of member communication are inclusive of PPCs, community-based organizations, member service representatives and/or other Plan staff, member newsletters, call center scripts, and provider relations representatives.

Providers receive an annual reminder of the language assistance services that are available to them in support of CalViva Health members which includes how to access the LAP at no cost to members. Methods for communication are inclusive of the online Provider Operations Manual, Provider Updates, Operational Toolkits (including the Rainbow Guide), mailings, in-person visits, and/or trainings/in-services.

5.2 Cultural Competency

CalViva Health integrates culturally competent best practices through provider and Plan staff in-services, training, education, and consultation. The training program offers topic specific education and consultation as needed by Plan staff and contracted providers. The cultural competency training program covers non-discrimination based on sex, race, color, national origin, ethnic group identification, ancestry, religion, language, age, gender, gender identity, marital status, sexual orientation, medical condition, genetic information, mental disability or physical disability.

- **Cultural Competency Training for staff**

Support for staff includes workshops, training, in-service, and cultural awareness events. Training and education on C&L services and/or cultural competency is provided on ongoing basis to Member Services, Provider Engagement, Health Education, Quality Improvement department staff, etc. The goal of these is to provide information to staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP, C&L resources, and member diversity.

Annually, the Plan hosts a Heritage / CLAS event for Plan staff as the main cultural competency training activity. Staff engages in training, interactive learning and events related to cultural competency. The cultural issues that impact seniors and persons with disabilities are topics covered during the Heritage / CLAS event. Cultural competency training courses include content on access to care needs for all members regardless of their gender, sexual orientation or gender identity. The event demonstrates CalViva Health's commitment to being a culturally competent organization by providing a forum for Plan staff to learn about diverse cultures, which increases their understanding of the diverse cultures represented in CalViva Health's membership. This understanding also serves to build sensitivities that promote a non-discrimination environment.

- **Cultural and Linguistic Consulting Services**

Each Health Equity staff member has a cultural subject matter area of expertise that includes: cultural issues that impact seniors and persons with disabilities, cultural issues that impede health care access for Lesbian, Gay, Bisexual & Transgender (LGBT+) populations, cultural disconnects that may result in perceived discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, health status, and the cultural issues that impede accessing health care services for recent arrivals. Health Equity staff also offers specialized consultation on many other areas including:
  - Case managers to assist in building trust with patients who are recently arrived immigrants
  - Quality improvement coordinators to help identify cultural issues and strategies to help improve preventative access to care
  - Grievance coordinators and provider relations representatives to address perceived discriminations including but not limited to those due to members' gender, sexual orientation or gender identity
  - Care coordinators trying to obtain medical information for patients hospitalized outside of the U.S.

- **Cultural Competency Education for Providers**

The Plan supports contracted providers in their efforts to provide culturally responsive and linguistically appropriate care to members. The services that are offered to contracted providers are intended to:
  - Encourage cultural responsiveness and awareness
  - Provide strategies that can easily be implemented into a clinical practice
  - Foster improved communication and health outcome for patients from diverse cultural and ethnic backgrounds, with limited English proficiency, disabilities, regardless of their gender, sexual orientation or gender identity

- Foster non-discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

To identify the cultural needs of providers, the Plan collects information from providers using a variety of methods, including the annual provider survey conducted by the Quality Improvement Department.

Cultural competency services are also promoted to providers through the provider website, the HICE provider toolkit, "Better Communication - Better Care" and tailored cultural competency workshops. Many topic areas for presentations on cultural aspects of health care, and provider group in-services on interpreter services, cultural and linguistic requirements and working with SPD population are available to providers upon request. Cultural Competency training for providers is documented in the provider directory.

Additionally, the Plan has developed materials for use in provider offices that specifically address cultural background and clinical issues. CalViva Health recognizes that diverse backgrounds include culture, ethnicity, religion, age, residential area, disability, gender, sexual orientation and gender identity. Because diversity is complex and an important component for individuals as they access and utilize services, emphasis is placed on developing materials that are researched and field-tested to assure quality and cultural appropriateness. Providers may access the materials by calling the Health Equity Department toll free number during business hours at (800) 977-6750.

- **Collaborations**

Representatives of the Plan have been an active participant and co-chair/lead on the Health Industry Collaboration Efforts (HICE). Participation on this collaboration has provided the Plan with suggestions to implement new cultural or linguistic legislation. It has also provided a forum to discuss language assistance program challenges faced by providers and other health plans that result in a more consistent experience for members with LEP.

5.3 Health Literacy

The Plan continues to make strides in the promotion of health literacy through the implementation of the health literacy initiative *Clear and Simple.* The Initiative offers: a) Plain Language on-line training b) Plain Language tip sheets, c) Support in development of documents at appropriate grade level, d) Access to plain language readability software, e) Readability software training, f) Cultural Competency and Plain Language checklists for materials production, g) A database that streamlines the English Material Review

process, h) Participation in National Health Literacy Month, and i) Provider training on motivational interviewing/reflective listening and plain language resources.

- **Plain Language 101 Training**

The available training provides Plan staff with a basic understanding of health literacy and its impact on health care access. For example, trainings cover useful tips on how to write in plain language such as avoiding jargon, using simple words, and giving examples to explain difficult concepts. This ensures that communications available to members are clear and easy to understand.

- **Readability Software and Training**

In an effort to sustain the Clear and Simple initiative, the Readability software was made available to all staff developing member informing materials. The software supports staff in editing written materials so that they are easily understandable for members. All staff that produces written materials for members are required to utilize readability studio, edit their documents and provide the grade level analysis to Health Equity prior to a request for English Material Review.

The Health Equity Department has developed and implemented Readability Studio training so that staff have the support to effectively navigate the software and produce member materials developed following the plain language guiding principles. The training is delivered utilizing adult learning theory and provides hands-on experiential learning in operating the software and editing written materials to a 6th grade reading level.

- **Clear and Simple Guide**

The Health Equity Department produces a Plain Language Guide that provides 15 tips for staff to follow when preparing member materials and as well as a document checklist to confirm plain language standards were applied. The guide is provided during training and is also available online.

- **English Materials Review (EMRs)**

The Health Equity Department conducts English material reviews through the EMR database. EMRs are conducted on all member informing materials to ensure that the information received by members is culturally and linguistically appropriate. Readability levels are assessed on the original document and revised accordingly to ensure they comply with required readability levels mandated by regulatory agencies. The review process ensures that document layouts are clean, easy-to-read, well organized, and that images are appropriate and culturally relevant and prepares documents to be ready to be translated, when indicated. Cultural competency and plain language checklists are required to be submitted with all EMR requests.

- **National Health Literacy Month**

National Health Literacy Month is promoted internally by Plan staff every October and offers an opportunity for staff to participate in various contests to exemplify how they are using the Clear and Simple principles in their everyday work.

5.4 Health Equity

CalViva Health is committed to supporting the health of our members and promoting the reduction of health disparities across our membership. In order to accomplish this, Plan staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.

- **Health Equity Interventions**

Health Equity Projects: This involves the development and implementation of an action plan to reduce health disparities. Plan staff look systematically and deliberately at the alignment of resources and development of strategies to reduce targeted health disparities. The interventions are aligned with DHCS PIP requirements. Disparity reduction efforts are implemented through a model that integrates collaboration across departments, e.g., Quality Improvement, Provider Engagement, Cultural and Linguistics, Health Education, Medical Directors, and Public Programs. The model utilizes a multidimensional approach to improving quality and delivery of care inclusive of community outreach and media, provider interventions and system level initiatives. The following highlights the core components of the disparity reduction model:

- Planning inclusive of key informant interviews, literature reviews, data analysis (spatial and descriptive)
- , dDevelopment of community and internal advisory groups
- and bBudget development
- Implementation of efforts are targeted at 3 core levels:

    1. 1.) Location: Member/Community where partnerships are formed to identify existing initiatives and leverage support of community feedback to design and implement interventions., 2.)
    2. Data: Provider interventions targeting high volume, low performing groups and providers who have disparate outcomes, and 3.).
    3. Internal programs to improve disparities in identification, engagement and outcomes in Case Management and Disease Management.

- Evaluation and improvement of health disparity reduction efforts.
- Social needs and social risks all play into determining appropriate partners, selecting, engagingengaging, and taking initiativesves with partners.

Consultation: Plan staff collaborates across departments to provide consultative services for cultural competency and linguistic perspectives in order to improve health disparities. Examples of consultations include partnership on QI intervention development and support of care management programs.

- **Collaborations**

CBO's: To support the reduction of health disparities, Plan staff interact with community-based organizations (CBOs) to identify C&L related concerns, obtain feedback on health equity and C&L service needs of the community and promote C&L services to community members.

5.5 Public Policy Committee (PPC)

CalViva Health maintains a Public Policy Committee, as one way for members to participate in establishing the public policy of the plan, to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care, and to establish and maintain community linkages. "Public policy" means acts performed by the Plan or its employees and staff to assure the comfort, dignity and convenience of members who rely on the Plan's facilities to provide health care services to them, their families, and the public.

The Public Policy Committee meets four times a year. Committee The PPC empowers members to ensure the Plan is actively driving interventions and solutions to build more equitable care by:responsibilities include
- oObtaining local level feedback, insights and perspectives to inform and address our quality and health equity strategy. and guidance in delivery of culturally and linguistically appropriate health care services inclusive of the population needs assessment, and establishing and maintaining community linkages.
- Providing the Plan with the community's perspective on health equity and disparities, population health, children's services, and relevant plan operations and programs.
- Informing the Plan's cultural and linguistic services program.
- Identifying and advocating for preventive care practices.
- Gathering feedback, develop, and update cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting groups who speak a primary language other than English.
- Advising on necessary Member or Provider targeted services, programs, and training.
- Making recommendations to the Plan regarding the cultural appropriateness of communications, partnerships, program design and services.

- Reviewing Population Needs Assessment (PNA) results, discuss and provide input into opportunities to improve performance with an emphasis on Health Equity and Social Drivers of Health.
- Providing input on the selection of targeted health education, cultural and linguistic, and QI strategies.
- Ensuring findings, recommendations and actions to/from the QI/UM Committee and Public Policy Committee (PPC) connect to holistic decisions and programming.
- Recommending strategies to effectively engage members, including but not limited to consumer listening sessions, focus groups, and/or surveys.
- Reviewing and approving meeting minutes from previous sessions.
- Providing input and advice, including, but not limited to, the following:
  a. Culturally appropriate service or program design;
  b. Priorities for health education and outreach program;
  c. Member satisfaction survey results;
  d. Findings of the Populations Needs Assessment (PNA);
  e. Plan marketing materials and campaigns.
  f. Communication of needs for Network development and assessment;
  g. Community resources and information;
  h. Population Health Management;
  i. Quality;
  j. Health Delivery Systems Reforms to improve health outcomes;
  k. Carved Out Services;
  l. Coordination of Care; and
  m. Health Equity;
  n. Accessibility of Services

The Plan will ensure that PPC meetings are accessible to PPC members and that PPC feedback is meaningfully incorporated in Plan's operations and governance. Information provided by the PPC members is included in the development of Health Equity Department materials, health education materials and programs and Quality Improvement Projects. They provide critical feedback for Health Net to understand that perception, experience, and satisfaction of services.

The Committee includes a culturally diverse group including CalViva Health members, member advocates (supporters), Commissioner of CalViva Health's governing board, the Fresno-Kings-Madera Regional Health Authority (RHA) Commission, and health care providers.

The PPC consist of no less than seven (7) members, who are appointed as follow:
- One member of the RHA Commission who serve as Chairperson of the PPC;
- One member who is a provider of health care services under contract with the Plan; and

- All others are Plan members (who collectively must make-up at least 51% of the committee membership) entitled to health care services from the Plan. PPC Plan members comprised of the following:
    o Two (2) from Fresno County
    o One (1) from Kings County
    o One (1) from Madera County
    o One (1) At-Large from either Fresno, Kings, or Madera Counties
- Two (2) Community Based Organizations (CBO) representatives appointed as alternate PPC members to attend and participate in meetings of the Committee in the event of a vacancy or absence of any of the members appointed above.
    o The alternates represent different Community Based Organizations (CBO) that serve Fresno, Kings, and/or Madera Counties and provide community service or support services to members entitled to health care services from the Plan.
    o Two (2) alternates from the same CBO not be appointed to serve concurrent terms.
- The Plan members and CBO representatives are persons who are not employees of the Plan, providers of health care services, subcontractors to the Plan or contract brokers, or persons financially interested in the Plan.

In selecting the members and/or CBO representatives of the PPC, the RHA selection committee make a good faith effort to ensure the PPC reflects the general Medi-Cal population in the Plan's service area (i.e., Fresno, Kings and Madera counties). Consideration is given to Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), and those with Limited English Proficient (LEP). To ensure at least 5% of the committee members represent a culturally diverse group of community members, consumers, and individuals, additional factors to be considered are race, ethnicity, sexual orientation, gender identity, SDoH, demography, occupation, and geography. Any such selection of a Plan member or a CBO representative are conducted on a fair and reasonable basis.

6.0 OVERSIGHT AND MONITORING

CalViva Health and HNCS collaborate to ensure that CalViva Health members receive consistent, high quality health equity and C&L services. The collaboration also forms a unity among the plans that permits a uniform message to be delivered to contracted providers and members. This collaboration is an avenue that increases services for the community and increases the impact that Health Equity programs can make. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity programs and services delegated to HNCS and the internal monitoring conducted by HNCS.

6.1 CalViva Health Monitoring and Evaluation

CalViva Health receives, reviews, and if ~~necessary~~necessary, approves numerous key reports in a calendar year. More information about the ~~Governing Body~~RHA Commission and structure is in Appendix 1.

The ~~Governing Body~~RHA Commission and QI/UM Committee reviews progress on Health Equity activities and initiatives at least annually. Committee responsibilities include:
- Review and approve the annual Health Equity documents:
  - Program Description
  - Work Plan
  - Work Plan Evaluations (Mid-Year and End of Year)
  - Health Equity End of Year Report
- Provide feedback and approval for program outcomes.
- Review program goals and semi-annual progress.
- Receive/review/analyze status reports from core areas
- Submit reports to the governing body (Board of Directors)
- Health Equity Oversight, including:
  - Monitors, approves, supports, and evaluates the activities for this program, and makes recommendations for improvement.
  - Conducts an annual evaluation of the effectiveness of the language assistance services offered to support members with limited English proficiency and to mitigate potential cultural or linguistic barriers to accessing care in compliance with requirements from the Department of Health Care Services (DHCS).

CalViva Health ensures C&L services, programs, and activities are meeting the required regulatory and compliance requirements through the following methods:

- **Member and Provider Communications Review**

CalViva Health reviews and approves all member materials before distribution to CalViva Health Members. The review process includes but is not limited to ensuring member materials have been approved by HNCS as culturally appropriate and the appropriate reading level. In addition, CalViva Health reviews and approves Health Equity provider communications prior to release to contracted providers.

- **Reports**

CalViva Health reviews and approves key Health Equity reports produced by HNCS including, but not limited to the LAP utilization report, annual work plan and program description, PNA, Geo Access Report, and mid-year/annual evaluations. The reports are

reviewed, discussed, and if necessary approved by CalViva Health's Quality Improvement (QI) workgroup, QI/UM Committee, Access workgroup and the RHA Commission. In addition, reports are also shared as information to CalViva Health's Public Policy Committee.

- **Audits**

CalViva Health conducts an oversight audit of health equity and C&L activities delegated to HNCS. The main elements covered in the audit include but not limited to: C&L/language assistance policies and procedures, assessing the member population, language assistance services, staff training, provider contracts, training and language assistance program, and evaluation and monitoring. The results of the audit are shared with HNCS, the QI/UM Committee, and the RHA Commission.

6.2 HNCS Health Equity Department Internal Monitoring and Evaluation

The Health Equity Department produces numerous key reports in a calendar year. The reports are an integral part of the regulatory and compliance requirements and are used to help identify areas where modifications and corrective measures may be needed. The key reports include but are not limited to the following:

- **Language Assistance Program Utilization Report**

The Health Equity Department summarizes the Language Assistance Program (LAP) utilization data on a monthly and quarterly basis. The monthly LAP utilization report summarizes the non-English call volume to the member service call center, interpreter vendor (telephone, face-to-face, ASL) call volume per language, and requests for oral and written translations from member service representatives. Language call volume and identified language preferences are tracked to identify developing trends and possible future member language needs. Health Equity Department produces a LAP report biannually that summarizes LAP data and assesses utilization and usage trends. The end of the year LAP Utilization report compares current usage by language and type of request to previous year's data to allow the Plan to project future language trends. Any notable trends will be reported to the Plans' QI/UM Committee.

- **Population Needs Assessment**

The Community Health Education and Health Equity Departments conduct a Population Needs Assessment (PNA) every three years to improve health care outcomes for members. The PNA is conducted through an analysis of CAHPs survey data and follows the DHCS guidance provided in APL 19-011. CalViva's Public Policy Committee members will provide input to the PNA and review the PNA results.

The results of the PNA are used to identify Health Equity program strategies to improve health outcomes and to reduce health disparities. The Health Equity work plan is adjusted biannually to include all strategies that have been identified to improve health outcomes and reduce health disparities for members. The Health Equity work plan serves as the PNA action plan that is submitted to DHCS every 3 years.

- ~~C&L~~ **Geo Access Report**

The Health Equity Department prepares a report to identify the need for linguistic services using ~~the Geo Access demographic~~a spatial analysis software program. The purpose of the Geo Access report is to understand if members have access to provider locations where either the doctor or office staff speak the preferred language of the member. This analysis is conducted for both PCP offices and Specialist offices. The locations of members and providers are compared across language preference. Using predetermined time and distance parameters, the software measures the time and distance for each member to each provider office by language and by county. Time and distance standards vary by type of place: urban, suburban, and rural. The language capabilities of the provider network are compared to the language needs of CalViva Health members. The availability of linguistic services by contracted providers for members with LEP is analyzed and recommendations made for provider network development. The Geo Access report is produced by the Health Equity Department every two years for review and comment, and submitted to the QI/UM Committee. ~~Upon review of the findings and follow up by provider network management, a status report will be developed and presented to document network findings.~~

- **Data Collection**

The Health Equity Department monitors the demographic composition of members for each CalViva Health county. Demographic information is used to assess the language needs of members; to identify possible cultural and socio-economic background barriers to accessing health care; and to understand the range of diversity within the communities that CalViva Health serves. Collected and analyzed on a regular basis, data is based on existing member language needs, race and ethnicity. The Health Equity Department holds the list of all races, ethnicity and language codes and categories used by all data systems. Health Equity collaborates with IT to assure that all new databases and modified databases can share member race, ethnicity, and language information.

Member individual-level data is collected either directly or indirectly by multiple sources. ~~within the organization~~. Protected electronic data system databases enable collected member race, ethnicity, sexual orientation, gender identity, and social needs data to be received, stored, and retrieved. When collecting data directly from patients or members, ~~the organization employs~~ a direct data collection framework that includes when data will be collected, where data will be collected, how and by whom data will be collected, and

what questions will be used to collect data as well as response options that include option to "decline" or "choose not to answer".

The Health Equity Department also maintains a log of all cultural or linguistic related grievances received. The logs for culture or language-related grievances and complaints are analyzed to determine if members' cultural and communication needs are being met and/or addressed by contracted providers. Information from the Appeals and Grievances Department, in conjunction with information from the community demographic profile, help to identify cultural and/or linguistic issues that may act as barriers to accessing health care. Should a communication need be identified, the Health Equity Department develops a provider or member education intervention or program to meet that need.

7.0 <u>SUMMARY</u>

CalViva Health, in collaboration with Health Net Community Solutions (HNCS), is committed to improving health outcomes by providing cultural and linguistic services and programs that facilitate effective communication between a diverse membership, diverse provider networks, and CalViva Health and HNCS. CalViva Health's goals and objectives are based on providing support, maintaining compliance, and creating cultural awareness through education, consultation, and support. In addition, the programs and services encompass how we communicate to our members and contracted providers about the health equity and C&L program and services available.

STAFF RESOURCES AND ACCOUNTABILITY

1. CalViva Health Committees

A. Governing Body/RHA Commission

The RHA Commission is the governing body with ultimate authority and responsibility for the oversight of CalViva Health.

B. QI/UM Committee

The QI/UM Committee monitors the quality and safety of care and services rendered to CalViva Health members. This Committee identifies opportunities for improvement, recommends policy decisions, evaluates the results of activities, institutes needed actions, and ensures follow up as appropriate. The Health Equity program description, work plan, language assistance utilization report and end of year reports are all submitted to the CalViva Health QI/UM committee for review and approval. The QI/UM committee provides regular reports to the RHA Commission.

C. Public Policy Committee (PPC)

The Public Policy Committee includes CalViva Health members, member advocates (supporters), an RHA Commissioner, and a health care provider. Committee responsibilities include obtaining feedback and guidance in the delivery of culturally and linguistically appropriate health care services and establishing and maintaining community linkages. The Health Equity program description, work plan, language assistance utilization report and end of year reports are shared as information to the Public Policy Committee. The Public Policy Committee provides regular reports to the QI/UM Committee and the RHA Commission.

2. CalViva Health Staff Roles and Responsibilities

A. Chief Medical Officer

CalViva Health's Chief Medical Officer's responsibilities include assuring that CalViva Health's programs are compatible and interface appropriately with the provider network

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and the overall scope of CalViva Health's QI program. A medical management team is under the direction of the Chief Medical Officer.

B. Chief Compliance Officer

CalViva Health's Chief Compliance Officer's responsibilities include assuring that CalViva Health's programs are in compliance with the DHCS contract, regulatory standards and reporting requirements. A compliance team is under the direction of the Chief Compliance Officer.

C. Equity Officer

CalViva Health's Equity Officer's responsibilities include assuring that CalViva Health's programs prioritize and address Health Equity where possible and also carrying out the strategic work of Equity throughout the organization. The Equity Officer will provide leadership on equity, diversity, and inclusion issues affecting the organization. The Equity Officer will also work collaboratively with the Chief Medical Officer to achieve the goal of equitable access and to reduce disparities in clinical care and quality outcomes. The Equity Officer will also engage and collaborate with internal and/or external stakeholders to advance Health Equity efforts and initiatives.

3. HNCS Health Equity Department Staff Roles and Responsibilities

The Health Equity Department is unique in its cross-functional support structure. The Department's function is to fulfill all cultural and linguistic contractual and regulatory requirements and serve as a resource and support for all health equity and C&L services. The Health Equity Department is staffed by the Director of Program Accreditation, a Manager of Health Equity Department, a Program Manager III, five Senior Health Equity Specialists, one Health Equity Specialist, a Project Coordinator II, and one supplemental staff.

A. HNCS Leadership Team

HNCS is a subsidiary of Health Net LLC. Through a dedicated and qualified staff, important cultural and linguistic services are developed and coordinated within the CalViva Health service area by HNCS. HNCS, as a subsidiary of Health Net LLC., continues to maintain their internal reporting responsibilities (e.g. Chief Executive Officer (CEO), Vice Presidents, Officers, Directors, etc.) however, activities conducted within the CalViva Health service area are subject to oversight by CalViva Health's staff and respective committees.

The Chief Health Equity Officer, under the Chief Medical Officer, is responsible for providing leadership in Health Equity efforts across the organization. Under the Chief

Health Equity Officer, the Health Equity Department contributes to planning program structure for Health Net. The Chief Health Equity Officer ensures the plan's health equity structure is aligned with Corporate and other state plans, as appropriate.

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

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

_____   _____

David Hodge, MD   Date

Regional Health Authority Commission Chairperson

_____   _____

Patrick Marabella, MD, Chief Medical Officer   Date

Chair, CalViva Health QI/UM Committee

Item #10
Attachment 10.C

Health Equity Program Description
and Work Plan Evaluation

2024 Executive Summary
and Work Plan Summary

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Pao Houa Lee, MBA, Senior Health Equity Specialist
COMMITTEE DATE:	May 16, 2024
SUBJECT:	Health Equity Work Plan 2024 – CalViva Health Summary Report

Purpose of Activity:

Present CalViva Health's Health Equity Work Plan for 2024, to obtain the committee's approval, and evaluate the progress against services to meet the end of the year goals.

Summary:

The Health Equity Work Plan 2024 supports and maintains excellence in Health Equity and C&L Services through the following strategies: provide oversight of Language Assistance Program (LAP), integration and expansion of targeted health disparity efforts, health literacy and plain language standards, supporting CalViva Health in being a culturally competent Health Plan, expanding on consulting services, and maintaining compliance with regulatory and contractual requirements.

The 2024 Work Plan is consistent with the 2023 Work Plan while incorporating and enhancing the following activities:

1. Expanded on data collection (Row #6).
2. Elaborated on member's communication and information they will receive (Row #10).
3. Consolidated interpretation and translation coordination support into one activity (Row #13).
4. Consolidated Health Equity P&P edits and updates into one activity (Row #17).
5. Edited due date for Geo Access report (Row #20).
6. Removed prior year's information technology efforts and updated with 2024's efforts to include SOGI data collection (Row #23).
7. Staff changed and updated (Row #27).
8. Added measurable objectives to findhelp oversight based on PPC's comments and feedback (Row #34).
9. Edited location for new methods for how providers can obtain C&L materials: provider's library (Row #41).
10. Included additional ways for how staff can complete C&L trainings: online (Row #46).
11. Expanded and consolidated cultural competency trainings (Row #51).
12. Updated PIP projects and included SUD/MH non-clinical project (Row #56, #57).

13. Removed prior year's disparity project (DLP) and added IHI/DHCS Child Health Equity Sprint project (Row #58).

<u>Next Steps:</u>

Once approved, implement and adhere to the Health Equity Work Plan 2024, and report to the QI/UM Committee.

2024
Health Equity
Work Plan

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

Mission:

CalViva Health's Health Equity mission is to be an industry leader in ensuring health equity for all members and their communities.

Goals:

CalViva Health's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The goals are equally important and reinforce each other to fulfill the mission:
1. To ensure meaningful access and positive health outcomes through the provision of culturally and linguistically responsive services to members and providers.
2. To promote for members and potential enrollees to be active participants in their own health and health care through clear and effective communication.
3. To advance and sustain cultural and linguistic innovations.

Objectives:

To meet these goals, the following objectives have been developed:
A. To ensure compliance with applicable Medi-Cal contractual requirements, state and federal regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).
B. To ensure staff and providers have C&L resources available to provide culturally competent services to CalViva Health members.
C. To be champions of cultural and linguistic services in the communities CalViva Health serves.
D. To promote and be champions for diversity of CalViva Health members, providers and Plan staff.

Selection of the Cultural and Linguistics Activities and Projects:

The Cultural and Linguistics Work Plan activities and projects are selected based on the results from the CalViva 2022 Population Needs Assessment Report (PNA) (i.e., demographics, health status, risk factors, and surveys), regulatory requirements, department evaluation report from the previous year, HEDIS results, contractual requirements, and strategic corporate goals and objectives. After review and input from senior management staff, projects and new departmental activities are identified and incorporated into this work plan. Programs and services are developed with special attention to the cultural and linguistic needs of our membership. This work plan addresses the needs of our Medi-Cal (MC) members.

Strategies:

The Health Equity Work Plan supports and maintains excellence in the cultural and linguistics activities through the following strategies:

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A. Goals and objectives are translated into an annual work plan with specific activities for the year to fulfill its mission of being an industry leader in ensuring health equity for all members and their communities;
B. Work plan objectives and activities reflect the Office of Minority Health's national Culturally and Linguistically Service (CLAS) standards, and directly address various contractual and regulatory requirements;
C. Support information-gathering and addressing needs through Population Needs Assessment (PNA), data analysis, and participation in the CalViva Health Public Policy Committee (PPC);
D. Interacting with community-based organizations, advocacy groups, community clinics and human service agencies to identify the cultural and linguistic-related concerns of the community.

The Health Equity Work plan is divided into the following areas in support of the Principal CLAS Standard (To provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs): 1) Language Assistance Program Activities, 2) Compliance Monitoring, 3) Communication, Training and Education and 4) Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity.

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	Main Area and Sub-Area	Activity	Measurable Objective	Due Dates	Mid-Year Update (1/1/24 - 6/30/24)	Year-End Update (7/1/24 - 12/31/24)
			Language Assistance Program Activities			
1	Rationale	**The LAP and applicable policies and procedures incorporate the fifteen national standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the Office of Minority Health. Standards 5, 6, 7 & 8 provide the basics for language support services for CalViva Health members.[1]**				
2	Responsible Staff:	**Primary: P. Lee, I. Diaz**	**Secondary: D. Fang, L. Espinoza**			
3	Audit	Assure C&L audit readiness to support DHCS Language Assistance Program (LAP) audit standards	Coordinate LAP audit requirements to include: collecting requested documentation, submitting documents as requested, participate in on-site interviews as requested	Annual		
4	Contracted Vendors	Conduct language assistance vendor management oversight	Review and update vendor contracts to ensure alignment with requirements	Ongoing		
5	Interpreter	Monthly collection of language utilization data for CalViva	Updated LAP utilization report to contain: monthly summary of bilingual phone calls answered by call center, in-person and telephonic interpreter utilization log	Semi-annual		
6	Data	Conduct membership data pulls. Facilitate alignment and collection of demographic data. Coordinate race/ethnicity/language membership data and document.	Validated membership reports. Coordinate 5579 report and review monthly membership data pulls.	Monthly		
7	Operational	Create language and alternate format standing request report	Number of reports generated and posted	Weekly		
8	Compliance	Monitor provider bilingual staff; ensure systems are capturing provider and office language capabilities	Annual provider communication and monitoring grievances, review of provider Ops manual	Ongoing		
9	Regulatory	Update and provide taglines and Non-Discrimination Notice (NDN) insert in support of departments and vendors that produce member informing materials	Annual review and update as needed and distribute updated documents to all necessary departments, maintain tagline and NDN decision guides, answer ad-hoc questions on the use and content, assure most recent documents are available on Health Equity SharePoint	June and December		

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10	Member Communication	Annual mailing to members advising how to access language assistance services and sending language assistance notice to assess language needs. Annual LAP mailing to survey REAL and SOGI.	Write or revise annual language assistance article distributed to CalViva members	Annual		
11	Operational	Ensure bilingual staff maintain bilingual certification; generate reporting and support to departments to identify staff who need bilingual certification updated	Number of staff certified annually	Annual		
12	Operational	Complete LAP Trend Analysis, including year over year LAP trend analysis	Report to summarize utilization of LAP services, number of bilingual staff and provide year over year trends for the utilization of LAP services	Q2		
13	Operational	Oversight of interpreter and translation operations. Review of metrics for interpreter/translation coordination	Conduct oversight meetings to review metrics for timeliness. Hold quarterly meetings with Centralized Unit and escalate when metrics are not being met. The number of interpreter/translation coordinated.	Quarterly		
14	Operational	Review interpreter service complaints (exempt grievance) reports and conduct trend analysis. Provide complaint information to impacted area for resolution, e.g., vendor, internal process	Monitor interpreter service vendors through service complaints	Annual (trend)		
15	Operational	Coordinate and deliver Health Equity Department Quarterly meetings to review requirements and department procedures for language and health literacy services	Minutes of meetings	Quarterly		
16	Operational	Complete Population Needs Assessment (PNA) in collaboration with Health Education. Review new PNA requirement and participate in PNA Workgroup to complete assessment report.	Support PNA data collection, interpretation for member demographics, disparity analysis and development of an action plan that addresses identified member needs	June		
17	Operational	Develop, update and maintain translation, alternate formats, interpreter services, bilingual assessment, and all Health Equity policies and procedures (P&Ps)	Annual update of P&Ps and off cycle revisions as needed and submitted to designated CalViva Health staff for utilization in the development or review of CalViva Health Health Equity P&Ps	Annual		

18	Operational	Collect and review LAP P&Ps from other departments to assure compliance with use of tagline, NDN, translation process and interpreter coordination	P&Ps will be reviewed and placed in Health Equity LAP compliance folder	Annual		
19	Operational	Complete Health Equity Geo Access report documenting Provider Network Management (PNM) findings every two years	Data collection and data analysis for Health Equity GeoAccess report, production of HEQ Geo Access report.	Q3 2025		
20	Operational	Complete annual Timely Access Reporting on the Language Assistance Program Assessment	LAP Assessment Timely Access Report	Annually		
21	Operational	Coordinate and provide oversight to translation review process	Number of translation reviews completed	Ongoing		
22	Training	Review, update and/or assign LAP online Training	Number of staff who are assigned training and percentage of completion	Annual		
23		Lead IT projects related to language assistance services such as standing request and website modifications. Submit JIRA (name of the system, Jira) and PID (project identification) requirements when appropriate and ensure C&L requirements are represented through project. Maintain SME knowledge for REAL and SOGI codes and categories	Successful implementation of IT projects	Ongoing		
24	Strategic Partners	Monitor strategic partners and specialty plans for LAP services	Request information from specialty plans and strategic partners semi-annually. Update report template to indicate delegation status of LAP, use of NOLA, any comments forwarded from delegation oversight and review of P&Ps	Ongoing		
25	Translation and Alternate Format Management	Develop and maintain Translation and Alternate Format Tracking (TAFT) database with comprehensive list of member informing materials available and department responsible. Database will help support prompt identification of document and department responsible. Ongoing updating with bi-annual requests to all departments to review/update their list. Oversee implementation, management and updating of TAFT database	List of available materials	Ongoing		

		Compliance Monitoring				
26	Rationale	Compliance monitoring conducted to ensure CalViva Health members receive consistent, high quality C&L services. The following processes are in place to ensure ongoing CalViva Health oversight of the Health Equity and C&L programs and services delegated to HNCS and the internal monitoring conducted by HNCS.				
27	Responsible Staff:	Primary: P. Lee, A. Said	Secondary: I. Diaz, N. Buller			
28	Complaints and Grievances	Oversight of complaints and grievances related to LAP or C&L services, including monitoring and responding to all C&L related grievances. Collect grievance and call center reports. Maintain contact with the call center to ensure C&L complaints are monitored. Grievance reports include grievances coded to C&L codes (including discrimination due to language or culture). Maintain grievance response log and list of materials, develop and document interventions when indicated	Report on grievance cases and interventions	Ongoing		
29	Complaints and Grievances	Conduct a trend analysis of C&L grievances and complaints by providers	Production of trend analysis report	August		
30	Complaints and Grievances	Review and update desktop procedure for grievance resolution process	Revised desktop procedure	December		
31	Oversight	Complete all CalViva required Health Equity/C&L reports	Develop Health Equity CalViva work plan, write/revise and submit Health Equity CalViva Program Description. Prepare and submit work plan, LAP mid year and end of year reports	Ongoing		
32	Oversight	Participate in CalViva required work groups and committees	Participate in the ACCESS workgroup, QI/UM workgroup, QI/UM committee, monthly operations management meetings. Provide support for Regional Health Authority meetings as needed or requested.	Ongoing		
33	Oversight	Support Public Policy Committee meetings for Fresno, Kings and Madera Counties	Assist at Public Policy Committee meetings as required.	Quarterly		

34	Regulatory	Provide oversight of findhelp platform and coordination of social service referrals for members.	Provide 2 training on findhelp to internal deparments, members, and providers on to promote the Social Needs Self-Assessment, quarterly. Produce analytics and segmented utilization reports to ensure 40 social needs assessments are completed each quarter. Review completed social needs assessments monthly and ensure that at least 85% of qualifying members are referred to an appropriate internal program; 60% referrals are closed. Add 50 social need programs within Findhelp to address social risks within each month.	Ongoing		
		Communication, Training and Education				
35	**Rationale**	**To provide information to providers and staff on the cultural and linguistic requirements, non-discrimination requirements, the LAP program, C&L resources, and member diversity.**				
36	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, N. Buller**			
37	Training and Support	Provide support and training to A&G on coding and resolution of grievances; re-align coding per 1557 non-discrimination reporting	Revised/updated Quick Reference Guide (QRG) for A&G staff regarding grievance responses, coding and process on sending to Health Equity, etc.	Ongoing		
38	Staff Training	Provide Health Equity in-services for other departments as requested (e.g., Call Center, Provider Relations).	Curriculum/power point, name of department and total number of participants who attended the in-service	Ongoing		
39	Staff Communication	Maintenance and promotion of Health Equity SharePoint site	Timely posting of important information on Health Equity SharePoint e.g., vendor attestation forms, threshold languages list, etc.	Ongoing		
40	Provider Communication	Prepare and submit articles for publication to providers. Potential topics: LAP services, culture and health care, and promotion of on-line cultural competence/Office of Minority Health (OMH) training	Copies of articles and publication dates	Ongoing		

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41	Provider Communication and Training	Promote C&L flyer and provider material about Health Equity Department consultation and resources available, inclusive of LAP program and interpreter services.	Provider material made available on provider's library.	Ongoing		

	Core Areas of Specialization: Health Literacy, Cultural Competency, and Health Equity	

	Health Literacy	

42	**Rationale**	**To ensure that the information received by members is culturally and linguistically appropriate and readability levels are assessed to ensure they comply with required readability levels mandated by regulatory agencies.**

43	**Responsible Staff:**	**Primary: A. Kelechian**	**Secondary: A. Schoepf**

44	English Material Review	Conduct English Material Review (EMR) per end-end document production guidelines (review of content and layout of materials for C&L appropriateness and low literacy)	Completion of all EMRs as tracked through the C&L database	Ongoing		
45	Operational	Review and update Health Literacy materials as needed inclusive of list of words that can be excluded during the readability assessment, database guide, checklists, readability assessment guide and other relevant materials	Update and post materials on Health Literacy SharePoint Explore new system platform to host EMR data	Ongoing		
46	Training	Quarterly training for staff on how to use the C&L database and write in plain language, including online training.	Number of staff trained. Quarterly training	Quarterly		
47	Training	Conduct activities and promotion of National Health Literacy Month (NHLM)	Production and tracking of action plan for NHLM and summary of activities	October		

	Cultural Competency	

48	**Rationale**	**To integrate culturally competent best practices through provider and staff in-services, training, education, and consultation. Training program offers topic specific education and consultation as needed by staff, contracted providers and external collaborations.**

49	**Responsible Staff:**	**Primary: P. Lee, S. Rushing**	**Secondary: L. Espinoza, I. Diaz**

50	Collaboration-External	Representation and collaboration on Health Industry Collaboration Efforts (HICE) for Health external workgroup	Minutes of meetings that reflect consultation and shared learning	Ongoing		

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51	Provider Training	Conduct cultural competency, implicit bias, and gender identity training/workshops for contracted providers and provider groups upon request. Training content to include access to care needs for all members from various cultural and ethnic backgrounds, with limited English proficiency, disabilities, and regardless of their gender, sexual orientation or gender identity. Work with provider communication to implement ICE for Health computer based training through provider update and/or provider newsletters and/or medical directors, promote Office of Minority Health (OMH) cultural competency training through provider operational manual and provider updates. Work with provider engagement to publish invites for trainings and as warranted create on-demand trainings. Review assignment criteria for LAP and Cultural Competency/DEI trainings and ensure that required providers are represented.	Output number of providers who received cultural competency training by type of training received	Annual		
52	Staff Training	Conduct annual cultural competence education through Heritage/CLAS Month events including informational articles / webinars that educate staff on culture, linguistics and the needs of special populations	Online tracking. Event summary and activity specific participation totals	Q3		
	Health Equity					
53	Rationale	**To support the health of CalViva Health members and promote the reduction of health disparities across our membership. In order to accomplish this, staff collaborates across departments and with external partners in order to analyze, design, implement and evaluate healthy disparity interventions.**				
54	Responsible Staff:	**Primary: P. Lee, D. Fang,**	**Secondary: A. Schoepf**			

55	Operational	Increase interdepartmental alignment between population health, SDoH, cultural competency and disparity initiatives across departments on disparity reduction efforts. Facilitate quarterly meetings. Provide consultation and support to internal departments on SDoH and disparities.	Facilitation of health disparity collaborative quarterly meetings and intra departmental collaboration on Health disparities. Conduct trainings and share resources to staff/departments on disparities model, SDoH, and disparities in health outcomes among disparate population. Consultation provided to other departments.	Quarterly		
56	Operational	Implement disparity model for PIP projects (W30-6+) include formative research, community, member and provider interventions	Development of modules; meet PIP disparity reduction targets	Ongoing		
57	Operational	Provide support for SUD/MH non-clincial PIP project.	Disparity reduction project work plan; evaluation, documentation of process outcomes	Ongoing		
58	Operational	Provide support for IHI/DHCS Child Health Equity Sprint project.	Disparity reduction project work plan; evaluation, documentation of process outcomes	Ongoing		
59	Operational	Provide consultation to departments on cultural competency and improving health care outcomes (including enrollment) for key demographics and key metrics to support health equity	Consultation and /or trainings provided	Ongoing		

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[1] National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

^   **Indicates revision.**

*   **Indicates new.**

04.30.2024

Item #11
Attachment 11.A

Health Education Work Plan Evaluation

Executive Summary

Attachment

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Amy M. Wittig, MBA, Director, Quality Improvement
                   Louba Aaronson, MPH, Director, Quality Improvement
                   Rahma K. Abdillah, MHA, Project Manager II, Quality Improvement

COMMITTEE DATE: May 16, 2024

SUBJECT: Health Education Work Plan Year-End Evaluation & Executive Summary 2023

Summary

The 2023 Health Education Work Plan Year-End Evaluation report documents progress of **15 initiatives** with **40 measurable objectives** (there are multiple objectives within each initiative).

Of the 40 measurable objectives:

- 25 are attained as of the end of the year.
- 1 is partially attained as of the end of the year.
- 7 are not attained and did not meet the measurable objective as of the end of the year.
- 2 were suspended given the Quality Department's quadrant analysis.
- 5 are canceled.

Purpose of Activity:

To provide for QI/UM Committee review and approval of the 2023 Health Education Work Plan Year-end Evaluation Summary.

Data/Results (include applicable benchmarks/thresholds):

The Health Education Department developed programs and services on a variety of topics to promote healthy lifestyles and health improvement for CalViva Health (CVH) members. The main areas of focus are member engagement, weight control, pregnancy, smoking cessation, preventive health care services, and chronic disease education.

Table 1. on the next page compares the 2023 year-end utilization outcomes of health education initiatives against 2023 measurable objectives.

Table 1: 2023 Mid-Year Utilization Outcomes of Health Education Initiatives

Initiative	2023 Measurable Objectives	2023 Year-End Outcomes	2023 Year-end Status
1. Chronic Disease Education: Asthma	Collect and analyze patient-level utilization and pharmacy data for asthma medications, and program effectiveness for members.	177 members enrolled in the 12-month program, but only 141 completed the program. AMR gap closure rate was 16% with a 0.10 AMR ratio improvement among members who completed the program. Most participants were between 22-65 years old, followed by 12–17-year-olds. More participants were female (61%), compared to male (39%). Slightly more than half of participants identified as Hispanic or Latino/Latinx at 57%, while 9% identified as African American or Black. 61% preferred English as a spoken language and 38% preferred Spanish. A detailed program evaluation is available. Emergency room visit analysis will be available July 2024.	Attained
	Promote Asthma Management: Launch 1-2 email campaigns addressing asthma triggers, prevention tips and resource links with a 15% read rate.	Canceled	Canceled
	Promote Asthma Health Education: Identify and distribute at least 200 asthma education materials to members with uncontrolled asthma.	Attended 3 community events where over 200 asthma education materials were provided. Events took place on: • 8/5/23: Back to School Backpack, a CalViva Health sponsored event. • 9/27/23: Fresno City College health fair. Provider Order Form request was received for asthma educational materials. Four (4) asthma resource requests were fulfilled in 2023. The development of an asthma educational resource regarding Asthma Remediation services was started in August 2023. The material is currently going through the CalViva Health review and approval process and will be used to collaborate with providers/PPGs who will then disseminate to our members.	Attained
2. Chronic Disease Education: Diabetes	Identify and onboard new Diabetes Prevention Program (DPP) provider including DHCS approval of provider.	Vendor started the onboarding process. MSA/BAA signed. SOW and member materials in progress for DHCS submission packet as of 12/31/23.	Attained
	Develop and launch 2-member outreach campaigns to promote new DPP.	Task is dependent on DHCS approval of new DPP.	Not Attained
	Develop and launch 1 provider outreach campaign to promote new DPP.	Task is dependent on DHCS approval of new DPP.	Not Attained
	At least 50 eligible members will enroll in the DPP program.	Task is dependent on DHCS approval of new DPP.	Not Attained
	Identify and distribute at least 400 *Diabetes Care* education booklets to members with uncontrolled diabetes.	The priority material for the diabetes care booklet was replaced with the Krames articles that are available for providers and members to access online and they can also request these articles from the Health Plan. The digital Versions of the	Attained

Initiative	2023 Measurable Objectives	2023 Year-End Outcomes	2023 Year-end Status
		Diabetes Care booklets are available for upcoming activities in 2024.	
3. Chronic Disease: Hypertension	Promotion of Cardiovascular Health resources: Distribute 150+ Healthy Hearts Healthy Lives (HHHL) toolkits to members with uncontrolled high blood pressure.	Strategy to promote HHHL toolkit is being considered via vendors. Hypertension health education was promoted in member newsletter.	Not Attained
4. Community Engagement	Reach 70% health plan member participation in Promotores Health Network activities by 12/31/2023.	226 Charlas with a 68% member Participation rate (4,415/6,468) as of 12/31/23.	Attained
	Increase promotion of preventive screenings by adding 18 presentations/conversations during PHN activities and events. Topics of focus will be HEDIS Performance Measure priorities. Goal is to build awareness through 6 focused conversations and presentations each quarter during Madera PHN classes and "Viernes social" by 12/31/2023.	A total of 52 presentations completed as of 12/31/23 on the following topics: - A1C Diabetes - High blood pressure - Vaccination - Cervical Cancer - Breast Cancer - Cholesterol	Attained
	Engage three community stakeholders to address social determinants of health priorities, link members to SDOH resources.	Engaged 3 community stakeholders as of 12/31/2023.	Attained
	Conduct 25 presentations on CalAIM services to promote ECM and CS programs to increase awareness with community partners.	Conducted 48 CalAIM presentations so far as of 12/31/23.	Attained
	Conduct and participate in 25 stakeholder and provider meetings to support development of CalAIM ECM and CS Network	Conducted 38 stakeholder and provider meetings as of 6/30/2023.	Attained
5. Mental/Behavioral Health	Promote myStrength program to members; increase member enrollment by 20% to 400 members.	Enrolled 364 (91%) members as of 12/31/2023.	Attained
	Partner with the FUM (Follow Up after ER Visits Due to Mental Illness) and FUA (Follow Up After ER Visits Due to Substance Use Disorder) QI Workgroup to develop and implement strategies and action plans to improve the FUM FUA Measures.	22 provider surveys completed and analyzed. Action plans for the PE team to support providers were implemented.	Attained
	Support Quality Department's Behavioral Health action plan to improve Behavioral Health HEDIS Measures. Develop strategies and action plans to reduce barriers and improve behavioral health HEDIS Measures.	Updated Krames materials and resources with CVH logos.	Attained
6. Preventive Health	Promotion of Breast Cancer (BCS) and Cervical Cancer Screenings (CCS): Coordinate via Every Woman Counts to provide a minimum of 18 BCS/CCS member classes for a minimum of 630 members.	As of December 2023, held 81 virtual and in person BCS/CCS classes, reaching 524 participants. EWC provides BCS and CCS health education brochures during their community classes. Educational brochures are DHCS branded.	Attained
	Develop and implement 1-2 educational interventions to improve breast cancer screening rate targeting non-compliant members in Fresno, Kings, or Madera County.	BCS PIP ended 12/31/2022. BCS educational materials are made available interdepartmentally to Quality Improvement, Provider Engagement, and Community Engagement Departments. Materials are used	Attained

Initiative	2023 Measurable Objectives	2023 Year-End Outcomes	2023 Year-end Status
		during outreach events and community presentations. Provider Order Form request was received for Breast Cancer Screening (BCS) educational materials. Two (2) BCS resources were fulfilled in 2023.	
7. Perinatal Education	Enroll 1,500 pregnant members in the CVH Pregnancy Program.	1,276 pregnancies were managed by the CVH Pregnancy Program in 2023.	Attained
8. Pediatric Education	Increase member engagement by 5% for the WCV Measure via call outreach to members (Concierge Program) barrier reduction support.	Concierge Program was not implemented in CalViva Health Counties.	Not Attained
	Create one Provider Update notifying providers of the changes concerning the CAIR registry and AB1789.	One provider update about AB 1789 sent on 2/9/2023. completed at mid-year.	Attained
9. Outreach to Undocumented Members (Health Equity)	Identify target population.	Canceled	Canceled
	Make recommendations for content and implementation of outreach.	Canceled	Canceled
	Initiate implementation of recommended intervention(s).	Canceled	Canceled
	Reach 3% of the target population by 12/31/2023.	Canceled	Canceled
10. Obesity Prevention	Enroll 200+ members in Fit Families for Life (FFFL) Home Edition self-paced program.	4 members were enrolled as of 12/31/2023.	Not Attained
	Enroll 50+ members in Healthy Habits for Health People (HHHP) self-paced program.	No members were enrolled as of 12/31/2023.	Not Attained
11. Tobacco Cessation Program	Increase by 5%-member participation in smoking cessation programs to 158 members in 2023.	Enrolled 115 members as of 12/31/2023.	Partially Attained
	Launch 1 email campaign to promote smoking cessation with at least a 15% read rate.	Canceled	Canceled
12. Fluvention	Implement at least one provider education activity to encourage the promotion of Flu vaccinations during patient visits.	Distributed a Provider Communication regarding Best Practices on HEDIS provider pages for 2023-2024 Flu Season.	Attained
	Inform members on Flu prevention and vaccination using 2 or more communication channels.	Email outreach and IVR messaging were deployed to members in early October.	Attained
	Conduct Vaccine Disparity Analysis and identify proportion of CIS-10 non-compliant members who are missing the flu vaccination and share results with Preventative Care Pod.	This initiative was canceled.	Canceled
13. Member Newsletter	Develop and distribute 1 Annual Medi-Cal Member Newsletter including NCQA required content.	Mailed newsletter to 157,602 unique households.	Attained
14. Compliance: Oversight and Reporting	Submit two semi-annual reports to the QI/UM Workgroup meeting.	Submit two semi-annual reports to the QI/UM as of 12/31/23	Attained
	Updated 6 Policies and Procedures.	Updated 6 Policies and Procedures as of 12/31/23.	Attained
	Attained all required incentive program reports for DHCS.	Completed all required incentive programs reports for DHCS.	Attained

Initiative	2023 Measurable Objectives	2023 Year-End Outcomes	2023 Year-end Status
15. Health Education Department Promotion, Materials Update, Development, Utilization, and Inventory	Assure health education materials covering required DHCS health topics are available to providers, members, and requesting employees. Review and update materials as needed.	Compliant as of 12/31/2023. Rebranded 40 Krames materials with the new CalViva Health logo. Replaced faxed version of the provider printed materials request form with an online version also accessible by QR code.	Attained
	Review and approve internal health education materials following DHCS APL 18-016 guidelines to assure compliance.	Compliant as of 12/31/2023.	Attained
	Review and develop action plans for health education materials impacted by new SB923 (gender-affirming care) guidance. Implement action plan to assure compliance with required gender-neutral language.	Complete. Identified three materials impacted by SB 923. Material owners will replace/update materials to assure compliance.	Attained

2023 Review of Interventions (or Goals) Suspended, Canceled or Not Attained as of the Year

Suspended, Cancelled, Not Attained Intervention	Notes
Chronic Disease Education- Asthma: • Email and mailing campaigns were canceled as of 12/31/2023.	• These activities were canceled because they have limited impact and are resource intensive. Team members are reviewing alternative ways to promote programs and health education resources through providers and QR codes/links to program content.
Chronic Disease Education-Diabetes: • Outreach campaigns to promote new DPP in progress as of 12/31 2023. • Implementation will be contingent upon DHCS approval of the program.	• Continue the process of onboarding new DPP vendor through Q1-Q2 2024. • Task is dependent on DHCS approval of new DPP. • FFFL home edition, used as a weight management tool, was offered in 2023.
Chronic disease Education- Hypertension: • As of 12/31/2023, the promotion of Cardiovascular Health resources is in progress.	• Strategy to promote HHHL toolkit is being considered via vendors. • Hypertension health education was promoted in member newsletter.
Pediatric Education: • As of 12/31/2023, increase member engagement by 5% for the WCV Measure via call outreach to members was not conducted.	• Concierge program was not implemented in CalViva Health Counties. • However, the Family Unit HEDIS outreach calls were made in CVH counties in 2023. 34% of those members reached self-reported they will schedule a WCV or already completed.
Outreach to Undocumented Members (Health Equity) • Initiative is Canceled.	• Initiative is canceled.
Obesity Prevention: • Only 4 members were enrolled as of 12/31/2023.	• Team members are reviewing alternative ways to promote programs and health education resources through providers and QR codes/links to program content

• No members were enrolled in Healthy Habits for Health People (HHHP) self-paced program.	
Tobacco Cessation Program • Email campaigns was canceled.	• This activity was canceled because email campaigns have limited impact, are resource intensive, and low volume of emails provided by members. The focus will continue the promotion of Kick It California via the State and alternative modes through providers and QR/codes links to content.

Next Steps for 2024

- Continue onboarding process with new proposed vendor for the Diabetes Prevention Program. Submit application to DHCS.

- Increase promotion of cardiovascular resources by way of providers and digital QR codes

- Continue "charlas" and engagement with other stakeholders.

- Continue to promote mental/behavioral health resources to members by way of providers and digital QR codes.

- Continue promotion of BCS and CCS screenings via Every Woman Counts.

- Continue enrollment of members in the CalViva Pregnancy Program.

- Re-evaluate opportunities for FFFL and HHHP programs (obesity prevention) to increase access to available resources.

- Continue promotion of the Kick It California program. Partnering with health plans to determine if a submission of the Tobacco Cessation Nicotine Replacement Therapy kits pilot project with Kick It California will be made.

- Implement Fluvention education activities to encourage the promotion of Flu vaccinations during patient visits.

- Continue distributing the Medi-Cal Member Annual Newsletter.

- Continue monitoring and updating as required policies & procedures and incentive programs.

- Collaborate with Marketing to update health educational resources as needed and increase member and provider promotion of the Krames online resources.

Item #11
Attachment 11.B

Health Education Work Plan Evaluation

2023 Annual Evaluation

2023 Health Education Department Year-End Work Plan

Patrick Marabella, MD, Chief Medical Officer

Amy Schneider, RN, BSN, Senior Director Medical Management

Table of Contents

I.   Purpose

The purpose of the Health Education Department (HED) Work Plan is to provide a systematic plan of health education activities for the calendar year for Fresno (F), Madera (M) and Kings (K) counties. It also documents the outcomes of proposed health education initiatives, programs, and services. The implementation of this plan requires the cooperation of CVH senior management and multiple departments such as Cultural and Linguistics Services, Quality Improvement, Utilization/Care Management, Members Services, Marketing, and Provider Engagement.

II.   HED's Vision: Empower and nurture the health of our communities.

II.   HED's Goals and Objectives:

Goals:
1. To provide free culturally and linguistically appropriate health education programs and resources to:
   - Support members and the community to achieve optimal physical, mental, and dental health;
   - Promote health equity;
   - Improve CVH's quality performance; and
   - Enhance member satisfaction and retention.
2. To engage communities, stakeholders, and partners by providing high quality health education programs and resources.

Objectives:
1. Encourage members to practice positive health and lifestyle behaviors.
2. Promote members to appropriately use preventive care and primary health care services.
3. Engage members to follow self-care regimens and treatment therapies.
4. Support provider offices for efficient and cost-effective delivery of health education services and referrals.

IV.   Selection of the Health Education Department Activities and Projects

The HED Work Plan activities and projects are selected from results of population needs assessments, relevant stakeholders, literature reviews, regulatory requirements, department evaluation reports from the previous year, quality performance results, contractual requirements, and strategic corporate goals and objectives. After review and input from senior management, projects and new departmental activities are identified and incorporated into this Work Plan. Programs and services are developed with special attention to the cultural and linguistic needs of our membership and available resources. The HED work plan addresses the needs of our Medi-Cal (MC) members.

V.   Strategies

The HED Work Plan supports and maintains excellence in Health Education departmental activities through the following strategies:
   - enhance member utilization of the plan's evidence-based health education, health equity (cultural and linguistic) resources, and appropriate health care services to help members better understand and manage their health conditions and improve HEDIS rates,
   - to meet health plan and state compliance requirements
   - assist and support the Quality Improvement/HEDIS team as they identify and promote best practices,
   - improve Health Education Department's efficiency and effectiveness,
   - increase provider support, resources, and communication to ensure provision of comprehensive health care services, and
   - support state and community collaboratives to promote preventive health initiatives.

The main health areas of focus are pregnancy, behavioral health, dental, weight control, member engagement, tobacco cessation, preventive health care services, vaccination, heart health, and chronic disease education, among others.

VI.   2023 At-A-Glance Reporting

The 2023 Year-End Evaluation elaborates on these highlights.

Objective	2023 Engagement
Asthma Education	177 members enrolled in the 12-month program, but only 141 completed the program. AMR gap closure rate was 16% with a 0.10 AMR ratio improvement among members who completed the program.
Diabetes Prevention Program	We secured a DPP vendor and initiated the contracting process.
Hypertension	Developed a strategy to promote digital opportunities and collaborate with vendors to increase promotion of cardiovascular resources. Promoted hypertension education in member newsletter.
Community Engagement/PHN	226 Charlas with a 68%-member participation rate (4415/6468) as of 12/31/23. Established three stakeholder partnerships.
Mental/Behavioral Health	Enrolled 364 members in myStrength. Completed 22 provider surveys on FUA FUM and shared tip sheets with providers to educate members and order printed materials for members.
Preventive Health	Conducted eighty-one virtual and in person Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS) classes, reaching 524 participants.
Perinatal Education	1,276 members managed by the CVH Pregnancy Program. Distributed 4,407 CVH Pregnancy Program packets (pregnancy and newborn packets) to members.
Pediatric Education	Reached 4,268 families through the Family Unit HEDIS outreach calls focused on pediatric measures CIS-10 and WCV. Created FAQ and Provider Update for AB1789 requiring the use of CAIR.
Outreach to Undocumented Members (Health Equity)	Project was cancelled to accommodate resources and priority adjustments.
Obesity Prevention	Four members were enrolled in the Fit Families for Life Home Edition Program. No members were enrolled in the Healthy Habits for Healthy People program.
Tobacco Cessation Program	Enrolled 115 members in smoking cessation programs.
Fluvention and COVID-19	Distributed a Provider Communication regarding Best Practices for 2023-2024 Flu Season. Telephonic outreach calls and emails were made to members.
Member Newsletter	Mailed Annual member newsletter to 157,602 unique households.
Health Education Materials	Rebranded/updated 40Krames member health education materials with the CalViva Health logo. 13 Provider Order forms requesting printed materials were fulfilled in 2023. Twenty-five topics were requested with the breakdown below. Top eight topics were on lead poisoning, breast feeding, dental, hypertension, asthma, exercise, diabetes, and weight control. Both English and Spanish were requested/provided. | Article Topic	Count of Articles	% of Articles
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Lead poisoning	7	10%
Breastfeeding	6	9%
Dental	6	9%
Hypertension	4	6%
Asthma	4	6%
Exercise	4	6%	

	Diabetes	4	6%
	Weight Control	4	6%
	Cold - self care	3	4%
	Preventive Screening Guidelines	2	3%
	Mental Health	2	3%
	Low Back Pain	2	3%
	Breast Cancer Screening	2	3%
	Nutrition	2	3%
	Chronic obstructive pulmonary disease (COPD)	2	3%
	Health Education flyer	2	3%
	Respiratory Infection	2	3%
	Flu	2	3%
	Heart Health	2	3%
	Stress Management	1	1%
	Fit Families for Life Flyer	1	1%
	Urinary Tract Infection	1	1%
	Nurse Advice Line	1	1%
	Cervical Cancer Screening	1	1%
	Smoking Cessation Tips	1	1%
Compliance	Completed and submitted 2 semi-annual work plan progress reports; updated 6 policies and procedures; and completed all required incentive program reports for DHCS.		
Health Education Information Line	Thirty-six calls were received on this line in 2023 addressing 38 topics. Sixty-three percent (24) of the calls were redirected to member services. The remainder addressed the following topics/fulfillment:		

Topic	Volume	% of Calls
Member Services	24	63%
Fit Families for Life enrollment	7	18%
Gym Membership (not available for Medi-Cal)	2	5%
Diabetes Material Request	2	5%
Provider Resources Form Request	1	3%
Find Help for Resources for Member	1	3%
Dental resource	1	3%

	1. CHRONIC DISEASE EDUCATION: ASTHMA							
	Goal of Initiative: To provide members with education on asthma control through promotion of effective asthma management strategies and multifaceted communication							
	Rationale: ☒MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☒COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☐ COMPLIANCE ☒QUALITY PERFORMANCE ☒PNA							
Regions	**Measurable Objective**	**Responsible Team Lead**	**Start Date**	**Completion Date**	**2022 Year-End Outcomes**	**Mid-Year 2023 Outcomes**	**2023 Year End Outcomes**	**Completed**
F	Collect and analyze patient-level utilization and pharmacy data for asthma medications, and program effectiveness for members.	J. Felix	8/1/2023	12/31/2023	104 members have completed the 12-month program.	Ninety-seven members have completed the 12- month program during this reporting period. To date, a total of 176 members completed the 12-month. program	177 members enrolled in the 12-month program, but only 141 completed the program. AMR gap closure rate was 16% with a 0.10 AMR ratio improvement among members who completed the program. Most participants were between 22-65 years old, followed by 12–17-year-olds. More participants were female (61%), compared to male (39%). Slightly more than half of participants identified as Hispanic or Latino/Latinx at 57%, while 9% identified as African American or Black. 61% preferred English as a spoken language and 38% preferred Spanish. A detailed program evaluation is available. Emergency room visit analysis will be available July 2024.	☒
F, M, K	Promote Asthma Management: Launch 1-2 email campaigns addressing asthma triggers, prevention tips and resource links with a 15% read rate.	J. Felix	7/1/2023	12/31/2023	New measure.	N/A – activity suspended as a result of the Quality department's quadrant analysis.	Canceled	☐
F, M, K	Promote Asthma Health Education: Identify and distribute at least 200 asthma education materials to members with uncontrolled asthma.	J. Felix	7/1/2023	12/31/2023	New measure.	Attended the Wellness Fair in Fresno where asthma educational materials were provided.	Attended 3 community events where 200+ asthma education materials were provided. Events took place on: 8/5/23: Back to School Backpack, a CalViva Health sponsored event. 9/27/23: Fresno City College health	☒

			fair. Provider Order Form request was received for asthma educational materials. Four (4) asthma resource requests were fulfilled in 2023. The development of an asthma educational resource regarding Asthma Remediation services started in August 2023. The material is currently going through CalViva Health review and approval process and will be used to collaborate with providers/PPGs who will then disseminate to our members.

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Evaluate Population Needs Assessment (PNA) findings and other sources such as HEDIS AMR measure data to identify member populations to outreach to in member outreach campaign (email). Data extraction to be done with QIRA.	F, M, K	Q2-Q3 2023	J. Felix	QIRA	Q1 2024
Work with data analytics and pharmacy to collect patient-level utilization data for program effectiveness.	F	Q2-Q3 2023	J. Felix	R. Calva-Songco, QIRA, Pharmacy, and PHM	Moved to Q4 based on program's revised completion date.
Develop content of health education messages for email campaign for Medi-Cal regions.	F, M, K	Q2-Q4 2023	J. Felix	A. Bednar	Canceled
Actively participate in the Respiratory Health POD for QI. Develop recommended member education resources for asthma.	F, M, K	12/31/2023	J. Felix	A. Bednar	Ongoing

Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☐ CONTINUE INITIATIVE UNCHANGED ☒ CONTINUE INITIATIVE WITH MODIFICATIONS

*Programs Owners and Drivers (PODs): The purpose of the PODs is to gain efficiencies across various teams and lines of business, streamline operations and reduce duplication within and across teams/programs, improve the design and grouping of programs to achieve strategic outcomes/goals, foster collaboration and align teams, create more opportunities for innovation and growth, and share best practices across lines of business.

2. CHRONIC DISEASE EDUCATION: DIABETES

Goal of Initiative:

To provide members with education on diabetes prevention and control through promotion of effective nutrition management strategies and multifaceted communication.

Rationale:

☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☐ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☐ COMPLIANCE ☐ QUALITY PERFORMANCE ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Identify and onboard new Diabetes Prevention Program (DPP) provider including DHCS approval of provider.	A. Mojadedi	1/6/2023	10/31/2023	N/A	Vendor identified and approval/ onboarding process in progress as of 6/30/2023.	Vendor started the onboarding process. MSA/BAA signed. SOW and member materials in progress for DHCS submission packet as of 12/31/23.	☒
F, M, K	Develop and launch 2-member outreach campaigns to promote new DPP.	A. Mojadedi	TBD	Q4 2023	N/A		Task is dependent on DHCS approval of new DPP.	☐
F, M, K	Develop and launch 1 provider outreach campaign to promote new DPP.	A. Mojadedi	TBD	Q4 2023	N/A		Task is dependent on DHCS approval of new DPP.	☐
F, M, K	At least 50 eligible members will enroll in the DPP program.	A. Mojadedi	TBD	Q4 2023	A total of 112 members enrolled in the DPP program in 2022.		Task is dependent on DHCS approval of new DPP.	☐
F, M, K	Identify and distribute at least 400 *Diabetes Care* education booklets to members with uncontrolled diabetes.	A. Mojadedi	6/1/2023	Q3 2023	90 booklets were provided to Clinica Sierra Vista in Q2 2022.	N/A – activity suspended as a result of the Quality department's quadrant analysis.	The priority material for the diabetes care booklet was replaced with the Krames articles that are available for providers and members to access online and they can also request these articles from the Health Plan. The digital Versions of the Diabetes Care booklets are available for upcoming activities in 2024.	☒
Major Activities		**Regions**	**Planned Timeframe For Completion**		**Responsible Lead(s)**		**Additional Lead(s)**	**Date Completed**

Release new Provider Communication to include pre-diabetes claims codes.	F, M, K	8/31/2023	R. Calva-Songco		Suspended based on the Quality department's quadrant analysis.
When DPP provider is secured, work interdepartmentally to secure all aspects of onboarding a new DPP provider.	F, M, K	TBA	A. Mojadedi	R. Calva-Songco	In Progress
When DPP provider is secured, launch new member outreach campaigns to promote DPP program to Medi-Cal members.	F, M, K	Q3 2023	A. Mojadedi		In Progress
When DPP provider is secured, request monthly member eligibility data file transfer from QIRA for DPP vendor.	F, M, K	Q3 2023	A. Mojadedi		In Progress
When DPP provider is secured, refer Medi-Cal members diagnosed with Type 2 diabetes participating in DPP program into disease management program. Timeline will be based contingent upon the start date of the DPP.	F, M, K	TBA	A. Mojadedi		Task is dependent on DHCS approval of new DPP.
When DPP provider is secured, schedule bi-weekly/monthly/quarterly vendor oversight meetings. Timeline will be based contingent upon the start date of the DPP.	F, M, K	TBA	A. Mojadedi		In Progress
When DPP provider is secured, evaluate effectiveness of DPP program in collaboration with QIRA. Timeline will be based contingent upon the start date of the DPP.	F, M, K	TBA	A. Mojadedi		Task is dependent on DHCS approval of new DPP.
When DPP provider is secured, collaborate interdepartmentally to promote DPP program. Timeline will be based contingent upon the start date of the DPP.	F, M, K	TBA	A. Mojadedi		Task is dependent on DHCS approval of new DPP.
Actively participate in the Diabetes POD for QI. Develop recommended member education resources.	F, M, K	12/31/2023	A. Mojadedi	G. Mathew	In Progress
Initiative Continuation Status (*populate at year-end*):		☐ CLOSED		☐ CONTINUE INITIATIVE UNCHANGED	☒ CONTINUE INITIATIVE WITH MODIFICATIONS

3. CHRONIC DISEASE EDUCATION: HYPERTENSION								

Goal of Initiative:
To provide cardiovascular health prevention and disease management awareness to plan and community members.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION   ☒ PROVIDER SUPPORT ☒ COLLABORATIVE   ☐ DEPT EFFICIENCY   ☐ OVERSIGHT   ☒ COMPLIANCE   ☒ QUALITY PERFORMANCE   ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Promotion of Cardiovascular Health resources: Distribute 150+ Healthy Hearts Healthy Lives (HHHL) toolkits to members with uncontrolled high blood pressure.	B. Head	5/1/2023	12/31/23	Mailing deferred to 2023.	As of 2023, no outreach mailers were conducted due to redirection from the quadrant analysis. Seeking different opportunities to increase promotion of cardiovascular resources.	Strategy to promote HHHL toolkit is being considered via vendors. Hypertension health education was promoted in member newsletter.	☐

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Work collaboratively with Heart Health/Blood Pressure POD to determine additional outreach efforts for HHHL toolkits.	F, M, K	4/1/2023 - 12/31/2023	B. Head	G. Mathew	5/1/2023- Heart Health/Blood Pressure POD combined into Chronic Conditions POD.
Send Healthy Hearts Healthy Lives (HHHL) toolkits to *newly identified* members with uncontrolled high blood pressure to be based on identified care gaps in 2023	F, M, K	6/1/2023 – 12/31/2023	B. Head	G. Mathew	N/A- Suspended based on department's quadrant analysis.
Distribute HHHL toolkits to members. Report number distributed.	F, M, K	12/31/2023	A. Campos	B. Head	No toolkits were sent. Activity was suspended.

Initiative Continuation Status (*populate at year-end*):   ☐ CLOSED   ☐ CONTINUE INITIATIVE UNCHANGED   ☒ CONTINUE INITIATIVE WITH MODIFICATIONS

4. COMMUNTIY ENGAGEMENT/PROMOTORES HEALTH NETWORK

Goal of Initiative:

Increase community awareness of CalViva Health's programs and services to help members achieve optimal health and wellbeing. For the Promotores, the focus for 2023 will be HEDIS and SDOH areas of need. Community Engagement will include activities focused on promoting and building the California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services Program.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☒ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☐ COMPLIANCE ☐ QUALITY PERFORMANCE ☐ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
M	Reach 70% health plan member participation in Promotores Health Network activities by 12/31/2023.	A.Corona	1/1/2023	12/31/2023	185 charlas with a 67%-member participation rate (2000/2970).	115 Charlas with a 74%-member participation rate (2607/3517) as of 6/30/23.	226 Charlas with a 68% - member Participation rate (4415/6468) as of 12/31/23.	☒
M	Increase promotion of preventive screenings by adding 18 presentations/conversations during PHN activities and events. Topics of focus will be HEDIS Performance Measure priorities. Goal is to build awareness through 6 focused conversations and presentations each quarter during Madera PHN classes and "Viernes social" by 12/31/2023.	A. Corona	1/1/2023	12/31/2023	New measure.	A total of 32 presentations/conversations completed as of 6/30/2023 on following topics: - A1C Diabetes - High blood pressure - Vaccination - COVID 19 - Cervical Cancer - Breast Cancer	A total of 52 presentations completed as of 12/31/23 on Following topics: - A1C Diabetes - High blood pressure - Vaccination - Cervical Cancer - Breast Cancer - Cholesterol	☒
M	Engage three community stakeholders to address social determinants of health priorities, link members to SDOH resources.	A. Corona	1/1/2023	12/31/2023	Established four stakeholder partnerships in 2022.	Engaged three community stakeholders as of 6/30/2023.	Engaged three community stakeholders as of 12/31/23.	☒
F, M, K	Conduct 25 presentations on CalAIM services to promote ECM and CS programs to increase awareness with community partners.	A. Corona E. Campos	1/1/2023	12/31/2023	N/A	Conducted 30 CalAIM presentations as of 6/30/23.	Conducted 48 CalAIM presentations as of 12/31/2023.	☒
F, M, K	Conduct and participate in 25 stakeholder and provider meetings to support development of CalAIM ECM and CS Network.	E. Campos	1/1/2023	12/31/2023	N/A	Conducted 38 stakeholder and provider meetings as of 6/30/2023.	Conducted 69 stakeholder and provider meetings as of 12/31/2023.	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Conduct PHN activities to increase member engagement (charlas, bailoterapias, walking club, etc.).	M	12/31/2023	A. Corona	N/A	Ongoing though 12/31/23

Promote preventive health screenings at community events and PHN Program activities.	F, M, K	12/31/2023	A. Corona	N/A	Ongoing though 12/31/23
Create an action plan to engage stakeholders and identify SDOH topic areas and make referrals to Community Supports Services.	M	12/31/2023	A. Corona	N/A	Ongoing though 12/31/23
Identify and/or create member informing materials to inform stakeholders on CalAIM Programs.	F, M, K	12/31/2023	A. Corona I. Rivera E. Campos	N/A	10/30/2023
Engage community stakeholders and potential providers to identify ECM/CS prospects and support the CalAIM provider network development for all services and populations of focus.	F, M, K	12/31/2023	I. Rivera E. Campos	N/A	Ongoing through 12/31/2023
Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☒ CONTINUE INITIATIVE UNCHANGED ☐ CONTINUE INITIATIVE WITH MODIFICATIONS					

5. MENTAL/BEHAVIORAL HEALTH

Goal of Initiative:
Educate members on the importance of mental health and support members with behavioral health resources.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☒ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☒ COMPLIANCE ☒ QUALITY PERFORMANCE ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Promote myStrength program to members; increase member enrollment by 20% to 400 members.	M. Lin	1/1/2023	12/31/2023	Enrolled 333 members.	Enrolled 355 members as of 6/30/2023.	Enrolled 364 members as of 12/31/2023.	☒
F, M, K	Partner with the FUM (Follow Up after ER Visits Due to Mental Illness) and FUA (Follow Up After ER Visits Due to Substance Use Disorder) QI Workgroup to develop and implement strategies and action plans to improve the FUM FUA Measures.	M. Lin	1/1/2023	12/31/2023	N/A	Provider surveys conducted and action plans implemented as of 6/30/2023.	22 provider surveys completed and analyzed. Action plans for the PE team to support providers were implemented.	☒
F, M, K	Support Quality Department's Behavioral Health action plan to improve Behavioral Health HEDIS Measures. Develop strategies and action plans to reduce barriers and improve behavioral health HEDIS Measures.	M. Lin	1/1/2023	12/31/2023	N/A	In Progress as of 6/30/2023	Completed. Updated Krames materials and resources with CVH logos.	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Develop the provider surveys and talking points by collaborating with the FUM FUA Workgroup.	F	2/28/2023	M. Lin	L. Ciotoli, K. De La Cruz, M. Aguilar, J. Lovell, V. Villaluz	1/30/2023
Create articles to promote the myStrength program in the Annual Medi-Cal Member newsletter.	F, M, K	3/31/2023	M. Lin	B. Head	3/30/2023
Implement provider assessments by collaborating with the FUA FUM Workgroup. Analyze data and identify barriers. Develop action plans to address HEDIS Measures barriers.	F	12/31/2023	M. Lin	L. Ciotoli, K. De La Cruz, M. Aguilar, J. Lovell, V. Villaluz	6/30/2023
Actively participate in the Behavioral Health POD for QI. Develop recommended member education resources.	F, M, K	12/31/2023	M. Lin	L. Ciotoli	12/31/2023

Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☐ CONTINUE INITIATIVE UNCHANGED ☒ CONTINUE INITIATIVE WITH MODIFICATIONS

	6. PREVENTIVE HEALTH							
	Goal of Initiative: To provide members with education on breast cancer and cervical cancer regular screenings through promotion of the importance of regular screenings and a multifaceted communication approach.							
	Rationale: ☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☒PROVIDER SUPPORT ☒ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☐ COMPLIANCE ☒QUALITY PERFORMANCE ☒PNA							
Regions	**Measurable Objective**	**Responsible Team Lead**	**Start Date**	**Completion Date**	**2022 Year-End Outcomes**	**Mid-Year 2023 Outcomes**	**2023 Year End Outcomes**	**Completed**
F, M, K	Promotion of Breast Cancer (BCS) and Cervical Cancer Screenings (CCS): Coordinate via Every Woman Counts to provide a minimum of 18 BCS/CCS member classes for a minimum of 630 members.	J. Felix	Q1 2023	12/31/2023	57 virtual and in-person BCS/CCS classes, reaching 1,051 participants.	29 virtual and in person BCS/CCS classes, reaching 241 participants as of 6/30/2023.	As of December 2023, 81 virtual and in person BCS/CCS classes, reaching 524 participants. EWC provides BCS and CCS health education brochures during their community classes. Educational brochures are DHCS branded.	☒
F, M, K	Develop and implement 1-2 educational interventions to improve breast cancer screening rate targeting non-compliant members in Fresno, Kings, or Madera County.	J. Felix	Q2 2023	12/31/2023	4 mobile mammography events (over 8 days); 127 members completed their BCS exams.	BCS PIP ended 12/31/2022. Other opportunities are being explored for 2023.	BCS PIP ended 12/31/2022. BCS educational materials are made available interdepartmentally to Quality Improvement, Provider Engagement, and Community Engagement Departments. Materials are used during outreach events and community presentations. Provider Order Form request was received for Breast Cancer Screening (BCS) educational materials. Two (2) BCS resources	☒

				were fulfilled in 2023.	

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Provide materials/resources to Every Woman Counts for distribution during outreach classes and events.	F, M, K	Ongoing	J. Felix	C. Omogbai (Every Woman Counts)	3/21/2023
Collaborate with Provider Engagement and other departments to promote and distribute BCS/CCS materials with providers.	F, M, K	Ongoing	J. Felix	Provider Engagement	12/31/2023
Develop BCS and/or CCS content for email campaign.	F, M, K	Q3 2023 - Q4 2023	J. Felix	B. Head	Activity suspended.
Evaluate data sources to identify member populations for member outreach campaign. Data extraction to be done with QIRA for a BCS/CCS email campaign.	F, M, K	Q4 2023	J. Felix	QIRA	N/A
Actively participate in the Preventative Care POD for QI. Develop recommended member education resources.	F, M, K	12/31/2023	J. Felix	R. Gill	Ongoing
Initiative Continuation Status (*populate at year-end*):		☐ CLOSED	☐ CONTINUE INITIATIVE UNCHANGED	☒ CONTINUE INITIATIVE WITH MODIFICATIONS	

7. PERINATAL EDUCATION

Goal of Initiative:
To provide accessible, high quality health care and education to women of childbearing age and babies to have healthy pregnancies, healthy newborns, increased exclusive breastfeeding rates and lower perinatal health care costs.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☐ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☐ COMPLIANCE ☒ QUALITY PERFORMANCE ☐ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Enroll 1,500 pregnant members in the CVH Pregnancy Program.	J. Coulthurst	1/1/2023	12/31/2023	N/A	1,016 Members enrolled as of June 2023.	1,276 pregnancies were managed by the CVH Pregnancy Program in 2023.	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Send Start Smart for Baby (SSFB) pregnancy packages to pregnant members to encourage enrollment in CVH Pregnancy Program.	F, M, K	12/31/2023	A. Fathifard	M. Estrada	12/31/2023
Promote the utilization of Telehealth services and the Nurse Advice Line via nanosites and member newsletter to make it more convenient for patients to receive the care that they need.	F, M, K	12/31/2023	A. Fathifard		12/31/2023
Collaborate with QI on the "Concierge Program" – to conduct outreach calls to PPC postpartum members while simultaneously taking inventory of SDOH needs.	F, M, K	12/31/2023	A.Fathifard	R. Abdillah, C.Vardanyan, C. Jones, L.Mucarsel	12/31/2023
Develop evaluation and implementation of a program and/or resources – based on findings – to identify and meet the needs of Plan members with a non-legal immigration status. Initial proposal includes pregnant members. (Health equity project.)	F, M, K	12/31/23	R. Calva-Songco	J. Coulthurst; M. Rosales; A. Fathifard; J. Felix; and L. Mucarsel	Activity canceled as of 9/2023.

Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☒ CONTINUE INITIATIVE UNCHANGED ☐ CONTINUE INITIATIVE WITH MODIFICATIONS

8. PEDIATRIC EDUCATION

Goal of Initiative:

Develop resources to inform and educate members about the significance of well-child visits, immunizations and to act as a support for improving select HEDIS measures by driving member engagement via educational and community screening services.

Rationale:

☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION   ☒ PROVIDER SUPPORT   ☐ COLLABORATIVE   ☐ DEPT EFFICIENCY   ☐ OVERSIGHT   ☒ COMPLIANCE   ☒ QUALITY PERFORMANCE   ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Increase member engagement by 5% for the WCV Measure via call outreach to members (Concierge Program) barrier reduction support.	J. Coulthurst	3/2023	12/31/2023	New measure.	Five WCV Appointments booked for 98 Members contacted with Well-Child Care Gaps (5.1% Scheduling Rate) as of 6/2023.	Concierge Program was not implemented in CalViva Health Counties. However, the Family Unit HEDIS outreach calls were made to 12, 449 WCV Black or African American members' family unit in 2023. 34% of those members self-reported they will schedule a WCV or already completed.	☒
F, M, K	Create one Provider Update notifying providers of the changes concerning the CAIR registry and AB1789.	A. Fathifard	1/2023	12/31/2023	New measure.	One provider update about AB 1789 sent on 2/9/2023.	Completed at mid-year	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Collaborate with Pediatric POD and HEDIS outreach team to develop strategic oversight over data collection and information gathering for family outreach calls.	F, M, K	12/31/2023	C. Jones	G. Toland, M. Dhonchak, A. Fathifard, J. Coulthurst	12/31/2023
Collaborate on the training of Member Services Representatives working for the call outreach program ("Concierge Program") in understanding of how to improve knowledge access to preventative and primary care services and sharing information with families.	F, M, K	7/31/2023	A. Fathifard	C. Vardanyan, R. Abdillah, C. Jones, L. Mucarsel	6/24/2023
Conduct in-depth review of AB1789 to understand the changes occurring to CAIR and work with Provider Communications to create a FAQ document educating providers on how the bill will impact their reporting going forward.	F, M, K	5/31/2023	A. Fathifard	J. Coulthurst; D. Morier	2/9/2023
Actively participate in the Pediatrics/Adolescents POD for QI. Develop recommended member education resources.	F, M, K	12/31/2023	A. Fathifard	J. Coulthurst, G. Toland, M. Dhonchak	12/31/2023. Ongoing into 2024.

Initiative Continuation Status (*populate at year-end*):	☐ CLOSED	☐ CONTINUE INITIATIVE UNCHANGED	☒ CONTINUE INITIATIVE WITH MODIFICATIONS

9. Outreach to Undocumented Members (Health Equity)

Goal of Initiative:
Design outreach to engage undocumented members with their care by providing a warm outreach and addressing health plan education needs for them.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☒ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☐ COMPLIANCE ☒ QUALITY PERFORMANCE ☐ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Identify target population.	R. Calva-Songco	2/13/2023	5/26/2023	New measure	On hold as of 6/30/2023	Canceled	☐
F, M, K	Make recommendations for content and implementation of outreach.	R. Calva-Songco	3/17/2023	6/9/2023	New measure	On hold as of 6/30/2023	Canceled	☐
F, M, K	Initiate implementation of recommended intervention(s).	R. Calva-Songco	8/31/2023	ongoing	New measure	On hold as of 6/30/2023	Canceled	☐
F, M, K	Reach 3% of the target population by 12/31/2023.	R. Calva-Songco	8/31/2023	12/31/2023	New measure.	On hold as of 6/30/2023	Canceled	☐

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Create cross-collaborative work group that will review data findings, make outreach recommendations, and do future implementations, as applicable.	F, M, K	2/28/2023	R. Calva-Songco	N/A	Canceled
Complete literature review to inform variables to be analyzed and existing best practices for serving undocumented populations.	F, M, K	4/21/2023	R. Calva- Songco	N/A	Canceled
Submit data request to QIRA team or other source.	F, M, K	4/28/2023	R. Calva- Songco	N/A	Canceled
Complete analysis of data to be provided by QIRA or other source(s). Confirm target population; confirm performance baseline rate(s); and establish performance goals.	F, M, K	5/26/2023	R. Calva- Songco	N/A	Canceled
Workgroup to make recommendations on target population, goals; and outreach to include monitoring and evaluation.	F, M, K	6/9/2023	R. Calva-Songco	N/A	Canceled
Modify and/or create original outreach content and obtain appropriate approvals, e.g., DHCS.	F, M, K	8/11/2023	R. Calva- Songco	N/A	Canceled
Initiate implementation of outreach.	F, M, K	8/31/2023	R. Calva- Songco	N/A	Canceled

Initiative Continuation Status (*populate at year-end*): ☒ CLOSED ☐ CONTINUE INITIATIVE UNCHANGED ☐ CONTINUE INITIATIVE WITH MODIFICATIONS

10. OBESITY PREVENTION

Goal of Initiative:
Promote health education resources about healthy lifestyle habits including nutrition education and increased physical activity for overweight and high-risk members.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION   ☒ PROVIDER SUPPORT   ☐ COLLABORATIVE   ☐ DEPT EFFICIENCY   ☐ OVERSIGHT   ☐ COMPLIANCE   ☒ QUALITY PERFORMANCE   ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Enroll 200+ members in Fit Families for Life (FFFL) Home Edition self-paced program.	A. Mojadedi	5/31/2023	12/31/2023	Two members were enrolled in 2022.	Four members were enrolled as of 6/30/2023.	Four members were enrolled as of 12/31/23.	☐
F, M, K	Enroll 50+ members in Healthy Habits for Health People (HHHP) self-paced program.	A. Mojadedi	5/31/2023	12/31/2023	No members were enrolled in 2022.	No members were enrolled as of 6/30/2023.	No members were enrolled as of 12/31/23.	☐

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Promote FFFL and HHHP in Annual Medi-Cal Member Newsletter.	F, M, K	9/30/23	B. Head (Interim)	B. Head	9/21/23
Determine outreach to pediatric members non-compliant in the weight assessment/counseling HEDIS measure.	F, M, K	5/3/23- 12/31/23	A. Fathifard	J. Coulthurst	N/A- Suspended based on department quadrant analysis.
Determine outreach to obese adult members.	F, M, K	5/3/23 – 12/31/23	B. Head (Interim)		5/5/2023- FFFL & HHHP Provider update with revised referral form and availability of resources were posted to provider page and included in May monthly provider update.
Develop plan to evaluate effectiveness of resources for FFFL & HHHP programs.	F, M, K	10/30/23-12/31/23	A. Mojadedi	R. Calva-Songco	In Progress. We will be updating this information in Q3 2024. A decision was made to transition to the Corporate health coaching program which will have weight management resources and a one-one coaching component.

Actively participate in the Health Education/Wellness QI POD. Develop recommended member education resources.	F, M, K	12/31/23	TBA		Health Education/Wellness POD will launch in 2024.
Initiative Continuation Status (*populate at year-end*):		☐ CLOSED	☐ CONTINUE INITIATIVE UNCHANGED	☒ CONTINUE INITIATIVE WITH MODIFICATIONS	

11. TOBACCO CESSATION PROGRAM

Goal of Initiative:
To improve health outcomes and reduce health care costs by decreasing tobacco use among CalViva Health membership.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☒ PROVIDER SUPPORT ☒ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☒ COMPLIANCE ☒ QUALITY PERFORMANCE ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Increase by 5%-member participation in smoking cessation programs to 158 members in 2023.	J. Felix	Q1 2023	12/31/2023	Enrolled 150 members by end of Q4 2022.	Enrolled 67 members as of 6/30/23.	Enrolled 115 members as of 12/31/2023.	☒
F, M, K	Launch 1 email campaign to promote smoking cessation with at least a 15% read rate.	J. Felix	Q2 2023	Q4 2023	New measure.	N/A – activity suspended as a result of the department's QI quadrant analysis.	Canceled	☐

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Participate in the CA Quits Statewide Health Systems quarterly meetings to network and share and learn about tobacco control opportunities.	F, M, K	Ongoing	J. Felix	R. Calva-Songco	12/31/2023
Use pharmacy and claims data for smoking related CDT and ICD-10 codes to monitor tobacco-related healthcare costs and for pharmacy to promote enrollment into Kick It California.	F, M, K	Q1-Q3 2023	J. Felix	Claims and QIRA	12/31/2023
Promote "Kick It California" tobacco cessation program to members through an email campaign and the member newsletter.	F, M, K	Q1-Q2 2023	J. Felix	A. Campos, B. Head	Promoted via member newsletter: 11/30/2023
Create tobacco cessation social media posts during "World No Tobacco Day" and "Tobacco Awareness" month.	F, M, K	Q4 2023	J. Felix	B. Head	Canceled

Initiative Continuation Status (*populate at year-end*):   ☐ CLOSED   ☐ CONTINUE INITIATIVE UNCHANGED   ☒ CONTINUE INITIATIVE WITH MODIFICATIONS

12. FLUVENTION								
Goal of Initiative: To reduce flu among members 6 months and older, and overall high-risk populations.								
Rationale: ☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☒ PROVIDER SUPPORT ☐ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☒ COMPLIANCE ☒ QUALITY PERFORMANCE ☒ PNA								
Regions	**Measurable Objective**	**Responsible Team Lead**	**Start Date**	**Completion Date**	**2022 Year-End Outcomes**	**Mid-Year 2023 Outcomes**	**2023 Year End Outcomes**	**Completed**
F, M, K	Implement at least one provider education activity to encourage the promotion of Flu vaccinations during patient visits.	A. Fathifard/ M. Anderson F. Arce	5/1/2023	12/31/2023	Distributed a Provider Communication regarding Best Practices for 2022-2023 Flu Season on 11/18/2022.	Going to release in Q3-Q4 2023.	Distributed a Provider Communication regarding Best Practices on HEDIS provider pages for 2023- 2024 Flu Season.	☒
F, M, K	Inform members on Flu prevention and vaccination using two or more communication channels.	A. Fathifard/ M. Anderson F. Arce	10/1/23	12/31/2023	Telephonic outreach calls were made with a 12%-member reach (81/700) and updated Web based COVID FAQs.	Multilayered outreach using six communication channels. Waiting until Q3-Q4 to deploy approved materials.	Email outreach and IVR messaging were deployed to members in early October.	☒
F, M, K	Conduct Vaccine Disparity Analysis and identify proportion of CIS-10 non-compliant members who are missing the flu vaccination and share results with Preventative Care Pod.	A. Fathifard/ M. Anderson	7/1/23	12/31/2023	New measure.	Conducting in Q3-Q4 2023	This initiative was cancelled.	☐
Major Activities		**Regions**	**Planned Timeframe For Completion**		**Responsible Lead(s)**		**Additional Lead(s)**	**Date Completed**
Work with Marketing to customize and approve Fluvention communications for members and providers.		F, M, K	10/31/2023		A. Fathifard		E. Chan, S. Noonan, and M. Zuniga.	Although the original target deadline was 6/30, due to the concerns shared from the compliance department, additional reviews were conducted, extending approval date into Q3 2023.

Collaborate with other managed care plans and the Department of Healthcare Services to learn about and share best practices and coordinate efforts to increase vaccination rates among Medi-Cal recipients.	F, M, K	12/31/2023	A. Fathifard		N/A-After the large collaborative efforts between Health Plans across the COVID Pandemic and Flu, many local collaboratives began to sunset.
Actively participate in the immunization (Adult - Flu) QI POD. Develop recommended member education resources.	F, M, K	12/31/2023	M. Anderson F. Arce	R. Gill	Ongoing as of 6/2023. Note that the adult immunization and prevention care pod merged into one.
Actively participate in the QI Department's Preventative Care POD. Develop recommended member education resources.	F, M, K	12/31/2023	M. Anderson F. Arce	R. Gill	Ongoing
Initiative Continuation Status (*populate at year-end*):	☐ CLOSED		☒ CONTINUE INITIATIVE UNCHANGED		☐ CONTINUE INITIATIVE WITH MODIFICATIONS

13. MEMBER NEWSLETTER

Goal of Initiative:
Educate members about priority health topics and inform members about available programs, services, and health care rights.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☐ COLLABORATIVE ☐ DEPT EFFICIENCY ☐ OVERSIGHT ☒ COMPLIANCE ☒ QUALITY PERFORMANCE ☐ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Develop and distribute 1 Annual Medi-Cal Member Newsletter including NCQA required content.	B. Head	10/10/2022	11/30/2023	Mailed newsletter to 189,370 unique households in Q4.	In progress as of 6/30/2023. Details below.	Mailed newsletter to 157,602 unique households.	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Request articles, write articles, edit articles according to production schedule for all newsletters.	F, M, K	1/31/2023 – 5/31/2023	B. Head	N/A	5/2/2023
Manage production of Medi-Cal member newsletter in Workfront.	F, M, K	1/31/2023- 10/31/2023	B. Head	N/A	9/27/23
Obtain all internal health plan and DHCS approvals.	F, M, K	2/3/2023 – 8/30/2023	B. Head	N/A	6/12/2023
Provide Program Accreditation member newsletter mail verification.	F, M, K	11/30/2023	B. Head	N/A	11/30/23
Post member newsletter to CVH website.	F, M, K	9/1/2023 – 11/30/2023	B. Head	N/A	9/21/23

Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☒ CONTINUE INITIATIVE UNCHANGED ☐ CONTINUE INITIATIVE WITH MODIFICATIONS

14. COMPLIANCE: OVERSIGHT AND REPORTING

Goal of Initiative:
To meet regulatory and company compliance.

Rationale:

☐ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☐ PROVIDER SUPPORT ☒ COLLABORATIVE ☐ DEPT EFFICIENCY ☒ OVERSIGHT ☒ COMPLIANCE ☐ QUALITY PERFORMANCE ☐ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Submit two semi-annual reports to the QI/UM Workgroup meeting.	R. Abdillah	1/1/2023	7/31/23	Completed 2 semi-annual work plan. progress reports.	Completed 1 semi-annual work plan progress report.	Submit two semi-annual reports to the QI/UM as of 12/31/23	☒
F, M, K	Update 6 Policies and Procedures and 1 Program Description.	R. Abdillah	1/1/2023	12/31/23	Updated 6 Policies and Procedures.	Updated 4 Policies and Procedures and 1 Program Description as of 6/30/2023.	Updated 6 Policies and Procedures as of 12/31/23.	☒
F, M, K	Complete all required incentive program reports for DHCS.	R. Abdillah	1/1/2023	Ongoing	Completed all required incentive program reports for DHCS.	Submitted 2 Member Incentive annual program report updates.	Completed all required incentive programs reports for DHCS.	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Complete all required reports for the Public Policy Committee meetings.	F, M, K	1/31/2023 and 8/30/2023	R. Calva-Songco	R. Abdillah	12/31/2023
Submit policies and procedures in health plan's project. management database.	F, M, K	February, April, May, July, December 2023	R. Abdillah	R. Calva-Songco; J. Felix	12/31/2023
Monitor submission of Member Incentive program annual evaluation reports.	F, M, K	12/31/2023	R. Abdillah	R. Calva-Songco	12/31/2023
Ensure bilingual HED staff are up to date with their bilingual assessment (ITAP).	F, M, K	12/31/2023	A. Campos		12/31/2023
Evaluate forthcoming new DHCS requirements for future Population Needs Assessment reports as part of the new Population Health Management strategy requirements.	F, M, K	12/31/2023	R. Calva-Songco	D. Patolia; A. Fathifard	12/31/2023

Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☒ CONTINUE INITIATIVE UNCHANGED ☐ CONTINUE INITIATIVE WITH MODIFICATIONS

15. HEALTH EDUCATION DEPARTMENT PROMOTION, MATERIALS UPDATE, DEVELOPMENT, UTILIZATION, and INVENTORY

Goal of Initiative:
To produce and update health education resources to assure compliance and promote healthy practices to members.

Rationale:
☒ MEMBER PROGRAM UTILIZATION AND SATISFACTION ☒ PROVIDER SUPPORT ☒ COLLABORATIVE ☒ DEPT EFFICIENCY ☒ OVERSIGHT ☒ COMPLIANCE ☒ QUALITY PERFORMANCE ☒ PNA

Regions	Measurable Objective	Responsible Team Lead	Start Date	Completion Date	2022 Year-End Outcomes	Mid-Year 2023 Outcomes	2023 Year End Outcomes	Completed
F, M, K	Assure health education materials covering required DHCS health topics are available to providers, members, and requesting employees. Review and update materials as needed.	M. Lin	1/1/23	Ongoing	Compliant. Rebranded and updated 33-member health education materials.	Compliant as of 6/30/2023.	Compliant as of 12/31/2023. Rebranded 40 Krames materials with the new CalViva Health logo. Replaced faxed version of the provider printed materials request form with an online version also accessible by QR code.	☒
F, M, K	Review and approve internal health education materials following DHCS APL 18-016 guidelines to assure compliance.	M. Lin	1/1/23	Ongoing	Compliant	Compliant as of 6/30/2023.	Compliant as of 12/31/2023.	☒
F, M, K	Review and develop action plans for health education materials impacted by new SB923 (gender-affirming care) guidance. Implement action plan to assure compliance with required gender-neutral language.	M. Lin	1/1/23	Ongoing	N/A	Reviewed and identified three materials impacted by SB 923 as of 6/30/2023	Completed. Identified three materials impacted by SB 923. Material owners will replace/update materials to assure compliance.	☒

Major Activities	Regions	Planned Timeframe For Completion	Responsible Lead(s)	Additional Lead(s)	Date Completed
Develop evaluation to determine the baseline of current member engagement with health education programs and member/provider resources; and determine a strategy to increase engagement. Determine the current utilization of health education programs and resources: by members; by providers; and by employees.	F, M, K	12/31/2023	M. Lin	A. Wittig R. Calva-Songco B. Head J. Justina A. Fathifard A. Campos (support)	12/31/2023
Develop strategy(ies) to increase utilization of health education programs and resources including identifying new approaches/tools: by members; by providers; and by employees.	F, M, K	12/31/2023	M. Lin	A. Wittig R. Calva-Songco B. Head A. Campos (support)	12/31/2023
Create and conduct training for the Health Education team on Health Education material production and management. Review and update material review desktop procedures.	F, M, K	3/31/2023	M. Lin		3/31/2023

Review and work with material owners on the Health Education materials that are due in 2023 for DHCS mandate 5-year review. Develop and implement action plans to assure compliance.	F, M, K	9/30/2023	M. Lin	A. Fathifard, B. Head, J. Felix	12/31/2023
Identify and review the materials impacted by SB923. Meet with material owners to develop action plans. Implement action plans to assure compliance.	F, M, K	12/31/2023	M. Lin	A. Fathifard, B. Head, J. Felix	12/31/2023
Lead the monthly material review team meeting to provide updates, assure compliance, and improve process improvement.	F, M, K	12/31/2023	M. Lin		12/31/2023
Review/approve Medi-Cal health education materials submitted through the Health Education Department inbox and to the	F, M, K	12/31/2023	M. Lin	B. Head; A. Campos (support)	12/31/2023
Marketing and Communications team. Track and conduct field tests.					
Work with Marketing, ICS, And RRD to launch the Custom Point System for materials order, fulfillment, and utilization.	F, M, K	6/30/2023	A. Campos	M. Lin	6/30/2023
Participate in the expansion to support Quality Improvement Department PODS to support improvement in designated areas for HEDIS by providing consult and production of member and/or provider health education materials/resources.	F, M, K	12/31/2023	A. Fathifard, B. Head, J. Felix, and M. Lin	QI Program Leads	12/31/2023
Initiative Continuation Status (*populate at year-end*): ☐ CLOSED ☐ CONTINUE INITIATIVE UNCHANGED ☒ CONTINUE INITIATIVE WITH MODIFICATIONS					

CROSSWALK OF ONGOING INTERDEPARTMENTAL WORK PLAN ACTIVITIES

Activity	Activity Leader	Regions	Complete?	Date	Year-end Update or Explanation *(if not complete)*
MEMBER ENGAGEMENT					
1. Member Incentive programs: Serve as consult on requests to develop new member incentive programs; review and approve new member incentive request forms; and ensure program evaluation reports are submitted on time.	**R. Calva-Songco/ Louba Aaronson R. Abdillah**	F, M, K	☒	12/31/23	A total of 3,868 CalViva Health members participated in the four-member incentive program during Q1-Q4 2023.

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   Date
Regional Health Authority Commission Chairperson

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

Item #12

Attachment 12.A

Population Health Management

PHM 2024 Strategy Program Description
& Change Summary

REPORT SUMMARY TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Tarjani Padmani, Manager, Clinical Pharmacy Services
COMMITTEE DATE:	May 16, 2024
SUBJECT:	PHM Strategy Description Change Summary

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Updated year from 2023 to 2024.
Throughout	Multiple	Updated Transitions of Care Program (TOC) to Transitional Care Services (TCS).
Throughout	Multiple	Spelled out acronyms, added acronyms.
Throughout	Multiple	Made grammatical and punctuational changes.
Throughout	Multiple	Updated footer to reflect updated revision date.
3,4	Stakeholder Engagement	Added information on Public Policy Committee (PPC) and description of its role and actions to Stakeholder Engagement section.
6	Population Stratification	Changed Micro Strategies to Micro Strategy®
8	Population Stratification	Changed DHCS PHM monitoring requirements to more specifically, DHCS PHM Monitoring Plan KPI requirements
11	Basic Population Health Management (BPHM)	Added ambulatory visits, vaccinations and immunizations (e.g., COVID-19, Flu, Pneumococcal) to key aspects of member navigation support.
12	Basic Population Health Management (BPHM)	Added ambulatory/preventative visits to ways in which we monitor utilization patterns.
12	Basic Population Health Management (BPHM)	Added information regarding working with Local Health Jurisdictions (LHJs) in the service area to develop SMART goals and promote meaningful participation in the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process. Added information about how the Plan will partner with LHJ in the service area to identify priority areas for the Plan to share data with LHJ.
13	Transitional Care Services	Added "Conducting initial outreach to member while they are inpatient to engage in the program and complete an inpatient discharge risk assessment" and "Coordinate care with hospital staff as needed to support safe transition to lower level of care" to list of what TCS program includes.
13	Transitional Care Services	Changed "Conducting an initial outreach call within 3 to 10 calendar days from discharge" to "Outreach call upon discharge". Added "ensure member has a scheduled follow up appt with PCP or specialist" to this section.
13	Transitional Care Services	Removed "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 instruction".

13	Transitional Care Services	Added information regarding length of time Members receive TCS and additional services that members may be referred to such as ECM, Community Supports, and complex care management.
13	PHM Programs and Services	Changed "its enrolled Members" to "our enrolled Members".
13	PHM Programs and Services	Added "to provide comprehensive wellness, prevention, and self-management tools" to introduction of PHM Programs and Services.
13,19	PHM Programs and Services: Improve Behavioral Health, PHM Programs and Services Focus Areas: Improve Behavioral Health	Changed "Depression and Antidepressant Medication Management" to "Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits" to reflect current target measures.
13,19	PHM Programs and Services: Improve Behavioral Health, PHM Programs and Services Focus Areas: Improve Behavioral Health	Updated Eligible Population to Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
14	PHM Programs and Services: Palliative Care	Removed program.
14, 20	PHM Programs and Services: Cardiac + Diabetes, PHM Programs and Services Focus Areas: Cardiac + Diabetes	Updated program name from "Cardio-Protective Bundle Project-SHAPE" to "Cardiac + Diabetes".
14	PHM Programs and Services: Chronic Condition: Congestive Heart Failure (CHF)	Removed program.
15	PHM Programs and Services: Chronic Condition Management App	Removed program.
15	PHM Programs and Services Focus Areas: Improve Preventative Health: Flu Vaccinations	Added Relevance section.
16	PHM Programs and Services Focus Areas: Tobacco Cessation	Added Relevance section.
16,17	PHM Programs and Services Focus Areas: Improve Preventative Health: Breast Cancer Screening	Updated Program services to include social media, multi-gap call outreach, tipsheets, Provider Best Practices guide, and Provider collaboration.
17	PHM Programs and Services Focus Areas: Improve Preventative Health: Breast Cancer Screening	Added Relevance section.
17	PHM Programs and Services Focus Areas: Diabetes Management Program	Updated Programs goal(s) from "CDC >9" to "Glycemic Status >9".

17	PHM Programs and Services Focus Areas: Diabetes Management Program	Removed social media and Project ECHO from Program services.
18	PHM Programs and Services Focus Areas: Diabetes Management Program	Added Relevance section.
19	PHM Programs and Services Focus Areas: CalViva Pregnancy Program (CPP)/ High-Risk Obstetrics (OB) CM	Added Relevance section.
19	PHM Programs and Services Focus Areas: Improve Behavioral Health	Updated Program goal(s) from "antidepressant medication management (AMM) Acute and Continuation Phase of Treatment Measure" to "Follow-Up After Emergency Department Visit for Mental Illness (FUM)"
19	PHM Programs and Services Focus Areas: Improve Behavioral Health	Updated Program services as follows: Updated live calls to members from "that were newly prescribed antidepressant medications, diagnosed with major depression, and are showing refill gaps between 15-50 days" to "with a very recent ED visit for Mental Illness or Intentional self-harm to conduct assessments and support timely follow-up to outpatient care". Added Fresno to list of Member counties. Added "Clinical Staff are able to identify depressive symptoms and provide additional counseling and resources to assist with stress management and avoidance of at-risk alcohol and substance abuse".
20	PHM Programs and Services Focus Areas: Improve Behavioral Health	Removed "Medical and behavioral" and "pharmacy" from claim types. Added "Hospital admissions, discharges, and transfers (ADT).
20	PHM Programs and Services Focus Areas: Improve Behavioral Health	Added Relevance section.
20	PHM Programs and Services Focus Areas: Cardiac + Diabetes	Removed "1550 Members annually" and added "high risk members" and "utilization (ER/IP), or both" to Program goal(s).
20	PHM Programs and Services Focus Areas: Cardiac + Diabetes	Added healthy weight (BMI) maintenance and encouraging physical activity and healthy eating to Program services.
20,21	PHM Programs and Services Focus Areas: Cardiac + Diabetes	Added Relevance section.
21	PHM Programs and Services Focus Areas: Care Management	Removed Digital Health Connect mobile app information.
22	PHM Programs and Services Focus Areas: Care Management	Added Relevance section.
22	PHM Programs and Services Focus Areas	Added References for all cited information within PHM Programs and Services Focus Areas table.
23	Care Coordination	Added information regarding referring a member to the Public Programs team.
23	Care Coordination	Removed "Physician Certification Statement (PCS)"
23	Care Coordination	Removed "appropriateness" from CBAS section.

23	Care Coordination	Changed "annual" assessments to "at least annually or when the Member experiences a significant change in condition" within LTC section.
23	Care Coordination	Added "criteria and is identified in the" within Overarching CM supporting section.
24,25,26	External Partnerships	Rearranged and updated Entities and Descriptions. Added following entities and descriptions: Departments of Social Services and In-Home Supportive Services (IHSS), Departments of Behavioral Health and Substance use Disorder Services (SUDs), Regional Centers, Departments of Child Welfare Services, County Targeted Case Management Programs, Local Continuums of Care (COCs), Area Agencies on Aging, Local Caregiver Resource Centers (CRCs), Local Home and Community-Based Services (HCBS) Waiver Agencies, Justice Departments & Correctional Facility Partners and Programs.
27	Delivery System Supports: Data and Information sharing and practitioners	Changed "are in the process of implementing" to "implemented".
27	Delivery System Supports: Data and Information sharing and practitioners	Removed "throughout 2023".
28	Delivery System Supports: Incentive Payments	Added "one of more of" within Description.
30	Delivery System Supports: Coordination of Member Programs	Removed "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" from Interdisciplinary/Integrated Care Management Team Rounds section.
31	Delivery System Supports: Coordination of Member Programs	Removed "and/or enlistment of field-based outreach staff (MemberConnections)" from Standardized Protocols for Unable to Reach Members section.
31	Delivery System Support: Coordination of Member Programs	Added Disengaged/housing insecure or homeless member support information within Standardized Protocols for Unable to Reach Members section.

Population Health Management Strategy Program Description

HEALTH NET – CALVIVA HEALTH

~~2022~~2024

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:

- o 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).
  - o 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.
  - o 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:
  - o 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.
  - o 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").
  - o 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.

• Public Policy Committee (PPC): CalViva Health maintains a Public Policy Committee as one way for members to participate in establishing the public policy of the plan, to obtain feedback and guidance

in the delivery of culturally and linguistically appropriate health care, and to establish and maintain community linkages. The Public Policy Committee meets four times a year. The PPC empowers members to ensure the Plan is actively driving interventions and solutions to build more equitable care. The Plan will ensure that PPC meetings are accessible to PPC members and that PPC feedback is meaningfully incorporated in Plan's operations and governance. Information provided by the PPC members is included in the development of Health Equity Department materials, health education materials and programs, and Quality Improvement Projects. The Committee includes a culturally diverse group including CalViva Health members, member advocates (supporters), Commissioner of CalViva Health's governing board, the Fresno-Kings-Madera Regional Health Authority (RHA) Commission, and health care providers.

• 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), 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
  - o 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
  - o 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

- o 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**
  - o 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**
  - o 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)**
  - o 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**
  - o 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**
  - o 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)**
  - o 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**
  - o Lab results data is captured via EMR integration, quality data, among other sources.
- **Admissions, Discharge and Transfer (ADT) data**
  - o ADT data is captured via HIE connections with various facilities and providers.
- **Race/ethnicity data**
  - o 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**
  - o 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:**
  - o 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 Strategy®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 Mmonitoring Plan KPI 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 (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 members 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:

- o   01: Healthy
- o   02: Acute Episodic
- o   03: Healthy, ~~At Risk~~At-Risk Level and
- o   04A: Chronic Big 5 Stable
- o   04B: Chronic Other Condition Stable
- o   04C: BH Primary Stable
- o   05A: Health Coaching
- o   05B: Physical Health CM
- o   05C: Behavioral Health CM
- o   06: Rare ~~High Cost~~High-Cost Condition
- o   07A: Catastrophic: Dialysis
- o   07B: Catastrophic: Active Cancer
- o   07C: Catastrophic: Transplant
- o   08A: Dementia
- o   08B: Institutional (custodial care)
- o   09A: LTSS and Medicare-Medicaid Plan (MMP) – Service Coordination
- o   09B: LTSS and MMP – High Needs Care Management
- o   10: End of Life

   * Definition of each category appears in "Appendix C".
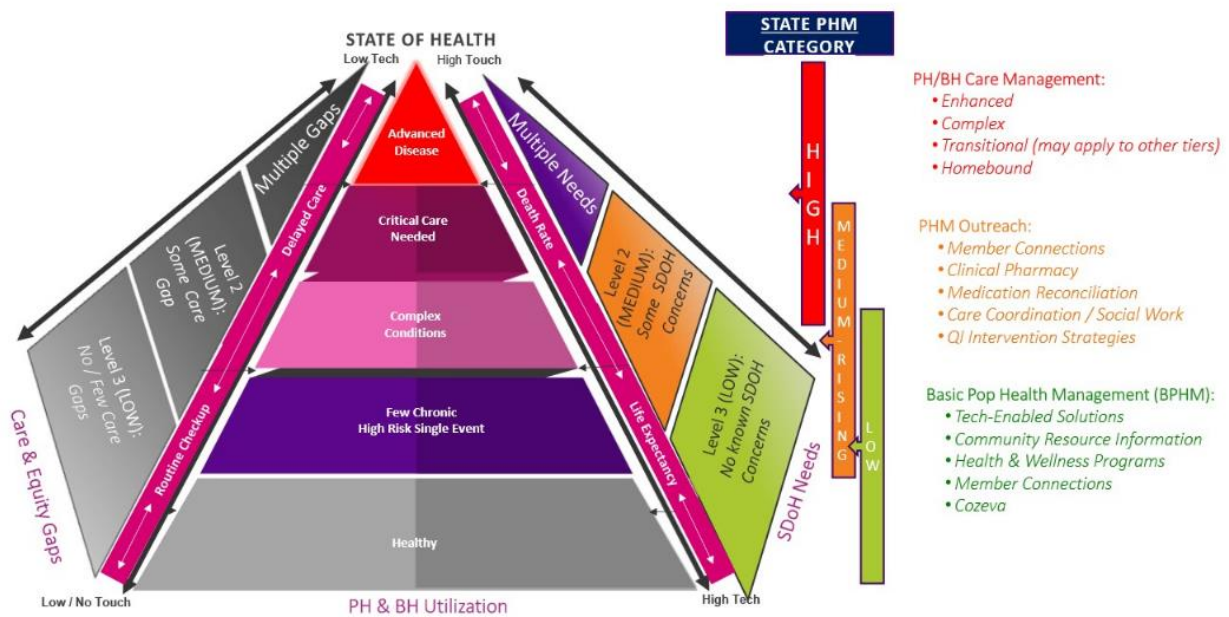
A description of subsets and the type of intervention offered to Members is described in the PHM Programs and Services portion of this document below.

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, ambulatory or preventive visits every 12 months, vaccinations and immunizations (~~e~~g.e.g., COVID-19, Flu, Pneumococcal), 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.
  - o 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
  - o 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:
  - o Invest in preventive programs, coordinate/collaborate with Local Health Departments (LHDs), Local Government Agencies (LGAs), and local organizations to address SDoH and identified health disparities.
  - o Support Members with culturally relevant health education, Member incentives; reminder outreach programs; and community engagement to promote prevention, screening, remove SDoH barriers.
  - o Activate our plan CHW model to work with families with historical gaps in screenings to proactively outreach and remove barriers.
  - o 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.
  - o 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, ambulatory/preventative 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.

We are working with Local Health Jurisdictions (LHJs) in the service area to develop SMART goals that align with the Bold Goals from DHCS Comprehensive Quality Strategy as well as to promote meaningful participation in the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process.

During the third and fourth quarters of 2023, CalViva Health representatives began collaboration with Fresno, Madera, and Kings counties' LHJs/LHDs to begin "meaningful participation" in their current or future CHA/CHIP cycles. Plan will work with LHJs to determine what combination of funding and/or in-kind staffing the plan will contribute to the LHJ CHA/CHIP process, which includes attending CHA/CHIP meetings and serving on the CHA/CHIP governance structure. CalViva Health representatives are also engaging with these LHJs to co-develop joint SMART goals. This collaborative work includes CalViva Health/Health Net partnering and aligning with the other Managed Care Plans (Anthem and Kaiser) providing Medi-Cal services in these three counties.

Plan will partner with LHJ in the service area to identify priority areas for plan to share data with LHJ. In 2025, the Plan will begin to share data agreed upon in 2024 with the LHJs in a timely manner. Plan will engage our community advisory committees (CACs) as part of our participation in the LHJ's CHA/CHIP process. Plan will publish CHA/CHIP on our website and complete the MCP/LHJ collaboration worksheet by deadline.

Plan will submit our annual PHM strategy deliverable using the DHCS template for the service area.

Transitionals of Care ServicesProgram

The purpose of the ~~Transitions~~ Transitional~~of~~ Care Services (TCS) ~~P~~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 Transition~~sal of~~ Care Services 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 T~~O~~CS 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 initial outreach to member while they are inpatient to engage in the program and complete an inpatient discharge risk assessment
- Coordinate care with hospital staff as needed to support safe transition to lower level of care
- ~~Conducting an initial o~~Outreach call ~~within 3 to 10 calendar days from~~upon discharge to review post hospital instructions, ~~and~~ conduct medication reconciliation with the member, and ensure member has a scheduled follow up appt with PCP or specialist
- 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~~

Members receive TCS for a minimum of 30 days. Staff may refer members to additional services, such as ECM and Community S~~s~~upports, at any time during program as appropriate. During the post discharge period, staff evaluates the member to provide the best support to the member in managing their continued needs. Staff will refer members on to complex care management if they need continued support in their health care goals.

PHM Programs and Services

We offer several PHM programs and services to our~~its~~ enrolled Members to provide comprehensive wellness, prevention, and self-management tools:~~.~~

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: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits ~~Depression and Antidepressant Medication Management~~	Members ages 6~~18~~ years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.~~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,

Program Name	Eligible Population
	complex conditions and other designated health factors and/or social determinants of health.
Palliative Care	Members with chronic, severe, progressive or terminal illness
Transitional 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 (formerly Cardio-Protective Bundle Project- SHAPE)	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

Program Name	Eligible Population
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
~~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
Relevance	The flu vaccine can prevent contracting the flu and other illness and can decrease health care utilization by reducing risk of going to the doctor or hospital, and keeping the community healthy. It is an important preventative tool for people with chronic health conditions. The ability to get the flu shot can also be an indicator of any health plan/network access barriers.

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.

Revised: ~~MarchApril~~July 29~~38~~, 202~~13~~

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 of 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.
Relevance	Tobacco use is the leading cause of preventable death and disease in the U.S., making it critically important that prevention and cessation programs are available to help people break their tobacco addiction for good. Almost 4 million Californians still smoke, including 146,000 adolescents. The cost of smoking in 2009 totaled $18.1 billion, including $9.8 billion in healthcare cost, $1.4 billion in lost productivity from illness, and $6.8 billion in lost productivity from premature mortality.[1] Tobacco cessation is critical to improve members' health outcomes and reduce health care costs by decreasing the rate of tobacco users among CVH membership.

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 • Social media to provide member education and increase the awareness regarding the importance of regular screening • Multi-gap call outreach to members Provider education and partnership to promote breast cancer screenings through: • Tipsheets on the Breast Cancer Screening HEDIS measure • Provide Breast Cancer Screening HEDIS measure specific best practices, coding practices, and clinic processes practices in the Provider Best Practices guide

	• Collaboration with priority Providers to identify opportunities to improve breast cancer screening utilization rates
Methods and data sources used to identify the eligible population	HEDIS care gap reports, enrollment data
Relevance	The American Cancer Society cites breast cancer as the second leading cause of cancer-related deaths and the second most common cancer among women in the US.[2] Regular breast cancer screenings (also known as a mammogram) can help detect the cancer while it is still in early stages, which is also when the cancer treatment is most likely to be successful. Breast cancer screening is an important preventative tool that can help keep members healthy and decrease health care utilization.

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: • Glycemic Status~~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
Relevance	According to the Centers for Disease Control and Prevention (CDC), 38.4 million people have diabetes (11.6% of the US population), and 1 in 5 individuals have undiagnosed diabetes.[3] Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities such as blindness, amputation, kidney failure, heart disease, stroke, and early mortality. Diabetes is the eighth leading cause of death in the United States in 2021. On average, people diagnosed with diabetes have medical expenditures 2.6 times higher than would be expected without diabetes, according to the Economic Costs of Diabetes report published by American Diabetes Association in 2022.[4] However, early detection and strict management of diabetes can significantly prevent, reduce, and delay complications of the disease, ultimately improving patient health outcomes while greatly reducing costs. Diabetes control is achieved through effective comprehensive diabetes care and management, and clinical preventive care practices that achieve optimal rates for the HEDIS diabetes-related measures, specifically blood sugar control, retinal eye exam, and kidney health evaluation.

CalViva Pregnancy Program (CPP) / High-Risk Obstetrics (OB) CM	
Eligible population:	Pregnant Members at risk for complications of pregnancy as determined ~~by having~~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.

Revised: ~~MarchApril~~~~July~~ 29~~38~~, 202~~13~~

Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims
Relevance	Pregnancy complications can be harmful for mom and baby. Early and regular prenatal care helps identify conditions and behaviors that can result in preterm and low weight births. Early identification of pregnant women and their risk factors is an important factor in improving birth outcomes. Interventions are aimed at increasing pre-natal visits thereby improving health outcomes and resulting in reducing utilization costs. Pregnancy complications can be harmful for mom and baby. Post-natal care is important in preventing and addressing the health of mom and baby after pregnancy. Interventions are aimed at improving health outcomes and resulting in reduced utilization costs. Pregnancy complications can be harmful for mom and baby. Preterm birth is the leading cause of US infant morbidity and mortality and low birth weight can cause serious and long-term health problems. Interventions are aimed at reducing pre-term deliveries thereby improving health outcomes and resulting in reduced utilization cost. Measuring member experience evaluated the effectiveness of the services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement.

Improve Behavioral Health: ~~*Depression and Antidepressant Medication Management*~~*Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits*	
Eligible population:	~~Members ages 18 and older that have been newly prescribed antidepressant medications and are diagnosed with major depression~~ Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
Focus area:	Patient safety or outcomes across settings
Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM)~~antidepressant medication management (AMM) Acute and Continuation Phase of Treatment Measure~~
Program services:	Behavioral Hhealth clinical staff ~~administrator~~ live calls to members with a very recent ED visit for Mental illness or Intentional self-harm to conduct assessments and support timely follow-up to outpatient care ~~that were newly prescribed antidepressant medications, diagnosed with major depression, and are showing refill gaps between 15 to 50 days,~~ for members in Fresno, Kings and Madera counties. Clinical staff are able to identify depressive symptoms and provide additional counseling and resources to assist with stress management and avoidance of at-risk alcohol and substance use.

Revised: ~~MarchAprilJuly 2938~~, 202~~13~~

Methods and data sources used to identify the eligible population	Hospital admissions, discharges, and transfers (ADT), ~~Medical and behavioral~~ claims or encounter, and ~~pharmacy claims,~~ ~~m~~Membership data
Relevance	Major depression is one of the most prevalent and treatable mental health disorders. Although antidepressants are considered effective treatment, non-adherence to antidepressants significantly hinders successful treatment of depression. Symptoms associated with major depression can last for years and has been linked to poor treatment outcomes (e.g., relapse occurrence) if left untreated. Conversely, many can improve through treatment with appropriate medications. Measuring antidepressant medication adherence for 84 days (12 weeks) among individuals diagnosed with depression evaluates the impact of the recommended treatment monitoring during the acute phase, during which remission (reduction of depressive symptoms) is induced. This measure ensures patients successfully adhere to treatment plans. Successful treatment of patients with major depressive disorder is promoted when patients adhere to the treatment plan through the continuation phase of treatment (six months), the period in which remission is preserved. Ultimately, adherence through the continuation and maintenance phase protects the patient against the recurrence of a subsequent major depressive episode.

Cardiac + Diabetes (formerly 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~~high risk members who were flagged for non-adherence, utilization (ER/IP), or both 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 to address Members' chronic conditions and healthy weight (BMI) maintenance, encouraging physical activity and healthy eating. 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
Relevance	Diabetes was the eighth leading cause of death in the United States in 2021.[5] If not properly managed, it can lead to renal, vision, hearing impairment and cardiovascular disease. If complicated with other chronic comorbid conditions

	like hypertension and CAD, the utilization is very high affecting the quality of life and the challenges to navigate through the healthcare system. In 2022, the total cost of diagnosed diabetes in the United States was $412.9 billion.$_5$ The utilization is primarily around pharmacy, inpatient and emergency room costs. Timely intervention, focus on prevention and developing wellness into the lifestyles, and implementation of evidence-based strategies to incorporate best practices are the goals of the initiative.

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~~transitional care services, 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
Relevance	One element of the Care Management program evaluation is to assess member satisfaction. Measuring member experience evaluated the effectiveness of Care Management services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement. Use of the emergency room may prevent or interrupt the receipt of coordinated services by the primary care physician. Readmission may reflect a failure of transition of care after hospital discharge. Readmissions not only increase health care costs, but also can signal a setback in member recovery after hospitalization. There are many factors which increase the potential for a readmission including member and caregiver understanding of discharge instructions, member and caregiver understanding of red flags and when to contact a physician and lack of medication reconciliation.

References:

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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 refer the member to the Public Programs team who will 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 implementeding 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 at least annually or when the Member experiences a significant change in condition 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 criteria and is identified in the 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:
Departments of Social Services and In-Home Supportive Services (IHSS)	CalViva Health will maintain MOUs with Local Departments of Social Services and In-Home Supportive Services (IHSS) programs in all services areas and will meet with these departments/programs quarterly at minimum, as is required under the new State contract.
Departments of Behavioral Health and Substance Use Disorder Services (SUDs)	CalViva Health will maintain MOUs with Local Departments of Behavioral Health and Substance Use Disorder Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Regional Centers	CalViva Health will maintain MOUs with the Regional Center(s) for all services areas and will meet with the Regional Center(s) quarterly at minimum, as is required under the new State contract.
Local Health Departments	CalViva Health will maintain MOUs with Local Health Departments (LHDs) in all services areas and will meet with LHDs quarterly at minimum, as is required under the new State contract. 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).
Departments of Child Welfare Services	CalViva Health will maintain MOUs with Local Departments of Child Welfare Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
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. CalViva Health will also maintain MOUs with the local WIC programs in all services areas and will meet with the WIC programs quarterly at minimum, as is required under the new State contract.
County Targeted Case Management Programs	CalViva Health will maintain MOUs with Local County Targeted Case Management (TCM) programs *(where applicable)* in all services areas and will meet with the TCM programs quarterly at minimum, as is required under the new State contract.
First Five programs and providers	CalViva Health will maintain MOUs with the local First Five programs in all services areas and will meet with these programs quarterly at minimum, as is required under the new State contract. We participate in coalitions and help establish processes for local programs. We provide First Five with sponsorships as needed or requested.
Local Continuums of Care (COCs)	CalViva Health will maintain MOUs with Local Continuums of Care (COCs) in all services areas and will meet with the COCs quarterly at minimum, as is required under the new State contract.

Revised: ~~MarchApril~~July 29~~38~~, 202~~13~~

Area Agencies on Aging	CalViva Health will maintain MOUs with the Area Agencies on Aging (AAAs) for all services areas and will meet with the AAAs quarterly at minimum, as is required under the new State contract.
Local Caregiver Resource Centers (CRCs)	CalViva Health will maintain MOUs with the local Caregiver Resources Centers (CRS) in all services areas and will meet with the CRCs quarterly at minimum, as is required under the new State contract.
Local Home and Community-Based Services (HCBS) Waiver Agencies	CalViva Health will maintain MOUs with the local Home and Community Based Services (HCBS) Waiver Agencies in all services areas and will meet with the HCBS agencies quarterly at minimum, as is required under the new State contract.
Justice Departments & Correctional Facility Partners and Programs	CalViva Health will maintain MOUs with the local Justice Departments/Correctional Facility partners and program in all services areas and will meet with the JI/CI partners quarterly at minimum, or as directed by DHCS, as is required under the new State contract.
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.
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.
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 when possible 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 implementeding 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 <u>one or more of</u> 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

- o 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.
- o 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.
- o 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~~<u>non-urgent</u> 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.

- o 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 Member Connection 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.

o 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.
o 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.

o 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.

o 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.

o 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.

o 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.

o 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.

o 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.
- Disengaged/housing insecure or homeless member support: Street Medicine providers support in reaching the most difficult to reach populations and provide basic care coordination and connection to PCP.

o 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 faceface-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 o 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.doc 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:
	    o When age <65 then risk of future costs < 2
	    o 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.do 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:
	   o When age <65 then risk of future costs < 2
	   o 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.do
	
	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.do	
	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.do
	
	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~~Atherosclerosis
- 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.do 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
	
	    o Traumatic Brain Injury (TBI)
	    o Cystic Fibrosis
	    o Multiple Sclerosis
	    o Hip or Pelvic Fracture
	    o Ulcers

	o Spinal Cord Injury
	    o Acute Myocardial Infarction (AMI)
	    o Muscular Dystrophy
	    o Learning Disabilities
	    o Spina Bifida
	    o Fibromyalgia
	    o Intellectual Disabilities
	    o Other Developmental Delays
	    o 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~~Focus Areas~~
	PHM.1.A.2	Focus Areas~~Focus Areas~~ Programs or Services Offered
	PHM.1.A.3	Activities Which Support PHM Programs and Services~~Activities Which Support PHM Programs and Services~~
	PHM.1.A.4	Coordination of Member programs~~Coordination of Member programs~~
	PHM.1.A.5	Informing Members about Available PHM Programs~~Informing Members about Available PHM Programs~~
	PHM.1.A.6	Basic Population Health Management (BPHM)~~Basic Population Health Management (BPHM)~~ (Health Equity Improvement Model)
	PHM.1.B	Informing Members about PHM Programs – Interactive Contact~~Informing Members about PHM Programs – Interactive Contact~~
	PHM.2.A	Population Stratification~~Population Stratification~~
	PHM.2.B	Population Needs Assessment (PNA)~~Population Needs Assessment (PNA)~~

	PHM.2.C	PNA Activities~~PNA Activities~~
	PHM.2.D	Population Stratification~~Population Stratification~~, Focus Areas~~Focus Areas~~,
	PHM.3.A	Activities Which Support PHM Programs and Services~~Activities Which Support PHM Programs and Services~~

Item #13
Attachment 13.A

Finance Report
Financials as of March 31, 2024

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Balance Sheet
As of March 31, 2024

			Total
1	ASSETS		
2	Current Assets		
3	Bank Accounts		
4	Cash & Cash Equivalents		467,705,632.87
5	Total Bank Accounts	$	467,705,632.87
6	Accounts Receivable		
7	Accounts Receivable		298,023,999.63
8	Total Accounts Receivable	$	298,023,999.63
9	Other Current Assets		
10	Interest Receivable		1,168,434.20
11	Investments - CDs		0.00
12	Prepaid Expenses		565,877.05
13	Security Deposit		23,662.50
14	Total Other Current Assets	$	1,757,973.75
15	Total Current Assets	$	767,487,606.25
16	Fixed Assets		
17	Buildings		5,774,032.16
18	Computers & Software		40,444.40
19	Land		3,161,419.10
20	Office Furniture & Equipment		81,740.60
21	Total Fixed Assets	$	9,057,636.26
22	Other Assets		
23	Investment -Restricted		303,592.00
24	Lease Receivable		2,772,636.21
25	Total Other Assets	$	3,076,228.21
26	TOTAL ASSETS	$	779,621,470.72
27	LIABILITIES, DEFFERED INFLOW OF RESOURCES, AND EQUITY		
28	Liabilities		
29	Current Liabilities		
30	Accounts Payable		
31	Accounts Payable		61,966,451.34
32	Accrued Admin Service Fee		9,618,631.00
33	Capitation Payable		242,348,378.12
34	Claims Payable		37,401.22
35	Directed Payment Payable		7,778,517.67
36	Total Accounts Payable	$	321,749,379.35
37	Other Current Liabilities		
38	Accrued Expenses		1,394,684.63
39	Accrued Payroll		119,127.07
40	Accrued Vacation Pay		353,471.71
41	Amt Due to DHCS		30,568,417.71
42	IBNR		65,773.55
43	Loan Payable-Current		0.00
44	Premium Tax Payable		0.00
45	Premium Tax Payable to BOE		326,428.43
46	Premium Tax Payable to DHCS		266,406,250.00
47	Total Other Current Liabilities	$	299,234,153.10
48	Total Current Liabilities	$	620,983,532.45
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	$	621,009,439.24
54	Deferred Inflow of Resources		2,334,315.95
55	Equity		
56	Retained Earnings		141,338,556.42
57	Net Income		14,939,159.11
58	Total Equity	$	156,277,715.53
59	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$	779,621,470.72

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Budget vs. Actuals: Income Statement
July 2023 - March 2024

		Total		
1	**Income**	**Actual**	**Budget**	**Over/(Under) Budget**
2	Interest Earned	5,965,638.86	2,700,000.00	3,265,638.86
3	Premium/Capitation Income	1,578,846,117.50	1,313,419,017.00	265,427,100.50
4	**Total Income**	**1,584,811,756.36**	**1,316,119,017.00**	**268,692,739.36**
5	**Cost of Medical Care**			
6	Capitation - Medical Costs	999,768,424.43	866,779,099.00	132,989,325.43
7	Medical Claim Costs	1,023,221.49	1,199,999.97	(176,778.48)
8	**Total Cost of Medical Care**	**1,000,791,645.92**	**867,979,098.97**	**132,812,546.95**
9	**Gross Margin**	**584,020,110.44**	**448,139,918.03**	**135,880,192.41**
10	**Expenses**			
11	Admin Service Agreement Fees	43,188,002.00	39,545,990.00	3,642,012.00
12	Bank Charges	0.00	5,400.00	(5,400.00)
13	Computer/IT Services	103,474.84	193,473.00	(89,998.16)
14	Consulting Fees	162,838.00	299,999.97	(137,161.97)
15	Depreciation Expense	245,652.30	270,000.00	(24,347.70)
16	Dues & Subscriptions	178,975.62	175,500.00	3,475.62
17	Grants	3,146,363.62	3,163,640.00	(17,276.38)
18	Insurance	263,374.87	315,120.00	(51,745.13)
19	Labor	2,741,719.00	3,406,973.00	(665,254.00)
20	Legal & Professional Fees	62,613.00	150,000.03	(87,387.03)
21	License Expense	948,785.26	1,048,133.97	(99,348.71)
22	Marketing	980,444.24	1,230,000.00	(249,555.76)
23	Meals and Entertainment	12,127.85	22,350.00	(10,222.15)
24	Office Expenses	55,344.22	68,400.00	(13,055.78)
25	Parking	127.00	1,170.00	(1,043.00)
26	Postage & Delivery	1,891.33	3,600.00	(1,708.67)
27	Printing & Reproduction	1,835.12	3,690.00	(1,854.88)
28	Recruitment Expense	2,228.01	84,375.00	(82,146.99)
29	Rent	0.00	9,000.00	(9,000.00)
30	Seminars and Training	5,304.12	21,600.00	(16,295.88)
31	Supplies	8,878.54	9,749.97	(871.43)
32	Taxes	517,343,303.47	391,875,003.00	125,468,300.47
33	Telephone	24,089.62	31,500.00	(7,410.38)
34	Travel	12,799.66	19,649.97	(6,850.31)
35	**Total Expenses**	**569,490,171.69**	**441,954,317.91**	**127,535,853.78**
36	**Net Operating Income/ (Loss)**	**14,529,938.75**	**6,185,600.12**	**8,344,338.63**
37	**Other Income**			
38	Other Income	409,220.36	450,000.00	(40,779.64)
39	**Total Other Income**	**409,220.36**	**450,000.00**	**(40,779.64)**
40	**Net Other Income**	**409,220.36**	**450,000.00**	**(40,779.64)**
41	**Net Income/ (Loss)**	**14,939,159.11**	**6,635,600.12**	**8,303,558.99**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Income Statement: Current Year vs Prior Year
FY 2024 vs FY 2023

		Total	
		July 2023 - March 2024	July 2022 - March 2023 (PY)
1	Income		
2	Interest Earned	5,965,638.86	3,594,067.32
3	Premium/Capitation Income	1,578,846,117.50	1,009,925,358.33
4	Total Income	$ 1,584,811,756.36	$ 1,013,519,425.65
5	Cost of Medical Care		
6	Capitation - Medical Costs	999,768,424.43	861,841,520.86
7	Medical Claim Costs	1,023,221.49	1,051,521.88
8	Total Cost of Medical Care	$ 1,000,791,645.92	$ 862,893,042.74
9	Gross Margin	$ 584,020,110.44	$ 150,626,382.91
10	Expenses		
11	Admin Service Agreement Fees	43,188,002.00	41,555,800.00
12	Computer/IT Services	103,474.84	150,640.43
13	Consulting Fees	162,838.00	21,950.00
14	Depreciation Expense	245,652.30	220,336.17
15	Dues & Subscriptions	178,975.62	207,179.74
16	Grants	3,146,363.62	3,760,454.56
17	Insurance	263,374.87	145,368.80
18	Labor	2,741,719.00	2,462,406.67
19	Legal & Professional Fees	62,613.00	68,351.33
20	License Expense	948,785.26	881,381.98
21	Marketing	980,444.24	1,054,335.75
22	Meals and Entertainment	12,127.85	17,415.67
23	Office Expenses	55,344.22	62,863.17
24	Parking	127.00	184.39
25	Postage & Delivery	1,891.33	2,661.32
26	Printing & Reproduction	1,835.12	1,275.20
27	Recruitment Expense	2,228.01	37,986.73
28	Rent	0.00	0.00
29	Seminars and Training	5,304.12	6,534.05
30	Supplies	8,878.54	7,535.77
31	Taxes	517,343,303.47	91,437,096.77
32	Telephone	24,089.62	22,380.84
33	Travel	12,799.66	13,423.07
34	Total Expenses	$ 569,490,171.69	$ 142,137,562.41
35	Net Operating Income/ (Loss)	$ 14,529,938.75	$ 8,488,820.50
36	Other Income		
37	Other Income	409,220.36	415,469.48
38	Total Other Income	$ 409,220.36	$ 415,469.48
39	Net Other Income	$ 409,220.36	$ 415,469.48
40	Net Income/ (Loss)	$ 14,939,159.11	$ 8,904,289.98

Item #13

Attachment 13.B

Fiscal Year 2025 Proposed Budget

Basic assumptions used in FY 2025 budget projections

1. FY 2025 enrollment projected to gradually decline throughout the fiscal year as we project our enrollment to trend closer to our pre-COVID membership, net of membership gains from new membership such as but not limited to dual Medi-Cal/Medicare members moving from voluntary to mandatory Medi-Cal managed care and undocumented adults ages 26-49 receiving full scope Medi-Cal benefits in 2024.

2. Revenues projected based on enrollment breakdown by aid category, using current aid code category specific rates as a benchmark known at time of budget preparation. Overall, revenues are projected to increase in comparison to prior year budget primarily due to the following:

   a) Increase in MCO taxes which was approved by the Centers for Medicare and Medicaid Services ("CMS") noting a substantial increase in the MCO tax amount from previous years. The MCO tax revenue is calculated per the new revised MCO tax proposal (i.e., revising the MCO tax that was recently approved by CMS in December 2023). Per DHCS, they are confident that the revised MCO tax proposal will pass California State Legislature and receive CMS' approval.

   b) Increase in capitation rates paid by DHCS to CalViva as a result of the additional funds generated by the new MCO tax which will be used to increase Medi-Cal rates, such as but not limited to increase in rates for primary care, specialty care, maternity care, and non-specialty mental health services.

   c) Increase in membership from prior year FY 2024 budgeted amounts as we have seen lower actual disenrollments vs previously projected disenrollments as a higher number of individuals remain eligible for Medi-Cal after eligibility redeterminations.

3. Administrative Services Fee expense projected at $11 pmpm based on enrollment. Overall, Administrative Services Fee expense projected to slightly increase due to higher projected enrollment in FY 2025 vs budgeted FY 2024 enrollment.

4. Interest income projected to increase due to additional funds being allocated to the money market fund.

5. Supplemental revenue from DHCS such as Maternity KICK and Ground Emergency Medical Transportation ("GEMT") payments projected based on current historical monthly average as a baseline.

6. Medical Cost Expense projected as Gross Medi-Cal Revenue less MCO taxes, $11 per-member, per-month ("pmpm") Administrative Services fee expense, and retention rate retained by CalViva.

7. We are projecting FY 2025 staffing at 21 full-time employees. Salary, Wages, and Benefits based on current staffing and rates. Projected wage increases of up to 5% based on employee performance at anniversary date, 8% increase in health insurance premiums based on January renewal, current deferral rate and employer contribution/match into the 457b-retirement program. The increase is primarily due to the potential addition of staff to support the new DHCS 2024 contractual requirements (e.g., NCQA, D-SNP, Long-Term Care, etc....) and potential succession planning efforts for key management positions near retirement age.

8. Depreciation expense based on current fixed assets useful life. Includes additional depreciation expense for potential tenant improvements to building during fiscal year 2025 for new tenant and expansion of CalViva office space.

9. Projected increase in Dues & Subscriptions expense as a result of increase in dues from trade organizations who have added additional staff to better represent health plans in relation to numerous changes affecting Medi-Cal managed care such as but not limited to the MCO tax targeted rate increases (i.e., increase to Medi-Cal fee schedule), and long-term care moving into Medi-Cal managed care.

10. Community Support/Grants expense based on continuation of providing grants to community-based organizations, scholarship funding to various local colleges, physician recruitment grants, and quality score incentive grants to providers. Increase to account for DHCS 2024 contractual requirement which requires Plans to submit a Community Reinvestment Plan for DHCS' approval in a form and manner to be specified by DHCS through a future document. Per DHCS 2024 contract, Plans must contribute 5% of annual net income to community reinvestment initiatives. In addition, if Plans do not meet quality outcome metrics as defined through a forthcoming guidance document, Plans must contribute an additional 7.5% of its annual net income to community reinvestment initiatives.

11. Projected increase to Insurance expense to account for increase in insurance premiums.

12. Projected increase to Legal & Professional expense to account for CalViva utilizing a vendor to add CalViva Health member ID option on our website where members can access their member ID online.

13. Knox-Keene DMHC License expense is to be based on last year's per member rate as an initial benchmark plus a forecasted rate increase and March 2024 enrollment for DMHC annual assessment fee to CalViva.

14. Marketing expense incurred directly by the Plan is projected based on marketing plan for the fiscal year. Marketing expense is consistent with prior year.

15. Projected increase to Office expense to account for the expansion of the CalViva office space and related office equipment and furniture below our fixed asset threshold of $10,000.

16. Projected increase to Recruitment expense to fill additional positions during FY 2025.

17. MCO tax expense calculated per recently revised MCO tax structure for FY 2025, noting a substantial increase from FY 2024. MCO tax is projected to be budget neutral (i.e., no gain or loss).

18. Projecting an increase to Capital Expenditures to account for potential tenant improvements to vacant office space in our building which we own and are currently marketing to potential tenants. Furthermore, projecting an increase to capital expenditures to account for improvements related to additional office space to be occupied by CalViva in the building we own.

Fresno Kings Madera Regional Health Authority dba CalViva Health

FY 2025 PROPOSED BUDGET

		<A>		<B>	<C> = <B> - <A>	<D> = <C>/<A>
		FY 2024 REVISED Approved Budget		Proposed FY 2025 Budget	Proposed FY 2025 vs FY 2024 REVISED Budget Difference	% Change from Proposed FY 2025 Budget vs FY 2024 REVISED Budget
1	Medical Revenue	1,731,790,682		1,816,037,012	84,246,330	4.86%
2	Interest Income	3,600,000		4,000,000	400,000	11.1%
3	Total Revenues	1,735,390,682		1,820,037,012	84,646,330	4.9%
4	Medical Cost Expense	1,129,334,874		1,179,560,582	50,225,707	4.4%
5	Gross Margin	606,055,808		640,476,430	34,420,622	5.7%
	Expenses					
6	Administrative Services Fee	51,397,610		53,681,100	2,283,490	4.4%
7	Salary,Wages & Benefits	4,546,256		5,033,122	486,865	10.7%
8	Bank Charges	7,200		7,200	0	0.0%
9	Consulting	400,000		400,000	0	0.0%
10	Computer & IT	257,960		257,960	0	0.0%
11	Depreciation	360,000		372,000	12,000	3.3%
12	Dues & Subscriptions	234,000		297,600	63,600	27.2%
13	Grants	3,925,000		4,325,000	400,000	10.2%
14	Insurance	403,683		447,571	43,888	10.9%
15	Legal & Professional	200,000		322,800	122,800	61.4%
16	License	1,397,512		1,425,157	27,646	2.0%
17	Marketing	1,500,000		1,500,000	0	0.0%
18	Meals	27,450		28,350	900	3.3%
19	Office	91,200		114,000	22,800	25.0%
20	Parking	1,560		1,560	0	0.0%
21	Postage & Delivery	4,800		4,920	120	2.5%
22	Printing & Reproduction	4,920		4,920	0	0.0%
23	Recruitment	112,500		157,500	45,000	40.0%
24	Rent	12,000		12,000	0	0.0%
25	Seminars & Training	28,800		28,800	0	0.0%
26	Supplies	13,000		13,000	0	0.0%
27	Telephone/Internet	42,000		42,000	0	0.0%
28	Travel	26,200		26,800	600	2.3%
29	Total Expenses	64,993,651		68,503,360	3,509,709	5.4%
30	Income before Taxes	541,062,157		571,973,070	30,910,914	5.7%
31	Taxes-MCO	532,812,500		563,750,000	30,937,500	5.8%
32	Excess Revenue (Expenses)	8,249,657		8,223,070	(26,586)	-0.3%
33	Other Income	600,000		435,000	(165,000)	-27.5%
34	Net Income/(Loss)	8,849,657		8,658,070	(191,586)	-2.2%
35	Capital Expenditure Budget	400,000		500,000	100,000	25.0%

		2024	2024	2024	2024	2024	2024	2025	2025	2025	2025	2025	2025	FY 2025	
	Fresno Kings Madera Regional Health Authority dba CalViva Health															
	Combined Fresno -Kings - Madera Counties															
	FY 2025 PROPOSED BUDGET															
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	**Budget Total**	
1	**Enrollment**														
2	Enrollment	419,325	417,025	414,725	412,425	410,125	407,825	405,525	403,225	400,925	398,625	396,325	394,025	**4,880,100**	
3	**Total Enrollment**	419,325	417,025	414,725	412,425	410,125	407,825	405,525	403,225	400,925	398,625	396,325	394,025	**4,880,100**	
4	**Revenue**														
5	Medical Revenue	154,536,708	153,973,019	153,409,330	152,845,641	152,281,951	151,718,262	150,954,573	150,390,884	149,827,195	149,263,505	148,699,816	148,136,127	**1,816,037,012**	
6	Interest Income	333,333	333,333	333,333	333,333	333,333	333,333	333,333	333,333	333,333	333,333	333,333	333,333	**4,000,000**	
7	**Total Revenues**	**154,870,042**	**154,306,352**	**153,742,663**	**153,178,974**	**152,615,285**	**152,051,596**	**151,287,906**	**150,724,217**	**150,160,528**	**149,596,839**	**149,033,150**	**148,469,460**	**1,820,037,012**	
8	Medical Cost Expense	101,309,851	100,779,918	100,249,984	99,720,050	99,190,116	98,660,182	97,933,248	97,403,314	96,873,381	96,343,447	95,813,513	95,283,579	**1,179,560,582**	
9	**Total Medical Cost Expense**	**101,309,851**	**100,779,918**	**100,249,984**	**99,720,050**	**99,190,116**	**98,660,182**	**97,933,248**	**97,403,314**	**96,873,381**	**96,343,447**	**95,813,513**	**95,283,579**	**1,179,560,582**	
10	**Gross Margin**	53,560,190	53,526,435	53,492,680	53,458,924	53,425,169	53,391,414	53,354,658	53,320,903	53,287,147	53,253,392	53,219,637	53,185,881	**640,476,430**	
11	**Expenses**														
12	Administrative Services Fee	4,612,575	4,587,275	4,561,975	4,536,675	4,511,375	4,486,075	4,460,775	4,435,475	4,410,175	4,384,875	4,359,575	4,334,275	**53,681,100**	
13	Salary,Wages & Benefits	382,296	389,656	454,131	392,131	392,131	484,131	397,742	403,199	473,199	398,168	398,168	468,168	**5,033,122**	
14	Bank Charges	600	600	600	600	600	600	600	600	600	600	600	600	**7,200**	
15	Consulting	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	33,333	**400,000**	
16	Computer and IT Expenses	21,497	21,497	21,497	21,497	21,497	21,497	21,497	21,497	21,497	21,497	21,497	21,497	**257,960**	
17	Depreciation Expense	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	31,000	**372,000**	
18	Dues & Subscriptions	24,800	24,800	24,800	24,800	24,800	24,800	24,800	24,800	24,800	24,800	24,800	24,800	**297,600**	
19	Grants/Community Support	1,500,000	256,818	256,818	256,818	256,818	256,818	256,818	256,818	256,818	256,818	256,818	256,818	**4,325,000**	
20	Insurance Expense	32,208	32,208	32,208	38,994	38,994	38,994	38,994	38,994	38,994	38,994	38,994	38,994	**447,571**	
21	Legal & Professional	26,900	26,900	26,900	26,900	26,900	26,900	26,900	26,900	26,900	26,900	26,900	26,900	**322,800**	
22	License Expense	118,763	118,763	118,763	118,763	118,763	118,763	118,763	118,763	118,763	118,763	118,763	118,763	**1,425,157**	
23	Marketing Expense	120,000	120,000	148,750	148,750	148,750	148,750	145,000	125,000	125,000	100,000	90,000	80,000	**1,500,000**	
24	Meals	1,000	1,200	5,500	2,500	1,650	6,000	1,650	1,650	1,800	1,800	1,800	1,800	**28,350**	
25	Office Expense	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	**114,000**	
26	Parking	130	130	130	130	130	130	130	130	130	130	130	130	**1,560**	
27	Postage & Delivery	410	410	410	410	410	410	410	410	410	410	410	410	**4,920**	
28	Printing & Reproduction	410	410	410	410	410	410	410	410	410	410	410	410	**4,920**	
29	Recruitment	13,125	13,125	13,125	13,125	13,125	13,125	13,125	13,125	13,125	13,125	13,125	13,125	**157,500**	
30	Rent	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**12,000**	
31	Seminars & Training	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	2,400	**28,800**	
32	Supplies	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	**13,000**	
33	Telephone/Internet	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	**42,000**	
34	Travel	2,000	2,000	2,000	4,800	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	**26,800**	
35	**Total Expenses**	6,938,530	5,677,609	5,749,834	5,669,120	5,640,170	5,711,220	5,591,431	5,551,587	5,596,437	5,471,107	5,435,807	5,470,507	**68,503,360**	
36	**Income before Taxes**	46,621,660	47,848,826	47,742,845	47,789,804	47,784,999	47,680,193	47,763,227	47,769,315	47,690,710	47,782,285	47,783,830	47,715,375	**571,973,070**	
37	**Taxes-MCO**	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	46,979,167	**563,750,000**	
38	**Operating Income (Loss)**	(357,507)	869,659	763,679	810,637	805,832	701,027	784,060	790,149	711,543	803,119	804,663	736,208	**8,223,070**	
39	**Other Income**	36,250	36,250	36,250	36,250	36,250	36,250	36,250	36,250	36,250	36,250	36,250	36,250	**435,000**	
40	**Net Income (Loss)**	(321,257)	905,909	799,929	846,887	842,082	737,277	820,310	826,399	747,793	839,369	840,913	772,458	**8,658,070**	
41	**Capital Expenditures**													**500,000**	

Item #13
Attachment 13.C

Compliance Report

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 YTD Total
# of DHCS Filings													
Administrative/ Operational	56	46	28	33	6								169
Member Materials Filed for Approval;	1	4	1	5	1								12
Provider Materials Reviewed & Distributed	10	14	9	8	2								43
# of DMHC Filings	8	8	8	11	3								38

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	5	4*	3	1									13
High-Risk	0	0	0	0									0

* One of the four cases involved a cybersecurity incident at Change Healthcare that caused widespread product outages affecting many plans nationally.
CalViva does not have a contractual relationship with Change Healthcare but CalViva's Plan Administrator, Health Net, does. Although Health Net submitted a Privacy Incident Report to DHCS on 2/28/24 no member PHI was impacted and DHCS closed the case as a "non-breach".

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 YTD Total
# of New MC609 Cases Submitted to DHCS	2	4	0	3	0								9
# of Cases Open for Investigation (Active Number)	17	17	15	17	17								

Report Date 5/16/2024

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 3/21/2024 Compliance Regulatory Report to the Commission, there were 3 new MC609 cases filed that involved: 1) a non-participating provider, who is not enrolled as a Medi-Cal Fee-for-Service, who was identified for allegedly performing laboratory tests that their CLIA does not authorize, and for collecting payment from beneficiaries up front and not billing Medicare; 2) a non-participating laboratory was identified via data mining for billing a non-covered service; and 3) a CalViva member who allegedly has been placing fraudulent transportation requests for approximately three years.

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: UMCM, Marketing, Claims/PDR and Health Equity The following audits have been completed since the last Commission report: Credentialing (CAP) and Behavioral Health

Regulatory Reviews/Audits and CAPS:	Status
Department of Managed Health Care ("DMHC") 2022 Medical Audit	The Plan received 2022 DMHC Final Audit Report on April 18, 2024, noting two findings. 1) The Plan failed to identify PQIs in exempt grievances and 2) The Plan inappropriately denies post-stabilization care. The DMHC has referred the post-stabilization deficiency to the Office of Enforcement to assess the Plan's noncompliance with post-stabilization laws. DMHC will be conducting a follow-up audit within 18 months to address these findings. The Plan is in the process to issue a CAP to Health Net to begin to immediately remediate both these deficiencies.
Department of Health Care Services ("DHCS") 2023 Medical Audit	The Plan submitted the final 2023 Audit CAP response to DHCS on 3/27/2024, and DHCS closed the CAP on 4/19/2024.
Department of Health Care Services ("DHCS") 2024 Medical Audit	The Plan submitted all the Pre-Audit Documentation on 4/12/2024, and Verification Files on 5/3/2024. The Audit Entrance Conference will be held on 5/20/2024 *via* video teleconference and all interview sessions and file reviews will go through 5/31/2024.
New Regulations / Contractual Requirements/DHCS Initiatives:	Status

California Advancing and Innovating Medi-Cal (CalAIM)	• **Enhanced Care Management (ECM):** On 2/2/24, DHCS issued to CalViva (and many other MCP plans) a "Pre-Cap" related to the Justice Involved POF with a focus on developing adequate provider networks and increasing uptake for this POF. The Plan provided responses to the Pre-CAP on 3/18/24 and has not heard back. • **Community Supports (CS)**: DHCS approval is still pending for the Community Supports MOC submitted on 1/29/24 for those services going live 7/1/24 [Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties; and Recuperative Care (Madera County].
Long Term Care (LTC) Carve-In Deliverable List – Phase II (ICF/DD and Subacute Care facilities	Effective 1/1/2024, LTC-ICF/DD and Subacute Care services were carved into MCPs statewide. The Plan submitted to DHCS the deliverables associated with LTC-ICF/DD facilities and Subacute facilities on 11/27/23 and 1/29/24, respectively. The Plan is awaiting DHCS approval of this submission. As it regards ICF/DD Network Readiness, the Plan submitted Phase I (i.e., must contract with at least one ICF/DD in the county) on 3/25/24, and received approval on 4/18/24. Phase II Network Readiness deliverables (i.e., additional attempts to contract and execute contracts) are due by 6/28/24.
Memorandum of Understanding (MOU)	DHCS requires each MCP to submit quarterly updates on the status of the multi-party MOUs with third party entities (LGAs, LEAs, LHDs and other MCPs in the county). The Plan's upcoming Q2 Status Report will indicate CalViva executed a DMC-ODS MOU with Fresno County on 4/22/24.
Annual Network Certifications	• 2023 Subnetwork Certification (SNC) – The Plan filed all the required documentation on 1/5/24. DHCS completed their initial review and asked for additional information on 2/20/2024 and 4/30/2024. The Plan submitted the additional information on 2/23/2024 and 5/3/2024 and is awaiting DHCS response. • 2023 Annual Network Certification (ANC) – The Plan submitted the required documentation by 3/25/24 and is awaiting DHCS response.
Timely Access and Annual Network Reporting (TAR)	• RY 2024 MY 2023- The Plan submitted the annual Timely Access Report (TAR) and Annual Network Report (ANR) on 5/1/2024 and is awaiting DMHC response. • RY 2023 MY 2022- DMHC issued a Network Findings Report with two findings related to Geographic Access and Data Accuracy. The Plan's response is due to the DMHC by September 9, 2024.
2024 Network Adequacy Validation (NAV) Audit	DHCS' external auditor, Health Systems Advisory Group (HSAG), sent notification on 3/15/2024 that they will be conducting a new annual Network Adequacy Validation (NAV) audit of MCPs per CMS requirements. The Plan must submit the required documentation by 5/15/2024. The audit will take place between 6/3/2021-7/26/2024.

DMHC Subdelegated Contract Review	On 4/24/24, DMHC requested CalViva to submit, under its DMHC lincense, Health Net's subdelegated contracted vendor agreements for vendors that perform various Knox-Keene functions on behalf of CalViva. The Plan will need to submit all current 19 vendor contracts as separate amendments to the DMHC and any new future subdelegated contracts. Note, this was the first time since DMHC approved CalViva's license in 2010 that it is requiring these subcontract vendor agreements.
NCQA Plan Accreditation	On 5/6/24, Health Net, on behalf of CalViva, submitted CalViva's NCQA Audit documentation. CalViva anticipates filing the NCQA Health Equity Accreditation documents by 3/11/25.
Plan Administration:	**Status**
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 2024.
Committee Report:	**Status**
Public Policy Committee (PPC)	Next Public Policy Committee meeting will be June 5, 2024, 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.

APPENDIX A

2024 DHCS All Plan Letters:

APL 24-001 STREET MEDICINE PROVIDER DEFINITIONS AND PARTICIPATION IN MANAGED CARE

APL 24-002 MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES FOR INDIAN HEALTH CARE PROVIDERS AND AMERICAN INDIAN MEMBERS

APL 24-003 ABORTION SERVICES

APL 24-004 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION REQUIREMENTS

APL 24-005 CALIFORNIA HOUSING AND HOMELESSNESS INCENTIVE

2024 DMHC All Plan Letters:

APL 24-005 - Change Healthcare Cyberattack (3.11.24)

APL 24-006 Annual Provider Directory Filing

APL 24-008 2024HealthPlanAnnualAssessments(4_15_24)

APL 24-009 Change Healthcare Cyberattack Response Filing

Item #13
Attachment 13.D

Medical Management
Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2024

Current as of End of the Month: March
Revised Date: 4/23/2024

CalViva - 2024

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2024 YTD	2023
Expedited Grievances Received	15	8	2	25	0	0	0	0	0	0	0	0	0	0	0	0	25	126
Standard Grievances Received	144	132	147	423	0	0	0	0	0	0	0	0	0	0	0	0	423	1761
Total Grievances Received	**159**	**140**	**149**	**448**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**448**	**1887**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**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%**	**100.00%**	**99.4%**
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	13	9	3	25	0	0	0	0	0	0	0	0	0	0	0	0	25	126
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**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%**	**100.00%**	**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	160	125	132	417	0	0	0	0	0	0	0	0	0	0	0	0	417	1702
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**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%**	**100.00%**	**99.9%**
Total Grievances Resolved	**173**	**134**	**135**	**442**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**442**	**1829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**153**	**118**	**119**	**390**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**390**	**1468**
Access - Other - DMHC	25	24	10	59	0	0	0	0	0	0	0	0	0	0	0	0	59	270
Access - PCP - DHCS	7	4	4	15	0	0	0	0	0	0	9	9	0	0	0	0	7	118
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	10	7	2	19	0	0	0	0	0	0	0	0	0	0	0	0	19	78
Administrative	25	30	35	90	0	0	0	0	0	0	0	0	0	0	0	0	90	186
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	12	12	16	40	0	0	0	0	0	0	0	0	0	0	0	0	40	122
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	35	23	25	83	0	0	0	0	0	0	0	0	0	0	0	0	83	339
Pharmacy/RX Medical Benefit	1	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	1
Transportation - Access	18	7	10	35	0	0	0	0	0	0	0	0	0	0	0	0	35	175
Transportation - Behaviour	8	1	4	13	0	0	0	0	0	0	0	0	0	0	0	0	13	89
Transportation - Other	12	9	12	33	0	0	0	0	0	0	0	0	0	0	0	0	33	86
Quality Of Care Grievances	**20**	**16**	**16**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**361**
Access - Other - DMHC	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3
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	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	3	5	10	0	0	0	0	0	0	0	0	0	0	0	0	10	60
PCP Care	8	5	5	18	0	0	0	0	0	0	0	0	0	0	0	0	18	94
PCP Delay	1	3	4	8	0	0	0	0	0	0	0	0	0	0	0	0	8	116
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	1	2	9	0	0	0	0	0	0	0	0	0	0	0	0	9	60
Specialist Delay	2	3	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	24
Exempt Grievances Received	**146**	**135**	**176**	**457**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**457**	**1885**
Access - Avail of Appt w/ PCP	4	1	2	**7**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**7**	15
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	3	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	7
Access - Wait Time - in office for appt	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	2
Access - Panel Disruption	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	15
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**	3
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	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	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	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	14
Attitude/Service - Provider	6	9	16	**31**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	31	43
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	5
Attitude/Service - Vendor	0	0	6	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	6	4
Attitude/Service - Health Plan	0	1	3	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	4	12
Authorization - Authorization Related	0	2	1	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	6
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	4
Eligibility Issue - Member not eligible per Provider	2	1	4	**7**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	7	48
Health Plan Materials - ID Cards-Not Received	19	17	20	**56**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	56	210
Health Plan Materials - ID Cards-Incorrect Information on Card	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	2
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	4
Mental Health Related	2	3	4	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	9	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	50	48	49	**147**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	147	652
PCP Assignment/Transfer - HCO Assignment - Change Request	15	15	19	**49**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	49	301
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	4	4	11	**19**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	19	37
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	7
PCP Assignment/Transfer - Mileage Inconvenience	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	14
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	1
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	7	4	6	**17**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	17	65
Transportation - Access - Provider Late	2	2	1	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	32
Transportation - Behaviour	4	0	1	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	76
Transportation - Other	2	4	3	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	9	53
OTHER - Other	1	4	5	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	10	14
Claims Complaint - Balance Billing from Provider	28	15	18	**61**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	61	235

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	2	2	6	0	0	0	0	0	0	0	0	0	0	0	0	6	34
Standard Appeals Received	22	17	32	71	0	0	0	0	0	0	0	0	0	0	0	0	71	331
Total Appeals Received	**24**	**19**	**34**	**77**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	77	365
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Appeals Ack Letter Compliance Rate	100.0%	100.0%	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%	100.00%	99.4%
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	3	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	6	35
Expedited Appeals Compliance Rate	100.0%	100.0%	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%	100.00%	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	16	30	12	58	0	0	0	0	0	0	0	0	0	0	0	0	58	325
Standard Appeals Compliance Rate	100.0%	100.0%	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%	100.00%	99.8%
Total Appeals Resolved	**18**	**31**	**15**	**64**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	64	361
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	18	31	15	64	0	0	0	0	0	0	0	0	0	0	0	0	64	353
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	9
DME	2	3	3	8	0	0	0	0	0	0	0	0	0	0	0	0	8	37
Experimental/Investigational	0	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	11	18	1	30	0	0	0	0	0	0	0	0	0	0	0	0	30	162
Other	1	4	4	9	0	0	0	0	0	0	0	0	0	0	0	0	9	35
Pharmacy/RX Medical Benefit	2	3	2	7	0	0	0	0	0	0	0	0	0	0	0	0	7	47
Surgery	2	3	2	7	0	0	0	0	0	0	0	0	0	0	0	0	7	62
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**	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	7
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	8	8	6	**22**	0	0	0	0	0	0	0	0	0	0	0	0	22	156
Uphold Rate	**44.4%**	**25.8%**	**40.0%**	**34.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	34.4%	43.2%
Overturns - Full	9	22	7	**38**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	38	194
Overturn Rate - Full	**50.0%**	**71.0%**	**46.7%**	**59.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	59.4%	53.7%
Overturns - Partials	1	1	1	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	10
Overturn Rate - Partial	**5.6%**	**3.2%**	**6.7%**	**4.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**4.7%**	2.8%
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	1
Withdrawal Rate	**0.0%**	**0.0%**	**6.7%**	**1.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	1.6%	0.3%
Membership	434,122	434,443	434,459		-	-	-		-	-	-		-	-	-			430,517
Appeals - PTMPM	0.04	0.07	0.03	0.05	-	-	-	-	-	-	-	-	-	-	-	-	0.05	0.09
Grievances - PTMPM	0.40	0.31	0.31	0.34	-	-	-	-	-	-	-	-	-	-	-	-	0.34	0.24

CalViva Health Appeals and Grievances Dashboard 2024 (Fresno County)

Fresno County - 2024

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2024 YTD	2023
Expedited Grievances Received	13	7	2	22	0	0	0	0	0	0	0	0	0	0	0	0	22	107
Standard Grievances Received	117	109	131	357	0	0	0	0	0	0	0	0	0	0	0	0	357	1447
Total Grievances Received	**130**	**116**	**133**	**379**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**379**	**1554**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited 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	11	8	3	22	0	0	0	0	0	0	0	0	0	0	0	0	22	107
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**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%**	**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	130	102	109	341	0	0	0	0	0	0	0	0	0	0	0	0	341	1389
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**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%**	**99.9%**
Total Grievances Resolved	**141**	**110**	**112**	**363**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**363**	**1497**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**124**	**97**	**97**	**318**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**318**	**1194**
Access - Other - DMHC	21	19	9	49	0	0	0	0	0	0	0	0	0	0	0	0	49	225
Access - PCP - DHCS	4	4	3	11	0	0	0	0	0	0	0	0	0	0	0	0	11	102
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	9	7	2	18	0	0	0	0	0	0	0	0	0	0	0	0	18	69
Administrative	24	24	29	77	0	0	0	0	0	0	0	0	0	0	0	0	77	160
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	10	10	13	33	0	0	0	0	0	0	0	0	0	0	0	0	33	97
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	28	22	21	71	0	0	0	0	0	0	0	0	0	0	0	0	71	283
Pharmacy/RX Medical Benefit	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Transportation - Access	13	6	6	25	0	0	0	0	0	0	0	0	0	0	0	0	25	126
Transportation - Behaviour	7	1	3	11	0	0	0	0	0	0	0	0	0	0	0	0	11	70
Transportation - Other	7	4	11	22	0	0	0	0	0	0	0	0	0	0	0	0	22	61
Quality Of Care Grievances	**17**	**13**	**15**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**303**
Access - Other - DMHC	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
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	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	2	4	7	0	0	0	0	0	0	0	0	0	0	0	0	7	51
PCP Care	6	5	5	16	0	0	0	0	0	0	0	0	0	0	0	0	16	78
PCP Delay	1	2	4	7	0	0	0	0	0	0	0	0	0	0	0	0	7	97
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	1	2	9	0	0	0	0	0	0	0	0	0	0	0	0	9	54
Specialist Delay	2	3	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	17

CalViva Health Appeals and Grievances Dashboard 2024 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	2	2	6	0	0	0	0	0	0	0	0	0	0	0	0	6	32
Standard Appeals Received	16	10	26	52	0	0	0	0	0	0	0	0	0	0	0	0	52	278
Total Appeals Received	**18**	**12**	**28**	**58**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**58**	**310**
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%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.6%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	3	6	0	0	0	0	0	0	0	0	0	0	0	0	6	32
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**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%**	**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	11	19	9	39	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	39	280
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**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%**	**100.0%**
Total Appeals Resolved	**13**	**20**	**12**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**312**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**13**	**20**	**12**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**304**
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	8
DME	1	2	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	36
Experimental/Investigational	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	8	9	1	18	0	0	0	0	0	0	0	0	0	0	0	0	18	137
Other	1	4	4	9	0	0	0	0	0	0	0	0	0	0	0	0	9	32
Pharmacy/RX Medical Benefit	1	2	1	4	0	0	0	0	0	0	0	0	0	0	0	0	4	39
Surgery	2	3	2	7	0	0	0	0	0	0	0	0	0	0	0	0	7	51
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**	**8**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	3
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	5	4	**14**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	14	139
Uphold Rate	**38.5%**	**25.0%**	**33.3%**	**31.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**31.1%**	**44.6%**
Overturns - Full	7	14	6	**27**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	27	167
Overturn Rate - Full	**53.8%**	**70.0%**	**50.0%**	**60.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**60.0%**	**53.5%**
Overturns - Partials	1	1	1	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	6
Overturn Rate - Partial	**7.7%**	**5.0%**	**8.3%**	**6.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.7%**	**1.9%**
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Withdrawal Rate	**0.0%**	**0.0%**	**8.3%**	**2.2%**	**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%**	**0.0%**
Membership	347,177	347,177	347,194															345,319
Appeals - PTMPM	0.04	0.06	0.03	0.04	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.01	0.06
Grievances - PTMPM	0.41	0.32	0.32	0.35	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.09	0.26

Kings County - 2024																2024	2023
Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	
Expedited Grievances Received	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	9
Standard Grievances Received	11	11	6	28	0	0	0	0	0	0	0	0	0	0	0	0	28	151
Total Grievances Received	**11**	**12**	**6**	**29**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**160**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	100.0%	100.0%	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
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	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	9
Expedited Grievance Compliance rate	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
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	17	9	10	36	0	0	0	0	0	0	0	0	0	0	0	0	36	148
Standard Grievance Compliance rate	100.0%	100.0%	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%	100.00%
Total Grievances Resolved	**17**	**10**	**10**	**37**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**	**157**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**9**	**10**	**33**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**	**128**
Access - Other - DMHC	0	3	1	4	0	0	0	0	0	0	0	0	0	0	0	0	4	22
Access - PCP - DHCS	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	7
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
Administrative	1	2	5	8	0	0	0	0	0	0	0	0	0	0	0	0	8	11
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	10
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	1	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	25
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Access	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	22
Transportation - Behaviour	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Transportation - Other	4	3	1	8	0	0	0	0	0	0	0	0	0	0	0	0	8	20
Quality Of Care Grievances	**3**	**1**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**29**
Access - Other - DMHC	0	1	0	1	0	0	0	0	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	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
PCP Care	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	11
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

CalViva Health Appeals and Grievances Dashboard 2024 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
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	1	1	3	0	0	0	0	0	0	0	0	0	0	0	0	3	11
Total Appeals Received	**1**	**1**	**1**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	11
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%	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
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Compliance Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	2	2	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	11
Standard Appeals Compliance Rate	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
Total Appeals Resolved	**2**	**2**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	0
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**2**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**	12
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	1	0	1	0	0	0	0	0	0	0	0	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	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Pharmacy/RX Medical Benefit	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	5
Uphold Rate	50.0%	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	41.70%
Overturns - Full	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	7
Overturn Rate - Full	50.0%	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	58.30%
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
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
Membership	38,436	38,757	38,756															38436
Appeals - PTMPM	0.05	0.05	-	0.03	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.01	0.026019
Grievances - PTMPM	0.44	0.26	0.26	0.32	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.08	0.33536

CalViva Health Appeals and Grievances Dashboard 2024 (Madera County)

Madera County - 2024																	
Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2024 YTD	2023
Expedited Grievances Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	10
Standard Grievances Received	16	12	10	38	0	0	0	0	0	0	0	0	0	0	0	0	38	163
Total Grievances Received	**18**	**12**	**10**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**	173
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**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%**	99.4%
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	10
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	100.0%
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	14	13	40	0	0	0	0	0	0	0	0	0	0	0	0	40	0
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**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%**	100.0%
Total Grievances Resolved	**15**	**14**	**13**	**42**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**	175
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**12**	**12**	**39**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**	146
Access - Other - DMHC	4	2	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	27
Access - PCP - DHCS	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	9
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Administrative	0	4	1	5	0	0	0	0	0	0	0	0	0	0	0	0	5	15
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	2	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	15
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	0	4	8	0	0	0	0	0	0	0	0	0	0	0	0	8	31
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Transportation - Access	4	1	3	8	0	0	0	0	0	0	0	0	0	0	0	0	8	27
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
Transportation - Other	1	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	5
Quality Of Care Grievances	**0**	**2**	**1**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**	29
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	5
PCP Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
PCP Delay	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	10
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6

CalViva Health Appeals and Grievances Dashboard 2024 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Standard Appeals Received	5	6	5	16	0	0	0	0	0	0	0	0	0	0	0	0	16	38
Total Appeals Received	**5**	**6**	**5**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	16	40
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Expedited Appeals Compliance Rate	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.00%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	9	3	15	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	15	31
Standard Appeals Compliance Rate	100.0%	100.0%	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%	100.0%
Total Appeals Resolved	**3**	**9**	**3**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	15	37
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**9**	**3**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	15	37
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	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Experimental/Investigational	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	8	0	10	0	0	0	0	0	0	0	0	0	0	0	0	10	21
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/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	2	2	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	12
Uphold Rate	**33.3%**	**22.2%**	**66.7%**	**33.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**33.3%**	**32.4%**
Overturns - Full	2	7	1	**10**	0	0	0	**0**	0	0	0	**0**	0	2	0	**7**	10	20
Overturn Rate - Full	**66.7%**	**77.8%**	**33.3%**	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**66.7%**	**54.1%**
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%**	**10.8%**
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%**	**2.7%**
Membership	48,509	48,509	48,509															46,762
Appeals - PTMPM	0.06	0.19	0.06	0.10	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.03	0.06
Grievances - PTMPM	0.31	0.29	0.27	0.29	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.07	0.31

CalViva Health Appeals and Grievances Dashboard 2024 (SPD)

CalViva SPD only - 2024																	
Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	**2024 YTD**	**2023**
Expedited Grievances Received	1	3	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	42
Standard Grievances Received	22	29	29	80	0	0	0	0	0	0	0	0	0	0	0	0	80	564
Total Grievances Received	**23**	**32**	**29**	**84**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**84**	**606**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	99.65%
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	3	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	42
Expedited Grievance Compliance rate	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.00%
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	28	18	30	76	0	0	0	0	0	0	0	0	0	0	0	0	76	550
Standard Grievance Compliance rate	100.0%	100.0%	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%	100.0%
Total Grievances Resolved	**29**	**21**	**30**	**80**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**80**	**592**
Grievance Descriptions - Resolved Cases	**29**	**21**	**30**	**80**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**80**	**592**
Access to primary care	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	41
Access to specialists	7	6	6	19	0	0	0	0	0	0	0	0	0	0	0	0	19	169
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	3	10	0	0	0	0	0	0	0	0	0	0	0	0	10	142
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	6	2	2	10	0	0	0	0	0	0	0	0	0	0	0	0	10	60
QOS Non Access	13	9	18	22	0	0	0	0	0	0	0	0	0	0	0	0	22	164
Exempt Grievances Received	**9**	**6**	**5**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**20**	**88**
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
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**	0
Attitude/Service - Provider	1	2	1	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**4**	1
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Vendor	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Health Plan Materials - ID Cards-Not Received	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	20
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**	0
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
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	2	0	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**5**	19
PCP Assignment/Transfer - HCO Assignment - Change Request	1	0	1	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	19
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0

CalViva Health Appeals and Grievances Dashboard 2024 (SPD)

Pharmacy - Quantity Limit	0	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	0
Pharmacy - Pharmacy-Retail	0	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	0
Transportation - Access - Provider Late	0	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	0
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
OTHER - Other	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Claims Complaint - Balance Billing from Provider	4	1	1	6	0	0	0	0	0	0	0	0	0	0	0	0	0	6	13

CalViva Health Appeals and Grievances Dashboard 2024 (SPD)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Standard Appeals Received	4	5	5	14	0	0	0	0	0	0	0	0	0	0	0	0	14	68
Total Appeals Received	**4**	**5**	**5**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**75**
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	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	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Expedited Appeals Compliance Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	3	0	4	7	0	0	0	0	0	0	0	0	0	0	0	0	7	66
Standard Appeals Compliance Rate	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Total Appeals Resolved	**3**	**0**	**4**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**76**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**5**	**4**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**71**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
DME	1	2	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	13
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	1	2	5	0	0	0	0	0	0	0	0	0	0	0	0	5	22
Other	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Pharmacy/RX Medical Benefit	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	14
Surgery	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	13
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	2	2	1	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	5	30
Uphold Rate	66.7%	0.0%	25.0%	71.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	71.4%	39.5%
Overturns - Full	1	3	2	**6**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	6	44
Overturn Rate - Full	33.3%	0.0%	50.0%	85.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	85.7%	57.89%
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Overturn Rate - Partial	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Withdrawal Rate	0.0%	0.0%	25.0%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.0%
Membership	49,987	49,987	47,341															49,899
Appeals - PTMPM	0.06	-	0.08	0.00	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.06
Grievances - PTMPM	0.58	0.42	0.63	0.00	-	-	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.52

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative Grievance	Balance billing issue, claims delay in processing
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy/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 behavior 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 #13

Attachment 13.E

Medical Management
Key Indicator Report

Healthcare Solutions Reporting
Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 3/01/2024 to 3/31/2024
Report created 4/25/2024

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:
Read Me
Main Report CalVIVA
CalVIVA Commission
CalVIVA Fresno
CalVIVA Kings
CalVIVA Madera
Glossary

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 CALVIVA California SHP
Report from 3/01/2024 to 3/31/2024
Report created 4/25/2024

ER utilization based on Claims data	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Qtr Trend	CY-2023	YTD-2024	YTD-Trend
MEMBERSHIP																				Quarterly Averages				Annual Averages	
Expansion Mbr Months	116,933	117,730	119,132	120,031	121,145	120,818	120,165	119,044	118,421	117,508	116,609		115,570	117,630	120,335		116,736	120,103	120,009	117,513	117,845		118,590	117,845	
Family/Adult/Other Mbr Mos	268,160	268,908	270,443	271,856	272,240	271,242	270,065	268,231	266,906	265,208	263,114		262,735	268,780	267,130		267,795	271,513	269,846	265,076	266,215		268,557	266,215	
SPD Mbr Months	48,284	49,064	49,555	49,767	49,936	50,130	49,918	49,723	49,525	49,225	48,958		46,290	46,063	46,178		45,458	49,753	49,924	49,236	46,177		48,593	46,177	
COUNTS																									
Admits - Count	2,438	2,189	2,139	2,244	2,095	2,196	2,161	1,995	1,975	2,019	2,169		2,279	2,113	2,106		2,233	2,159	2,117	2,054	2,166		2,141	2,166	
Expansion	558	643	641	693	651	702	698	624	593	656	669		716	669	658		598	662	675	639	681		643	681	
Family/Adult/Other	839	919	880	954	886	925	906	873	901	850	929		906	839	941		896	907	901	893	895		899	895	
SPD	975	607	610	591	549	563	545	492	476	506	566		649	586	501		709	583	533	516	579		585	579	
Admits Acute - Count	1,290	1,399	1,389	1,511	1,362	1,436	1,416	1,281	1,289	1,318	1,446		1,351	1,374	1,381		1,346	1,421	1,378	1,351	1,369		1,374	1,369	
Expansion	454	529	527	561	530	582	557	469	475	504	511		517	512	499		486	539	536	497	509		515	509	
Family/Adult/Other	415	450	418	492	401	417	419	415	427	425	490		433	447	480		437	437	417	447	453		435	453	
SPD	418	416	441	454	427	436	433	393	385	386	441		399	411	397		419	441	421	404	402		421	402	
Readmit 30 Day - Count	215	248	235	227	225	256	251	212	225	217	241		225	231	162		241	229	240	228	206		234	206	
Expansion	79	98	90	83	90	119	97	79	84	89	97		88	82	65		94	88	98	90	78		92	78	
Family/Adult/Other	41	63	43	50	38	33	44	32	37	40	36		33	48	33		50	44	36	38	38		42	38	
SPD	95	87	102	94	97	104	110	101	104	88	108		104	101	64		97	98	105	100	90		100	90	
**ER Visits - Count	12,825	14,551	14,500	15,839	13,957	13,986	14,141	13,627	13,600	13,954	14,581		13,317	11,817	6,130		13,318	14,765	13,918	14,045	10,421		14,012	10,421	
Expansion	3,417	3,780	3,779	4,117	3,772	4,013	4,080	3,614	3,742	3,491	3,716		3,628	2,874	1,491		3,547	3,889	3,902	3,650	2,664		3,747	2,664	
Family/Adult/Other	7,856	8,982	8,825	9,631	8,211	7,967	7,971	8,206	8,095	8,569	8,979		7,914	7,460	4,049		8,155	8,889	8,048	8,548	6,474		8,410	6,474	
SPD	1,513	1,743	1,841	2,044	1,928	1,938	2,034	1,759	1,705	1,841	1,827		1,697	1,428	582		1,576	1,938	1,910	1,791	1,236		1,804	1,236	
PER/K																									
Admits Acute - PTMPY	35.5	38.3	37.7	40.8	36.6	38.7	38.4	35.0	35.3	36.4	40.2		38.0	37.9	38.0		37.4	38.4	37.4	37.3	38.0		37.6	38.0	
Expansion	46.6	53.9	53.1	56.1	52.5	57.8	55.6	47.3	48.1	51.5	52.6		53.7	52.2	49.8		50.0	53.9	53.6	50.7	51.9		52.1	51.9	
Family/Adult/Other	18.6	20.1	18.5	21.7	17.7	18.4	18.6	18.6	19.2	19.2	22.3		19.8	20.0	21.6		19.6	19.3	18.5	20.3	20.4		19.4	20.4	
SPD	103.9	101.7	106.8	109.5	102.6	104.4	104.1	94.8	93.3	94.1	108.1		103.4	107.1	103.2		110.6	106.3	101.1	98.5	104.6		104.0	104.6	
Bed Days Acute - PTMPY	195.3	202.0	218.1	215.8	190.5	204.4	200.3	189.5	196.8	203.2	220.9		203.0	200.9	183.9		202.6	208.1	198.1	206.9	195.9		203.9	195.9	
Expansion	266.2	300.5	323.5	313.9	281.3	297.7	327.1	295.6	293.9	300.3	304.6		288.3	309.4	259.5		295.8	306.1	306.8	299.6	285.5		302.1	285.5	
Family/Adult/Other	70.1	83.5	77.0	86.4	65.7	73.3	65.1	65.5	69.9	67.0	96.0		78.5	72.8	78.2		74.1	76.4	68.0	77.6	76.4		74.0	76.4	
SPD	727.4	621.0	744.1	695.4	656.5	699.2	632.2	608.7	656.4	711.3	702.2		704.9	679.7	597.4		725.2	698.6	646.8	689.9	660.7		689.3	660.7	
ALOS Acute	5.5	5.3	5.8	5.3	5.2	5.3	5.2	5.4	5.6	5.6	5.5		5.3	5.3	4.8		5.4	5.4	5.3	5.5	5.2		5.4	5.2	
Expansion	5.7	5.6	6.1	5.6	5.4	5.1	5.9	6.3	6.1	5.8	5.8		5.4	5.9	5.2		5.9	5.7	5.7	5.9	5.5		5.8	5.5	
Family/Adult/Other	3.8	4.2	4.2	4.0	3.7	4.0	3.5	3.5	3.6	3.5	4.3		4.0	3.6	3.6		3.8	4.0	3.7	3.8	3.7		3.8	3.7	
SPD	7.0	6.1	7.0	6.4	6.4	6.7	6.1	6.4	7.0	7.6	6.5		6.8	6.3	5.8		6.6	6.6	6.4	7.0	6.3		6.6	6.3	
Readmit % 30 Day	8.8%	11.3%	11.0%	10.1%	10.7%	11.7%	11.6%	10.6%	11.4%	10.7%	11.1%		9.9%	10.9%	7.7%		10.8%	10.6%	11.3%	11.1%	9.5%		10.9%	9.5%	
Expansion	14.2%	15.2%	14.0%	12.0%	13.8%	17.0%	13.9%	12.7%	14.2%	13.6%	14.5%		12.3%	12.3%	9.9%		15.7%	13.2%	14.6%	14.1%	11.5%		14.4%	11.5%	
Family/Adult/Other	4.9%	6.9%	4.9%	5.2%	4.3%	3.6%	4.9%	3.7%	4.1%	4.7%	3.9%		3.6%	5.7%	3.5%		5.6%	4.8%	4.0%	4.2%	4.2%		4.7%	4.2%	
SPD	9.7%	14.3%	16.7%	15.9%	17.7%	18.5%	20.2%	20.5%	21.8%	17.4%	19.1%		16.0%	17.2%	12.8%		13.7%	16.7%	19.7%	19.4%	15.5%		17.1%	15.5%	
**ER Visits - PTMPY	353.1	398.5	394.0	427.9	375.6	377.2	383.1	371.8	373.0	385.3	405.8		374.2	326.0	168.8		369.9	399.1	377.4	388.0	289.1		383.7	289.1	
Expansion	350.7	385.3	380.7	411.6	373.6	398.6	407.4	364.3	379.2	356.5	382.4		376.7	293.2	148.7		364.7	388.6	390.2	372.7	271.3		379.2	271.3	
Family/Adult/Other	351.6	400.8	391.6	425.1	361.9	352.5	354.2	367.1	363.9	387.7	409.5		361.5	333.1	181.9		365.4	392.9	357.9	387.0	291.8		375.8	291.8	
SPD	376.0	426.3	445.8	492.9	463.3	463.9	489.0	424.5	413.1	448.8	447.8		439.9	372.0	151.2		416.0	467.4	459.2	436.5	321.1		445.4	321.1	
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%	98.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	99.1%	100.0%				
Preservice Urgent	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	96.0%		100.0%	99.1%	100.0%	99.1%	98.2%				
Postservice	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100.0%	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%		100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	95.7%	96.0%	100.0%	100.0%	100.0%	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		96.9%	100.0%	98.9%	100.0%	100.0%				
Deferrals - Urgent	100.0%	N/A	100.0%	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	null	null	NA	NA	NA	NA	NA	NA	NA	NA	NA		null	null	null		null	null	null	null	null				
CCS ID RATE													CCS ID RATE				CCS ID RATE						CCS ID RATE		
CCS %	8.02%	7.98%	7.94%	7.90%	7.90%	7.90%	7.88%	7.83%	7.72%	7.77%	7.70%		7.56%	7.59%	7.63%		8.17%	7.91%	7.87%	7.73%	7.59%		7.92%	7.59%	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 3/01/2024 to 3/31/2024
Report created 4/25/2024

ER utilization based on Claims data	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Qtr Trend	CY-2023	YTD-2024	YTD-Trend
Inpatient Maternity Utilizatin ALL CV Mbrshp — Rate Per Thousand																									
Births	12.5	13.6	13.2	13.3	13.6	14.4	14.7	13.7	14.0	13.2	14.1		14.6	12.8	13.7		13.7	13.4	14.3	13.8	13.7		13.8		
OB % Days	0.6%	2.4%	2.8%	3.9%	4.4%	4.5%	6.7%	5.6%	6.6%	5.9%	5.9%		3.3%	5.7%	9.6%		2.1%	3.7%	5.6%	6.1%	6.2%		17.0%		
OB % Admits	18.7%	22.8%	22.8%	22.0%	24.1%	24.4%	25.1%	25.9%	23.7%	23.4%			22.7%	22.0%	23.7%		22.3%	22.9%	24.9%	24.3%	22.8%		30.0%		
Perinatal Care Management																									
Total Number Of Referrals	135	160	150	149	149	84	132	167	170	147	133		319	201	163		472	598	476	386	683		318	683	
Pending	0	0	0	0	0	0	0	0	0	0	0		4	14	20		0	2	1	21	38		3	38	
Ineligible	1	10	11	5	5	3	3	10	9	8	7		9	8	6		18	32	10	19	23		5	23	
Total Outreached	134	150	139	144	144	81	129	157	161	139	126		306	179	137		454	564	465	346	622		310	622	
Engaged	57	54	51	50	62	64	128	130	146	130	115		225	138	99		157	224	183	137	462		228	462	
Engagement Rate	43%	36%	37%	35%	43%	79%	99%	83%	91%	94%	91%		74%	77%	72%		35%	40%	39%	40%	74%		74%	74%	
Total Cases Managed	309	320	313	316	331	322	394	476	574	600	599		699	687	602		344	432	496	410	936		702	936	
Total Cases Closed	41	57	47	47	70	57	48	58	90	116	127		150	184	136		136	154	182	180	470		150	470	
Cases Remained Open	258	261	258	267	251	261	341	419	478	495	469		547	509	442		199	263	263	224	442		547	442	
Physical Health Case Management																									
Total Number Of Referrals	211	368	343	239	258	198	220	194	161	114	132		187	276	314		799	840	612	407	777		2,658	777	
Pending	0	0	0	0	1	1	2	0	2	4	19		3	2	23		0	1	3	25	28		29	28	
Ineligible	78	68	56	56	52	32	37	32	35	16	22		21	20	33		194	164	101	73	74		532	74	
Total Outreached	133	300	287	183	205	165	181	162	124	94	91		163	254	258		605	675	508	309	675		2,097	675	
Engaged	96	154	173	115	134	116	124	98	81	72	62		81	127	134		343	422	338	215	342		1,318	342	
Engagement Rate	72%	51%	60%	63%	65%	70%	69%	60%	65%	77%	68%		50%	50%	52%		57%	63%	67%	70%	51%		63%	51%	
Total Screened and Refused/Decline	26	97	55	42	35	26	21	29	12	7	13		36	33	39		172	132	76	32	108		412	108	
Unable to Reach	11	49	59	26	36	23	36	35	31	15	16		46	94	85		90	121	94	62	225		367	225	
Total Cases Closed	113	102	105	188	122	128	132	137	107	102	94		115	102	88		325	415	397	303	305		1,440	305	
Cases Remained Open	371	399	464	406	415	399	384	354	336	302	262		226	252	296		399	415	354	262	296		262	296	
Total Cases Managed	491	522	609	616	560	547	538	503	441	403	362		360	372	404		746	848	769	591	621		1723	621	
Complex Case	42	49	68	82	85	85	79	69	61	60	62		65	59	63		61	94	95	84	98		161	98	
Non-Complex Case	449	473	541	534	475	462	459	434	380	343	300		295	313	341		685	754	674	507	523		1562	523	
Transitional Care Services																									
Total Number Of Referrals	98	110	166	301	283	261	338	228	278	277	130		265	290	147		296	750	827	685	702		2,558	702	
Pending	0	0	0	0	0	0	0	0	0	4	13		0	0	9		0	0	0	17	9		17	9	
Ineligible	9	16	9	11	6	10	11	7	13	19	18		43	39	11		33	26	28	50	93		137	93	
Total Outreached	89	94	157	290	277	251	327	221	265	254	99		222	251	127		263	724	799	618	600		2,404	600	
Engaged	72	76	128	275	270	241	322	220	256	217	52		100	164	103		216	673	783	525	367		2,197	367	
Engagement Rate	81%	81%	82%	95%	97%	96%	98%	100%	97%	85%	53%		45%	65%	81%		82%	93%	98%	85%	61%		91%	61%	
Total Screened and Refused/Decline	3	3	4	1	2	6	0	0	6	10	14		31	24	4		7	7	6	30	59		50	59	
Unable to Reach	14	15	25	14	5	4	5	1	3	27	33		91	63	20		40	44	10	63	174		157	174	
Total Cases Closed								212	230	191	79		61	47	129		195	476	645	500	237		1,816	237	
Cases Remained Open	29	19	59	96	73	80	96	69	61	50	12		29	132	107		19	73	69	12	107		12	107	
Total Cases Managed	107	112	147	339	443	357	452	380	382	310	125		126	204	254		265	695	901	654	393		2,248	393	
Behavioral Health Care Management																									
Total Number Of Referrals	76	89	46	59	61	37	51	40	26	40	38		78	91	72		235	166	128	104	241		633	241	
Pending	0	0	0	0	0	0	0	0	0	0	0		0	0	2		0	0	0	0	2		0	2	
Ineligible	6	11	6	4	6	3	4	3	1	5	10		6	5	2		21	16	10	16	13		63	13	
Total Outreached	70	78	40	55	55	34	47	37	25	35	28		72	86	68		214	150	118	88	226		570	226	
Engaged	49	43	28	34	46	27	37	36	25	21	12		37	71	52		139	108	100	58	160		405	160	
Engagement Rate	70%	55%	70%	62%	84%	79%	79%	97%	100%	60%	43%		51.0%	83.0%	76.0%		65%	72%	85%	66%	71%		71%	71%	
Total Screened and Refused/Decline	2	3	4	6	2	1	2	1	0	1	4		2	2	1		6	12	4	5	5		27	5	
Unable to Reach	19	32	8	15	7	6	8	0	0	13	12		33	13	15		69	30	14	25	61		138	61	
Total Cases Closed	61	50	31	48	43	41	46	41	34	26	27		34	25	30		154	122	128	87	89		491	89	
Cases Remained Open	154	149	146	131	138	126	109	106	95	89	75		64	119	142		149	138	106	75	142		75	142	
Total Cases Managed	221	203	179	182	180	164	160	149	129	118	104		113	149	175		307	264	237	170	236		572	236	
Complex Case	9	11	16	16	15	16	16	15	12	15	15		14	10	9		13	17	20	18	18		32	18	
Non-Complex Case	212	192	163	166	165	148	144	134	117	103	89		99	139	166		294	247	217	152	218		540	218	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 3/01/2024 to 3/31/2024
Report created 4/25/2024

ER utilization based on Claims data	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
				First Year of Life Care Management									First Year of Life Care Management				First Year of Life Care Management					First Year of Life Care Management		
Total Number Of Referrals	0	0	0	1	7	15	19	26	28	18	27		32	29	47		0	8	60	73	108		141	108	
Pending	0	0	0	0	0	0	0	0	0	0	0		0	0	1		0	0	0	0	1		0	1	
Ineligible	0	0	0	0	0	0	0	0	0	2	1		1	1	0		0	1	0	3	2		4	2	
Total Outreached	0	0	0	0	0	0	0	0	28	16	26		31	28	46		0	7	60	70	105		137	105	
Engaged	0	0	0	0	0	0	0	0	28	16	21		31	28	46		0	3	60	65	105		128	105	
Engagement Rate	0%	0%	0%	0%	0%	0%	0%	0%	1	1	0.81		100.0%	100.0%	100.0%		0.0%	43.0%	100.0%	93.0%	100.0%		93.0%	100.0%	
Total Screened and Refused/Decline	0	0	0	0	0	0	0	0	0	0	2		0	0	0		0	2	0	2	0		4	0	
Unable to Reach	0	0	0	0	0	0	0	0	0	0	3		0	0	0		0	2	0	3	0		5	0	
Total Cases Closed	0	0	0	0	0	0	0	0	8	4	4		2	8	10		0	0	3	16	20		19	20	
Cases Remained Open	0	0	0	0	0	0	0	0	74	91	108		140	160	196		0	3	56	108	196		108	196	
Total Cases Managed	0	0	0	0	0	0	0	0	88	95	113		143	169	207		0	3	62	125	217		128	217	

Item #13
Attachment 13.F

Medical Management
Quarterly Summary Report

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: May 16th, 2024

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 1 2024 (May 2024)

Purpose of Activity:

This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Case Management, and Population Health Management performance, programs and regulatory activities in Quarter 1 of 2024.

I.   Meetings

Two meetings were held in Quarter 1, one on February 15th and one on March 21st. The following guiding documents were approved at *the February & March meetings*:

1. QI/UM Committee Charter 2024
2. 2023 Quality Improvement End of Year Evaluation
3. 2024 Quality Improvement/Health Education Program Description
4. 2024 Quality Improvement/Health Education Work Plan
5. 2023 Utilization Management/Case Management End of Year Evaluation
6. 2024 Utilization Management Program Description
7. 2024 Case Management Program Description
8. 2024 Utilization Management/Case Management Work Plan
9. Population Health Management Segmentation Report
10. Population Health Management Assessment Report
11. Non-Behavioral Health Member Experience Report
12. Behavioral Health Member Experience Report

In addition, the following general documents were approved at the meetings:
1. Pharmacy Provider Updates
2. Medical Policies
3. Pharmacy Policies

II.   QI Reports -   The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance Dashboard** provides a summary of all grievances to track volumes, turn-around times and case classifications. A year-to-year evaluation is also presented.
   a. The total number of grievances through January 2024 is consistent with recent months.
   b. The "Quality of Service" grievance type represented the majority of grievances.

   c. The volume of "Quality of Care" grievances remained consistent when compared with recent months. Most were related to PCP Care.

   d. Exempt Grievances continue to be lower in volume compared to the prior year. Balanced billing and transportation related grievances continue to be the most common, but transportation related volumes are lower. The focus is currently on high priority transport types such as Dialysis.

   e. The total number of appeals received for the first month of 2024 remained consistent with recent months. Approximately half of cases were advanced imaging denials.

   f. **A & G Validation Audit Report** for Q3 2023 indicates that all cases were reconciled.

2. **Potential Quality Issues (PQI) & Provider Preventable Conditions (PPC) Reporting** provides a summary of the quarterly evaluation of cases/issues that may result in substantial harm to a member. The number of member generated PQI cases reported in the Q4 2023 report was consistent with previous quarters. Non-member generated cases were reported as six (6) and there were sixteen (16) Peer Review cases.

There were no (0) PPC cases ready for review in Q4.

3. **MHN Performance Indicator Report for Behavioral Health** MHN Performance Indicator Report for Behavioral Health Services (Q4 2023) was presented. Fourteen (14) out of the Fifteen (15) metrics met or exceeded their targets.

   a. Accuracy and timeliness of approvals and denials for prior authorization were 94% compliant. Two (2) cases did not meet turn-around times for non-ABA cases. Care manager coached.

   b. There were five (5) PQI cases, zero (0) with Untoward Effects.

   c. All provider disputes were resolved within timeliness standards, resulting in a 100% compliance rate.

4. **The Blood Lead Screening Report** for Quarter 3 2023 was presented. This report describes clinical guidelines for blood lead screening, reporting requirements related to blood lead screening and, emphasizes the importance of parents/caregivers receiving anticipatory guidance related to blood lead poisoning prevention and blood lead level testing and follow-up services from providers. A 5% improvement is noted compared to Q2. Improvement is needed in documentation of anticipatory guidance for parents and increased use of point of care testing may improve rates.

5. **NCQA System Controls CR Oversight Report 2023** identifies any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe:

   a. How primary source verification information is received, dated, and stored.

   b. How modified information is tracked and dated from its initial verification.

   c. Titles or roles of staff who are authorized to review, modify, and delete information, and

   d. Circumstances when modification or deletion is appropriate.

   e. Security controls in place to protect the information from unauthorized modification.

   f. How the organization monitors its compliance with the policies and procedures in factors a-d at least annually and takes appropriate action when applicable.

Quarterly audits were performed with no modifications to CalViva provider records during 2023, there were no cases to audit. The Health Net audit results provided to CalViva reflect 100% compliance with audit criteria therefore monitoring was determined to be adequate with full compliance with policy and procedure.

6. **Additional Quality Improvement Reports were presented** including Initial Health Appointment, Member Incentive Report, County Relations, Performance Improvement Project Updates, and others scheduled for presentation at the QI/UM Committee during Q1.

III. **Access Related Reporting for Q1** included the **Access Work Group minutes from November 28th,2023 and the Access Workgroup Quarterly Reports for Q4 2023 & Q1 2024.**

1. The following are some of the key standing reports/matters approved and discussed:

- **MY 2022 Access and After-Hours CAP Evaluation:** CAPS were issued to 10 Tier 1 PPGs and 11 direct network providers. At the end of 2023, all PPG and Direct Network providers had submitted their Improvement Plans which were reviewed and validated by the Plan. Fifteen (15) Timely Access webinars were held with 190 participants from CVH counties. CAP was officially closed on 2/8/24.
- **Practitioner Availability Report:** A new NCQA required report that included data from Jan to Dec 2022 measuring network availability of PCPs including Family Practice, General Practice, Internal Medicine, and Pediatrics, and includes high volume specialties (OB and Hematology/Oncology) was presented. The report evaluates two aspects of geo-access with time and distance (90% internal standard):
    - PCP within 10 miles or 30 min
    - High volume Specialist within 45 miles or 75 min
- Overall, in terms of time and distance the Plan met the standard. Additionally, physician-to-member ratios were reviewed for PCPs & SCPs. CVH did not meet the ratio standards for Family Practice, General Practice, Internal Medicine, or Oncology/Hematology. It was noted that these specialties and ratios are NCQA-specified. CVH will continue its efforts to improve ratios for specialties not meeting goal.
2. **Other Access-related** reporting included the Standing Referrals Report, Specialty Referrals Report, and Provider Office Wait Time Report.

IV. **UMCM Reports** - The following is a summary of some of the reports and topics reviewed:
1. **The Key Indicator Report (KIR) and Concurrent Review Report** provided data through January 31, 2024. A quarterly comparison was reviewed with the following results:
    a. Utilization for all risk types remained consistent in January 2024.
    b. SPD Admits and Bed Days remain low, and Acute Admits and Bed Days remain consistent.
    c. ER visits per thousand members per year have remained consistent.
    d. Turnaround Times were met in all areas in January 2024.
    e. Case Management (CM) results remain stable and demonstrate positive outcomes in most areas, consistent with previous months.
    f. All members discharged from the hospital will be receiving Transitional Care Services (TCS) first and then directed to other case management services as needed after 30 days.
2. **Inter-rater Reliability Results for Physicians and Non-physicians** is an annual evaluation of UM physicians and staff to ensure InterQual® Clinical Decision Support Criteria along with other evidence-based policies and guidelines are used consistently during clinical reviews for medical necessity.
    All UM staff and physicians undergo InterQual training upon hire with annual updates and retesting. Q4 2023 testing results include:
    a. The initial overall pass rate was 82%.
    b. Following remediation and retesting, the final overall pass rate was 97%.
    c. For all physician and non-physician reviewers who failed to pass the retesting, the Plan initiated documented coaching in Q1-2024.
3. **Case Management and CCM Report** summarizes the Case Management (CM), Transitional Care Services (TCS), MemberConnections, Palliative care, and Emergency Department (ED) diversion activities for 2023 through the fourth quarter. This includes referral volumes, member engagement, and an evaluation of Program effectiveness. This report covered the fourth quarter of 2023 with utilization related outcome measures through third quarter 2023. The outcome measures include Readmission rates, ED utilization, Pre-term deliveries for the OB population, Member satisfaction, and Overall Healthcare costs. Positive results are seen for all outcome measures this quarter.
4. **Additional UMCM Reports** including the CCS report, Inter-rater Reliability Report, PA Member Letter Monitoring, SPD Health Risk Assessment, TurningPoint, NIA/Evolent, MedZed, Enhanced Care Management & Community Supports, and others scheduled for presentation at the QI/UM Committee during Q1.

V. **Pharmacy quarterly reports** include Pharmacy Operations Metrics, Top Medication Prior Authorization (PA) Requests, Inter-rater Reliability Review Report and Quality Assurance Results which were all reviewed for Quarter 4. All metrics are expected to be within 5% of the standard or goal. All metrics were within 5% of the goal this quarter with an average turn-around time rate of 98.6%. Prior authorization volumes were slightly lower in Q4 compared to Q3 with no outliers identified.

    a.   Inter-rater Reliability & Quality Assurance reports identified Criteria Application to be the main issue in Q4 consistent with Q3. In two (2) cases, improper Criteria Application likely led to improper approval or denial decisions. A more detailed review and QA on cases in Q4 has been performed and results have been shared with PA management to address this concern. Quarterly reviews will continue to monitor for improvement.

VI. **HEDIS® Activity**

In Q1, HEDIS® related activities focused on data capture for measurement year 2023 (MY23). Managed Care Medi-Cal health plans will have eighteen (18) quality measures that they will be evaluated on for MY2023 and the Minimum Performance Level (MPL) is the 50th percentile. Activities included:

1. Finalized and submitted the 2024 HEDIS® Roadmap by January 31, 2024.
2. MY2023 HEDIS® data gathering from clinics and providers throughout the three-county area with final submission to DHCS and HSAG by June 14th, 2024 (extended 2 weeks d/t Change Healthcare impact).
3. Completed Annual HEDIS® Audit on March 7th,2024.
4. Initial reports in review for compliance with MCAS measures.

Our current improvement projects are:

- *Clinical - Well Child Visits W-30+6 in AA/Black Population Performance Improvement Project (PIP)2023-2026.* In progress. Working with Black Infant Health to implement interventions for improvement. Next report due to HSAG/DHCS September 2024.

- *Non-clinical – Improve Provider Notifications within 7-days for Members Seen in the E.D. for SUD/MH Issue Performance Improvement Project (PIP) 2023-2026.* In progress. Working with Community Medical Centers to implement interventions for Improvement.

- *Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative April 2024 through March 2025.* In progress. Working with Clinica Sierra Vista (CSV) and IHI to improve WCV through testing of interventions related to Provider/Caregiver Experience, Equitable Scheduling and Community Resources. Reports due to IHI throughout the year. Team meetings with CSV to start in June.

- *Lean (Green) Equity Improvement Projects in Kings (Child Domain) and Madera (Behavioral Health Domain) assigned in April 2024.* A-3 Project Summaries due to DHCS 5/30/24.

- *Comprehensive (Orange) Improvement Project in Fresno County (Child & Behavioral Health Domains) assigned in April 2024.* Fishbone Diagram due to DHCS 5/31/24.

VI. **Findings/Outcomes**

Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the ongoing monitoring of the quality and safety of care provided to CalViva members. No significant compliance issues have been identified. Oversight and monitoring processes will continue.

Item #13
Attachment 13.G

Executive Dashboard

Month	2023 March	2023 April	2023 May	2023 June	2023 July	2023 August	2023 September	2023 October	2023 November	2023 December	2024 January	2024 February	2024 March
CVH Members													
Fresno	351,313	353,806	355,821	357,098	355,405	353,005	350,061	348,373	346,709	345,319	343,493	347,888	348,065
Kings	38,772	39,184	39,372	39,665	39,611	39,697	39,366	38,824	38,583	38,436	38,232	38,901	38,877
Madera	47,408	47,892	48,217	48,323	48,426	48,375	48,124	47,588	47,150	46,762	46,717	48,656	48,684
Total	437,493	440,882	443,410	445,086	443,442	441,077	437,551	434,785	432,442	430,517	428,442	435,445	435,626
SPD	49,750	50,141	50,455	50,626	50,793	50,616	50,476	50,222	49,987	49,899	47,393	47,212	47,029
CVH Mrkt Share	67.14%	67.21%	67.26%	67.28%	67.36%	67.44%	67.46%	67.51%	67.59%	67.65%	67.15%	66.84%	66.83%
ABC Members													
Fresno	157,746	158,447	158,902	159,464	158,068	156,328	155,030	154,141	152,908	151,942	151,485	155,843	155,594
Kings	25,797	25,854	25,987	26,085	25,976	25,952	25,737	25,319	25,075	24,901	25,311	25,600	25,550
Madera	30,579	30,831	30,902	30,915	30,793	30,642	30,333	29,752	29,339	29,018	28,693	29,862	29,595
Total	214,122	215,132	215,791	216,464	214,837	212,922	211,100	209,212	207,322	205,861	205,489	211,305	210,739
Kasier													
Fresno											3,562	3,998	4,627
Kings											2	54	67
Madera											574	673	800
Total											4,138	4,725	5,494
Default													
Fresno	56.64%	54.69%	53.92%	53.61%	55.37%	55.25%	64.51%	55.31%	52.18%	54.90%	48.76%	57.21%	
Kings	64.22%	65.94%	61.94%	61.04%	63.36%	61.54%	56.71%	63.12%	65.00%	58.18%	62.64%	53.82%	
Madera	55.74%	57.61%	59.75%	57.35%	56.39%	55.58%	64.21%	55.26%	58.30%	56.41%	55.86%	54.76%	
County Share of Choice as %													
Fresno	68.58%	69.75%	68.52%	70.20%	69.06%	65.32%	48.06%	66.31%	65.72%	51.27%	66.82%	59.92%	
Kings	65.27%	55.15%	65.50%	56.54%	60.82%	50.51%	65.47%	66.67%	61.84%	69.21%	65.78%	62.47%	
Madera	62.03%	62.69%	61.02%	65.93%	64.78%	63.87%	57.35%	63.79%	66.57%	57.79%	69.02%	58.71%	
Voluntary Disenrollment's													
Fresno													
Kings													
Madera													

IT Communications and Systems	**Active Presence of an External Vulnerability within Systems**	**NO**	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	**NO**	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	**NO**	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	**NO**	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	**NO**	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Age of Workstations	**4 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communication and Systems. The Average Age of Workstations is decreasing as older workstations are being updated.		

		Year	2022	2023	2023	2023	2023	2024
		Quarter	Q4	Q1	Q2	Q3	Q4	Q1
Member Call Center CalViva Health Website	(Main) Member Call Center	# of Calls Received	24,875	35,660	34,897	34,897	34,875	41,520
		# of Calls Answered	24,707	35,418	34,625	34,595	34,533	41,114
		Abandonment Level (Goal < 5%)	0.70%	0.70%	0.80%	0.90%	1.00%	1.00%
		Service Level (Goal 80%)	96%	94%	87%	88%	83%	85%
	Behavioral Health Member Call Center	# of Calls Received	602	813	940	860	1,436	940
		# of Calls Answered	596	808	930	848	1,426	936
		Abandonment Level (Goal < 5%)	1.00%	0.60%	1.10%	1.40%	0.70%	0.40%
		Service Level (Goal 80%)	92%	91%	89%	89%	95%	97%
	Transportation Call Center	# of Calls Received	9,278	12,407	12,107	12,554	8,239	9,469
		# of Calls Answered	9,241	12,394	12,083	12,466	8,181	9,384
		Abandonment Level (Goal < 5%)	0.20%	0.10%	0.00%	0.50%	0.50%	0.60%
		Service Level (Goal 80%)	88%	94%	93%	87%	86%	79%
	CalViva Health Website	# of Users	27,000	54,000	42,000	40,000	45,000	54,000
		Top Page	Do You Qualify?	Main Page	Main Page	Main Page	Main Page	Main Page
		Top Device	Mobile (57%)	Mobile (60%)	Mobile (60%)	Mobile (61%)	Mobile (61%)	Mobile (61%)
		Session Duration	~ 1 minute	~ 2 minutes	~ 1 minute	~ 1 minute	~ 1 minute	~ 1 minute
Message from the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Call Center and Website.							

	Year	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Month	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Hospitals	10	10	10	10	10	10	10
	Clinics	156	157	157	156	156	156	156
	PCP	398	407	392	383	395	396	398
	PCP Extender	328	330	332	357	380	391	392
	Specialist	1463	1471	1470	1493	1461	1468	1471
	Ancillary	239	243	243	244	258	266	278
	Year	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Behavioral Health	530	472	507	593	598	592	353
	Vision	25	30	37	104	110	104	108
	Urgent Care	11	11	12	14	14	16	16
	Acupuncture	4	4	4	4	4	3	3
Provider Network & Engagement Activities	**Year**	**2022**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	% of PCPs Accepting New Patients - Goal (85%)	95%	92%	97%	97%	97%	98%	96%
	% Of Specialists Accepting New Patients - Goal (85%)	98%	97%	97%	98%	98%	98%	98%
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	97%	97%	96%	96%	97%	96%	93%
	Year	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Month	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Providers Touched by Provider Relations	439	560	507	480	597	519	428
	Provider Trainings by Provider Relations	986	1,195	1,698	1,028	821	970	1154
	Year	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
	Total Providers Touched	2,552	1,932	3,354	1,952	1,530	5,554	1,544
	Total Trainings Conducted	808	1,353	257	3,376	5,754	11,238	2,945
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.							

	Year	2022	2022	2022	2023	2023	2023	2023
	Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Claims Processing	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	99% / 99% NO	95% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	94% / 95% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	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% / NA NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	96% / 99% NO	99% / 100% NO	99% / 99% NO	100% / 100% NO	87% / 100% NO	76% / 100% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	78% / 87% YES	81% / 89% YES	90% / 94% YES	82% / 91% YES	91% / 97% NO	95% / 98% NO	99% / 99% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	79% / 95% YES	55% / 89% NO	95% / 100% YES	90% / 100% YES	83% / 98% YES	68% / 92% NO	47% / 89% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	88 / 100% YES	98% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 99% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	94% / 100% YES	99% / 99% NO	99%/100% NO	99%/100% NO	99% / 100% NO	100% / 100% YES	99% / 100% YES
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	64% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure							100% / 100% NO
Message from the CEO	Q4 2023 numbers are available. PPG 9 is a new PPG in the CalViva Health Service Area. Management is working with PPG 1, 3, and 8 on Performance.							

	Year	2022	2022	2022	2023	2023	2023	2023
	Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Provider Disputes	**Medical Provider Disputes Timeliness (45 days)** Goal (95%)	98%	97%	96%	98%	99%	99%	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%	N/A	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	78%	98%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	84%	11%	31%	81%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	45%	85%	71%	40%	66%	65%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	99%	41%	55%	90%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	86%	98%	100%	43%	65%	85%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	100%	100%	47%	63%	97%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	43%	96%	98%	N/A	100%	67%	95%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	99%	99%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)							N/A
Message from the CEO	Q4 2023 numbers are available. Management is working with PPG 2, 3, 4, and 5 on imrproving performance. PPG 9 is a new PPG in the CalViva Health Service area.							