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

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

DATE: February 14, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

Please find the agenda and supporting documents enclosed for the upcoming Commission meeting on:

Thursday, February 20, 2025
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 St.
Visalia, CA 93291

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

Meeting materials have been emailed to you.

Currently, there are **12** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
February 20, 2025
1:30pm - 3:30pm

Meeting Locations:

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

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

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

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B	**Appointed / Reappointed Board of Supervisors Commissioners** • BL 25-001 2025 Appointed / Reappointed BOS Commissioners • Appointment confirmations: *Fresno & Kings Counties* *Action: Ratify reappointment County Board of Supervisors Commissioners*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B	**Fresno County At-Large Seat Nomination(s)** • BL 25-002 Fresno County At-Large Seat Nomination(s) • Application – J. Frye *Action: Approve appointment*	D. Hodge, MD, Chair
5 Action	Attachment 5.A Attachment 5.B Attachment 5.C Attachment 5.D Attachment 5.E	**Consent Agenda:** • Commission Minutes dated 1/16/25 • Finance Committee Minutes dated 10/17/24 • QI/UM Committee Minutes dated 10/17/24 • Compliance Report • 2025 Code of Conduct *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
6		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)**	J. Nkansah, CEO
Information	No attachment		

		A. Conference with Legal Counsel - Existing Litigation, pursuant to Government Code section 54596.9 **a. Fresno County Superior Court Case No. 24CECG02996**	
7 Information	Attachment 7.A Attachment 7.B *No attachment*	**Annual Administration** • BL 25-003 Annual Administration • Form 700 • Ethics Training (*link will be emailed*)	D. Hodge, MD, Chair
8 Action	Attachment 8.A	**Community Support Policy & Procedure** • Community Support Policy *Action: Approve the Community Support Policy*	J. Nkansah, CEO
9 Action	Attachment 9.A Attachment 9.B	**Annual Delegation Oversight of Health Net** • BL 25-004 2024 Annual Delegation Oversight and Monitoring Report of Health Net • Executive Summary 2024 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report *Action: Approve the 2024 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report; and Approve Health Net Community Solutions, Inc. to continue their delegated functions for another year.*	J. Nkansah, CEO
10 Action	Attachment 10.A	**New Ad-Hoc Committee regarding Conference Report Involving Trade Secret** • BL 25-005 New Ad-Hoc Committee regarding Conference Report Involving Trade Secret—Discussion of Service, Program, or Facility with an Estimated Date of Public Disclosure of January 2028 *Action: Approve the new Ad-Hoc Committee*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 11-13* ***One vote will be taken for combined items 11-13***	
11 Action	Attachment 11.A Attachment 11.B	**2024 Annual Quality Improvement & Health Education Work Plan Evaluation** • Executive Summary • Year End Evaluation	P. Marabella, MD, CMO
12 Action	Attachment 12.A Attachment 12.B Attachment 12.C Attachment 12.D	**2024 Annual Utilization Management Case Management Workplan Evaluation** • Executive Summary • Year End Evaluation **2025 Utilization Management Program Description & Change Summary** **2025 Utilization Management Case Management Work Plan**	P. Marabella, MD, CMO

		Action: Approve 2024 Quality Improvement Year End Evaluation, and the 2024 Utilization Management Case Management Year End Evaluation, and 2025 Utilization Management Program Description.	
13 Action		**Care Management**	P. Marabella, MD, CMO
	Attachment 13.A	• 2025 Program Description & Change Summary	
14 Action		**Compliance**	M.L. Leone, CCO
	Attachment 14.A	• 2024 Annual Compliance Program Evaluation	
	Attachment 14.B	• 2025 Compliance Program Description	
	Attachment 14.C	• 2025 Fraud Prevention Program	
	Attachment 14.D	• 2025 Privacy and Security Plan	
	Attachment 14.E	• 2025 Emergency Preparedness & Crisis Response Plan	
		Action: Approve 2024 Compliance Program Evaluation, 2025 Compliance Program Description, 2025 Fraud Prevention Program, the Privacy and Security Plan, and the 2025 Emergency Preparedness & Crisis Response Plan	
15 Action		**Standing Reports**	
		Finance Report	
	Attachment 15.A	• Financials as of December 31, 2024	D. Maychen, CFO
		Medical Management	
	Attachment 15.B	• Appeals and Grievances Report	P. Marabella, MD, CMO
	Attachment 15.C	• Key Indicator Report	
		Equity	S. Xiong-Lopez, Eq. Officer
	Attachment 15.D	• Equity Report	
		Executive Report	
	Attachment 15.E	• Executive Dashboard	J. Nkansah, CEO
	No attachment	• Annual Report – *hard copy provided independent of packet*	
		Action: Accept Standing Reports	
16		**Final Comments from Commission Members and Staff**	
17		**Announcements**	
18		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
19		**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 February 20, 2025, 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-B

Appointed / Reappointed
BOS Commissioners

3.A BL 25-001
3.B Appointment Confirmations

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Garry Bredefeld
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D. - At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
Public Health Department

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

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

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

DATE: February 20, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Appointed / Re-Appointed County BOS Commissioners

BL #: 25-001
Agenda Item 3
Attachment 3.A

Discussion Points:

Fresno County has appointed Supervisor Garry Bredefeld
Fresno County Alternate is Supervisor Pacheco
Kings County has re-appointed Supervisor Joe Neves
Kings County Alternate is Supervisor Rusty Robinson

Term thru:	Commission Seat	Currently Occupied By:
January 2025 January 2025 January 2025 January 2025 January 2026 January 2026	Board of Supervisors—Fresno County Board of Supervisors—Fresno County Alt Board of Supervisors—Kings County Board of Supervisors—Kings County Alt Board of Supervisors—Madera County Board of Supervisors—Madera County Alt	Garry Bredefeld Brian Pacheco Joe Neves Rusty Robinson David Rogers Jordan Wamhoff
March 2027	Madera At-Large Commission Appointed	Paulo Soares
May 2027	Fresno At-Large County Appointed Community Medical Center	Soyla Griffin Aldo De La Torre
January 2025	Fresno At-Large Commission Appointed	John Frye Jr.
May 2027	Valley Children's Hospital	Jennifer Armendariz
May 2025	Fresno At-Large County Appointed Fresno At-Large County Appointed	David Cardona, MD David S. Hodge, MD
March 2026	Kings At-Large County Appointed	Lisa Lewis, Ph.D.
April 2026	Kings At-Large Commission Appointed	Kerry Hydash
May 2026	Fresno At-Large County Appointed	Joyce Fields-Keene
September 2026	Madera At-Large	Aftab Naz, MD
	Indefinite terms:	
	David Luchini, Fresno County Health Dept	
	Rose Mary Rahn, Kings County Health Dept	
	Sara Bosse, Madera County Health Dept	

BOARDS, COMMISSIONS, OR COMMITTEES ON WHICH THE BOARD OF SUPERVISORS SERVE 2025		
	AGENCY	**2025**
16	**Fresno Council of Governments (FCOG)/ Fresno County Rural Transit Agency (FCRTA)/ Fresno County Regional Transportation Mitigation Fee Agency** (Chairman or Designee) *Alternate	Pacheco *Magsig
17	**Fresno County Tobacco Funding Corporation** (Vice President)	Bredefeld Chavez (V.P.)
18	**Fresno/Clovis Convention & Visitors Bureau** (Chairman or Designees)	Magsig PW&P Designee
19	**Fresno-Kings-Madera Regional Health Authority** *Alternate	Bredefeld *Pacheco
20	**Fresno-Madera Area Agency on Aging - Governing Board** *Alternate	Bredefeld *Remaining Board Members
21	**Fresno Regional Workforce Development Board**	Chavez
22	**Kings River East Groundwater Sustainability Agency** (Chairman or Designees)	Mendes *PW&P Designee
23	**Law Library Board of Trustees** (Chairman, another Board Member, or a member of the Bar Association)	Bredefeld
24	**Local Agency Formation Commission (LAFCo)** *Alternate	Mendes Magsig *Vacant
25	**McMullin Area of Kings Groundwater Sustainability Agency** *Alternate	Pacheco *Mendes
26	**North Fork Kings Groundwater Sustainability Agency**	Mendes
27	**North Kings Groundwater Sustainability Agency** *Alternate	Pacheco *Mendes
28	**Pleasant Valley State Prison Citizens Advisory Committee**	Mendes Pacheco
29	**Retirement Board**	Magsig
30	**San Joaquin River Conservancy** *Alternates	Bredefeld *Pacheco *Magsig

COUNTY OF KINGS
BOARD OF SUPERVISORS

KINGS COUNTY GOVERNMENT CENTER
1400 W. LACEY BOULEVARD.HANFORD, CA 93230
(559) 852-2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

January 14, 2025

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

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

Dear Cheryl;

At a regular meeting of Kings County Board of Supervisors on January 14, 2025, the following members were appointed to the CalViva - Fresno/Kings/Madera Regional Health Authority:

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

Alternate Appointments
Rusty Robinson, Supervisor Dist. 4
1400 W. Lacey Blvd
Hanford, CA 93230
(559) 852-2367
rusty.robinson@co.kings.ca.us

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

Respectfully,

Catherine Venturella,
Clerk to the Board of Supervisors

Item #4

Fresno County
At-Large Seat Nomination

4.A BL 25-002
4.B Application (J. Frye)

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Garry Bredefeld
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D.- At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
Public Health Department

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

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

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

DATE: February 20, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Commission Appointed – Fresno At-Large Seat

BL #: 25-002
Agenda Item 4
Attachment 4.A

BACKGROUND:

Under the terms of the Joint Exercise of Powers Agreement (JPA) between the Counties of Fresno, Kings and Madera (Section 6.B.2) and the Bylaws of the Fresno-Kings-Madera Regional Health Authority Commission (Section 2.3.4), the Commission shall appoint three (3) At-Large commissioners (one person representing each county). The appointees must be a resident of or employed in the county they are representing.

Qualified applicants shall represent the general public, beneficiaries, physicians; hospitals, clinics and other non-physician health care provider. Individuals considering Commission at-large positions should have a commitment to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances, delivers high quality care and is financially viable.

DISCUSSION:

The Commission Appointed Fresno At-Large position is up for reappointment as of January 2025.

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

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

RECOMMENDED ACTION:

Review application and reappoint Fresno County At-Large Commissioner for a three year term.

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

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

Name of Applicant: John W Frye Jr
Home Address: City: Fresno Zip: 93711
Current Employer: Retired (Jan 1, 2018)
Business Address: N/A City: Zip:
Home Phone: (559) 974-1530 Work Phone: N/A E-mail Address: jwfryejr@aol.com

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

RHA Commissioner Fresno Count at large (— to Present)
RHA Commissioner at large (—to—)

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

Central Valley Health Plan (2016-17)
Valu Care (1997-2000)

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

Healthcare Executive in area hospitals (urban & rural) for 38 years
Experience with health plans & Medi-Cal

List community organizations to which you belong:

Poverello House Board Finance Committee (1998- present)
Poverello House Board Member (1992-2019), Chair (2016-17)

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

None

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

None

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

1. Name: Greg Hund
   Affiliation: Retired CEO – Cal Viva
   Contact Phone Number: (559) 967-2317
2. Name: Nancy Hollingsworth
   Affiliation: Retired CEO- Saint Agnes Medical Center
   Contact Phone Number: (559) 301-1712
3. Name: Steve Barsotti
   Affiliation: Past Board Chair- Madera Community Hospital
   Contact Phone Number: (559) 674-8536

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

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

(Signature)

12/19/2024
(Date)

COMPLETE FORM AND RETURN TO:

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

Applications will be kept on file for a year.

Item #5
Attachment 5.A-E

Consent Agenda

5.A Commission Minutes 1/16/25
5.B Finance Minutes 10/17/24
5.C QIUM Minutes 10/17/24
5.D Compliance Report
5.E 2025 Code of Conduct

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
January 16, 2025

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	✓	**Jennifer Armendariz**, Valley Children's Hospital Appointee
			Paulo Soares, Commission At-large Appointee, Madera County
	Commission Staff		
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)	✓	**Amy Schneider**, R.N., Senior Director of Medical Management
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Cheryl Hurley**, Commission Clerk, Director Office/HR
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Sia Xiong-Lopez**, Equity Officer
✓	**Mary Lourdes Leone**, Chief Compliance Officer		
	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 1:32 pm. A quorum was present.		
#2 Roll Call	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
Cheryl Hurley, Clerk to the Commission	Supervisor Quintero was presented with a plaque and thanked for his service on the FKM RHA Commission from 2017 – 2024. Supervisor Quintero departed the meeting after this presentation, as his service to the Commission ended January 7, 2025.		
#3 Consent Agenda • *Commission Minutes dated 10/17/24.* • *Finance Committee Minutes dated 9/19/24.* • *QI/UM Committee Minutes dated 9/19/24.* • *Public Policy Committee Minutes dated 9/4/24.* Action J. Neves, Vice-Chair	All consent items were presented and accepted as read. *Dr. Hodge arrived at 1:49 pm during Closed Session; not included in vote*		***Motion**: Consent Agenda was approved.* *11 – 0 – 0 – 5* *(Rogers / Frye)* *A roll call was taken*
#4 Closed Session	Jason Epperson, General Counsel, reported out of closed session. The Commission met in closed session to discuss items agendized specifically item 4A Conference with Legal Counsel - Existing Litigation, pursuant to Government Code section 54596.9. Fresno County Superior Court Case No. 24CECG02996; item 4B Conference Report Involving Trade Secrets; and item 4C Conference Report Involving Trade Secrets. The Commission discussed those items, and direction was given to staff. There were no other reportable actions, and they recessed from Closed Session at 2:09 pm.		
#5 Draft CY 2025 Rates Information D. Maychen, CFO	The draft CY 2025 rates were received late October 2024. After reviewing and analyzing those rates, it appeared those rates are lower than what the plan believes to be sufficient. There are numerous factors contributing to those findings. In developing the 2025 draft rates, DHCS used utilization claims data from FY 2023. The problem with that is recently the Plan has seen a substantial increase in utilization in the 2024 utilization data. Specifically related to the Community Supports services that came into effect as part of the CalAIM initiative in 2022. When this program rolled out in 2022, utilization was relatively low, as a		***No Motion***

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	high number of members were not yet aware of these new services, but as promotion of these new services increased over the past two years, utilization has substantially increased. Based off the draft 2025 rate calculations, DHCS will be funding approximately 6% of the cost of the Community Supports services for CY 2025. The Plan requested DHCS review more current utilization data from 2024 to develop the 2025 rates. In addition, when DHCS drafts the rates, they perform a population acuity adjustment to see how severely ill the membership is. DHCS did increase it from the 2024 rates; however, what the Plan has seen in recent claims data is an increase in acuity. The Plan believes that one of the contributing factors are the transitioning population of undocumented immigrants ages 26-49 that began receiving Medi-Cal benefits in January 2024, and also pent-up demand from COVID-19 for medical services which is why Plans are asking DHCS to look at more recent utilization data when applying the acuity adjustment. Plans asked DHCS for transparency in what their rate assumptions are and how many they believe are LTC members in that combined rate. Previously, when DHCS made substantial changes to rates, Plans were given forewarning and allowed feedback; in this current case, DHCS made the change without giving Plans the option to provide feedback. CVH provided a comment letter to DHCS voicing concerns; within that letter it was stated that if the concerns are not addressed, the Plan would potentially file a Notice of Dispute which is legal action challenging the rate DHCS has published. Plan CEOs and Plan CFOs met with DHCS leadership to communicate concerns, and around late December, DHCS revised the CY 2025 rates, noting that DHCS did increase the rates and used more recent claims and utilization data. At this point upon reviewing those revised CY 2025 rates, the Plan does not believe a Notice of Dispute will be filed. It appears the rates are more in line with current utilization and projected utilization and medical costs.		
#6 Quarterly CAHPS Root Cause Analysis Report Action P. Marabella, CMO	Dr. Marabella presented the new Quarterly CAHPS Root Cause Analysis Report. NCQA accreditation requires that health plans evaluate member satisfaction for physical health at least annually, evaluate member satisfaction for behavioral health at least annually, and aggregate all complaints and appeals into the following required categories: • Quality of Care		***Motion**: Approve Quarterly CAHPS Root Cause Analysis Report* *12 – 0 – 0 – 4* *(Neves / Naz)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Access • Attitude and Service • Billing and Financial Issues • Quality of Practitioner Office Site Data is captured through member surveys (CAHPS & ECHO Surveys) annually and analyzed to identify opportunities for improvement, set priorities and decide which opportunities to pursue in the coming year. Once priority areas are identified, then the Plan will implement actions to improve member satisfaction and address the priority issues identified. On a quarterly basis throughout the year, monitoring is performed using Member Complaint and Appeal data categorized in a similar fashion. This allows the Plan to evaluate the success of actions taken in an ongoing manner and identify early any new trends. At the end of the year an evaluation is performed using the same data sources identified above to assess the effectiveness of the actions taken and modify the plan accordingly for future improvements (prior survey results are compared to the new survey results. The quarterly monitoring process is: • CAHPS Team conducts root cause analysis (RCA) to highlight member pain points. • Analysis is based on resolved cases. • Conducted on a quarterly basis. • To better understand CAHPS results, rate movement, and identify any new areas for improvement. Grievance definition used: • An expression of dissatisfaction with any aspect of the operations, activities, or behavior of one's health plan, or its providers, regardless of whether remedial action is requested. Appeal definition used: • A request for your health plan to review a decision that denies a benefit or payment. All of the Appeals and Grievances (A&G) data comes from the A&G Ops team. The following trends were discussed:		*A roll call was taken.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	<u>Year-over-Year comparison for Q3 Appeals & Grievances volume by County (2023 to 2024):</u> • There was an increase in the **appeals** volume in Q3 2024 for Fresno (45.6%), Kings (100%), and Madera (200%) counties, which resulted in a higher PTMPY rate compared to 2023 Q3. • There was an increase in the volume of **grievances** (12.2%) in Fresno County. Kings and Madera counties showed a decrease of 28.3% and 36.9% respectively compared to 2023 Q3. <u>2024 Q1 – Q3 Trends for Appeals & Grievances volume comparison by County</u>: • Appeals showed an increase in volume of 29.2% in Fresno County, 20% in Kings County, and a decrease of 21% in Madera County compared to Q2. • Overall, grievance volume for Q3 showed a slight decrease compared to Q2 in Fresno (1.64%) and Madera (28%) counties. Kings County stayed the same as Q2. <u>Year over Year comparison for Q3 Top Appeal & Grievance trends by Classification Codes (2023 to 2024):</u> • In 2024 Q3, there was a 60.2% increase in appeals for Not Medically Necessary classification code compared to 2023 Q3. • For grievances, there was a decrease in 3 of the top 5 grievances: 5.4% in Access to Care, 30.1% Balanced Billing, and 22% Quality of Care – PCP compared to 2023 Q3. • Administrative Issues and transportation grievances had an increase of 85% and 17.2% respectively compared to last year, same quarter. <u>Quarter over Quarter 2024 Top Appeal & Grievance trends by Classification Codes</u>: • In 2024 Q3, there was a 19.8% *increase* in appeals for *Not Medically Necessary* classification code compared to 2024 Q2. • For grievances, *an increase* was noted in 3 of the top 5 grievances in volume, 11.4% in Access to Care, 2.7% Administrative Issues, 36% Transportation compared to 2024 Q1. • There was a decrease of 34.8% in Balance Billing and 6.1% in Quality of Care - PCP grievances in 2024 Q3 compared to 2024 Q2.	*Commissioner De Le Torre asked what the overturn rate is on Appeals?* *Dr. Marabella stated the overturn rate has been higher than desired as most of the Appeals have to do with Advanced Imaging and the problem with Imaging is incorrect or insufficient information being submitted by the requesting provider. Once correct information is submitted it's overturned.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Trending Appeals by Category: • In 2024 Q3, appeals appear steady compared to last year, same time, in two out of the four categories. Diagnostic –CAT Scan had an increase of 166.6% compared to 2023 Q3. • As for 2024 Q2 & Q3 appeals, there was an increase of 42.1% in the category of Diagnostic – MRI. Other – Self Injectable Medication and Outpatient – Procedure appeals returned after skipping 2024 Q2 (0 cases) with an increase of 180% and 175% compared to 2024 Q1. Trending Grievances by Category: • Most of the trending grievances had a decrease in 2024 Q3 compared to 2023 Q3. • Prior Authorization Delay (13.7%), Transportation Missed Appointment (70.2%), and Inappropriate Payment Demand (participating providers) (30.6%) had a decrease in volume compared to 2023 Q3. • The trending grievances that had a noted increase are PCP Referral for Services of 200% and Health Plan of 420% compared to 2023 Q3. • Prior Authorization Delay and Inappropriate Payment Demand (participating providers) volume showed an improvement of 15.3%, Referral Process of 57.1%, and Inappropriate Payment Demand (participating providers) of 27.1% in Q3 compared to Q2. • There was an increase in grievance volume in PCP Referral for Services of 114.2% and Delay in Referral by PCP of 116.6% from previous quarter. Actions and next steps include: • Live and recorded Provider Training Webinars started in July 2024 to address Prior Authorizations and e-consults. • Best Practices Tip Sheet was released in September 2024 with guidelines developed for Prior Authorizations on how to avoid processing delays and improve member satisfaction. • Corrective Action Plans (CAPs) for PPGs with low scores in the PAAS and PAHAS surveys to improve timeliness of appointments with PCPs and Specialists.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Isolated appeals cases had discussion with Plan leadership on issues and opportunities to improve members' experience with PPG leaders. • Future activities include analyzing CAHPS results and A&G quarterly data at the CalViva A & G Work Group to identify priority opportunities and establish interventions to address identified issues and improve member satisfaction.		
#7 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of September 30, 2024</u> As of September 30, 2024, total current assets recorded were approximately $494.8M; total current liabilities were approximately $338.4M. Current ratio is approximately 1.46. Total net equity as of the end of September 2024 was approximately $166.2M, which is approximately 643% above the minimum DMHC required TNE amount. As of the end of September interest income actual recorded was approximately $2.9M, which is approximately $1.6M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately $502.9M which is approximately $41M more than budgeted due to enrollment being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $342.2M which is approximately $39.9M more than budgeted due to enrollment being higher than projected. License expense actual recorded was approximately $373K which is approximately $16K more than budgeted due to DMHC's license fee assessment rate being higher than projected. Recruitment expense was approximately -$549 due to a timing issue and a credit back from a job posting. Total net income for the first three months of FY 2025 actual recorded was approximately $4.5M, which is approximately $2.8M more than budgeted primarily due to interest income being approximately $1.6M higher than projected and enrollment being higher than projected.		***Motion**: Standing Reports Approved* *10 – 0 – 0 – 6* *(Frye / Neves)* *A roll call was taken.* *David Luchini left meeting at 3:06 pm, not included in vote.* *Dr. Naz left meeting at 3:09 pm, not included in vote.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Compliance** M.L. Leone, CCO	**Compliance Report** Year to date there have been 357 Administrative & Operational regulatory filings for 2024; 46 Member Materials filed for approval; 149 Provider Materials reviewed and distributed, and 119 DMHC filings. There have been 33 potential Privacy & Security breach cases reported year to date, with three (3) being high risk. Since the 10/17/2024 Compliance Regulatory Report to the Commission, there were seven (7) new MC609 cases filed, with a year to date total of 24. There are 29 cases that remain open and under investigation. The 7 new cases encompassed: • 3 of the cases involved hospice care providers who had duplicate and overlapping hospice services. • 1 case involved a participating provider for excessive billing and upcoding. • 1 case involved a participating provider for unnecessary drug testing and illegal remuneration. • 1 case involved a non-participating provider receiving payment for services outside of their current active CLIA. • 1 case of a provider with possible services not rendered or was a possible "phantom" provider. The Annual Oversight Audits currently in progress since last reported include UMCM, Access & Availability, and Call Center. Audits completed were ER (CAP required), Privacy & Security (CAP required), Provider Network (CAP required), Claims (CAP required), Health Education (no CAP), Continuity of Care (no CAP), Fraud, Wate & Abuse (no CAP), and Pharmacy (no CAP). Regarding the DHCS 2023 Focused Audit for Behavioral Health and Transportation, on 9/6/24, the Plan received DHCS' Final Report findings and formal CAP request. There were nine deficiencies (4 for behavioral health and 5 for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	required to submit monthly updates on all CAP activities. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 1/10/25. Regarding the DHCS 2024 Medical Audit, on 10/3/2024, DHCS sent out the 2024 Audit Report and CAP request. There were two deficiencies. The Plan has since submitted updates on 11/1/24 and 12/1/24. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 2/1/25. Regarding the DMHC 2025 Medical Follow-Up Audit, on 1/6/25, the Plan received written notice from the DMHC of their intent to conduct a "Follow-Up" Audit of the outstanding deficiencies from the 4/18/24 Final Report of the 2022 Routine Medical Survey. The deficiencies concerned the Plan failing to identify potential quality issues (PQIs) in exempt grievances and inappropriately denying payment of post-stabilization care. All requested documents must be submitted by 2/5/25. Regarding the 2023 Annual Network Certification, on 11/15/24, the Plan received DHCS written notice that the Plan was deemed compliant and had passed the 2023 ANC with no deficiencies. Regarding the 2023 Subnetwork Certification, on 12/10/24, the Plan received written notice that all deficiencies had been corrected and closed the 2023 SNC. Regarding the 2024 Subnetwork Certification Landscape Analysis, on 9/25/2024, the Plan received the 2024 SNC preliminary request for the Landscape Analysis and submitted a response on 10/25/2024. On 1/3/2025, the Plan submitted the 2024 SNC deliverable certifying subnetwork compliance with network adequacy and access standards. With regard to Population Health Management, MCPs are required to submit the PHM Strategy Deliverable to DHCS annually. The purpose of the annual PHM Strategy Deliverable is for MCPs to demonstrate their engagement in local health jurisdictions' (LHJs) community health assessments (CHAs) and community health improvement plans (CHIPs) and provide other updates on the MCP's		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	implementation of the PHM Program to inform DHCS' monitoring efforts. CalViva is required to submit its PHM Strategy deliverable by 11/22/24. With regard to the Non-Discrimination Notice, the Plan has posted to the CalViva website its revised Non-Discrimination Notice (NDN). The revisions were made to be compliant with the Office for Civil Rights (OCR) Final Rule under section 1557 of the Affordable Care Act (ACA) as published in the Federal Register on May 6, 2024. The NDN was required to be updated anywhere it is used no later than November 2, 2024. The Plan has posted the revised notice on its website and in the lobby of its administrative office. With regard to the Notice of Privacy Practices, The Plan has revised its NOPP to include additional language specific to how a member's race, ethnicity, language, sexual orientation, and gender identity will be protected, and additional language on how the Plan processes a member request Confidential Communications. This has been included in the Plan's DHCS/DMHC-approved 2025 Member Handbook and will be posted to the Plan's website. Since the last update to the Commission, the Plan has executed two additional MOUs with Kings County: The Kings County Department of Behavioral Health DMC MOU, and the Kings County Department of Public Health WIC MOU. The Public Policy Committee met on December 4, 2024. The following reports were presented: • 2024 Work Plan Mid-Year Evaluation • 2024 Executive Summary and Work Plan Mid-Year Evaluation • 2024 Summary and Language Assistance Program Mid-Year Report • MY 2023 Quality Improvement & HEDIS Update • Q3 2024 Appeal and Grievance Report • A&G Dashboard review by Dr. Marabella Additionally, the PPC was given a presentation on Social Determinants of Health and asked to provide feedback on the Plan's goals for mitigating social risks. A review of the online portal "Community Connect" powered by Findhelp was given to demonstrate how members' social needs are assessed, and also how members		

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• **Medical Management** P. Marabella, MD, CMO	and providers can utilize Community Connect to refer members to various social service resources and programs. The next PPC meeting will be held on March 5, 32025, 11:30am-1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through Q3 2024. • The total number of grievances through Q3 2024 remains high when compared to previous YTD. The Quality-of-Service category represents the highest volume of total grievances. • For the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Access-Other, Administrative, and Interpersonal. Balanced Billing continues to be an issue and is being addressed. Transportation Access has improved. • The volume of Quality of Care (QOC) cases remains consistent when compared to previous YTD. • The volume of Exempt Grievances remains consistent when compared to previous YTD. • Total Appeals volume has significantly increased when compared to previous YTD. The majority being Consultation, DME, Advanced Imaging, and Other (SNF-Long Term Care related). Uphold and overturn rates remain consistent. <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through Q3 2024. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through Q3 2024.		

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

	• Acute Admissions, Bed Days, and Acute Length of Stay (all adjusted PTMPY), for TANF, MCE, and SPDs remain consistent with recent months with the following exceptions:
	  ○ For Bed Days (adjusted PTMPY), there is a steady decline compared to previous year.
	  ○ Acute Length of Stay (adjusted PTMPY) also shows a decline.
	• Readmission rates have declined with the assistance of Case Management.
	
	Case Management (CM) engagement rates are up, and all areas continue to improve.
	
	<u>QIUM Quarterly Summary Report</u>
	
	Dr. Marabella provided the QI, UMCM, and Population Health update for Q4 2024. Two meetings were held in Quarter 4, one on October 17th, 2024, and one on November 21st, 2024.
	
	The following program documents were approved:
	1. 2024 Health Equity Work Plan Mid-Year Evaluation & Executive Summary
	2. 2024 Health Equity Language Assistance Program Mid-Year Report
	3. Quality Improvement Health Equity Transformation Program 2024
	
	In addition, the following general documents were adopted/approved at the meetings:
	1. Medical Policies Update
	2. Pharmacy Provider Updates
	3. Public Health Policies & Procedures Annual Review
	4. Utilization Management & Care Management Policies and Procedures Annual Review
	5. 2024 Preventive Health Guidelines for Members
	
	The following Oversight Audit Results were presented and accepted at the October meeting:
	1. 2024 Appeals and Grievances Oversight Audit		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The following Quality Improvement Reports were reviewed: Appeals and Grievance Dashboard & Quarterly Reports for Q3 2024; Behavioral Health Performance Indicator Report; and Facility site & Medical Record & PARS Review Report. Additional Quality Improvement reports from Q2 & Q3 were reviewed as scheduled during Q4. The following Access Reports were reviewed: Provider Appointment Availability (PAAS) & After-Hours Access Survey (PAHAS) Results, Access Workgroup Quarterly Reports for Q4, and the Access Work Group minutes from July 30th, 2024. Other Access-related reporting included the Standing Referrals Report, Provider Office Wait Time, and Specialty Referrals Report. The Utilization Management & Case Management reports reviewed were the Key Indicator Report & UM Concurrent Review Report. Additional UMCM reports were reviewed as scheduled during Q4. Pharmacy quarterly reports reviewed were Pharmacy Executive Summary, Operation Metrics, Top 25 Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR). The Q4 HEDIS® Activities were focused on analyzing the results for MY2023 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile and initiating or enhancing activities to address opportunities for improvement. Quality Improvement Activities included two Performance Improvement Projects, the Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative, the Lean Equity Improvement Projects, and the Comprehensive Improvement Project. No significant compliance issues have been identified. Oversight and monitoring processes will continue. <u>Credentialing Sub-Committee Quarterly Report</u>		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The Credentialing Sub-Committee met on October 17, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. The 2025 Credentialing Sub-Committee meeting dates were presented and approved. Reports covering the second quarter for 2024 were reviewed for delegated entities and third quarter 2024 for Health Net including Behavioral Health. The 2024 Adverse Events report for Q3 was reviewed. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period. There was one (1) case identified in Q3 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 third quarter of 2024. There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of appointment availability. There were no (0) cases identified outside of the ongoing monitoring process this quarter. The Access & Availability Substantial Harm Report Q3 2024 was presented and reviewed. The purpose of this report is to identify incidents of 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 Issue (PQI) cases identified related to appointment availability and the cases are ranked by severity level. After a thorough review of all third quarter 2024 PQI/QOC cases, the Credentialing Department identified zero (0) new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1). Credentialing Adverse Actions for Q3 for CalViva Credentialing Sub-Committee from Health Net Credentialing Committee was presented. There were two (2) cases presented for discussion for July, August, and September for CalViva Health. One (1) case was placed on pending status awaiting the Medical Board of California's decision and one (1) case was placed on annual monitoring for compliance with the Medical Board of California's orders. Ongoing monitoring and reporting will continue.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Peer Review Sub-Committee Quarterly Report The Peer Review Sub-Committee met on October 17th, 2024. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2024 were reviewed for approval. There were no significant cases to report. The 2025 Peer Review Sub-Committee meeting dates were presented and approved. The 2024 Adverse Events Report for Q3 was reviewed. This report provides a summary of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. This includes all cases with a severity code level of III or IV, or any case the CalViva CMO requests to be forwarded to the Peer Review Committee. There were nine (9) cases identified in Q3 that met the criteria for reporting and were submitted to the Peer Review Committee. Six (6) of these cases involved a practitioner and three (3) cases involved organizational providers (facilities). Of the nine (9) cases, three (3) were tabled, one (1) was deferred, one (1) was closed to track and trend with a letter of concern, and four (4) were closed to track and trend. Five (5) cases involved Seniors and Persons with Disabilities (SPDs), and none (0) involved Behavioral Health. There were no (0) incidents involving appointment availability resulting in substantial harm to a member or members in Q3. There were no (0) cases that met the Peer Review trended criteria for escalation. There were no (0) cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4) There were thirty-four (34) cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. The Access & Availability Substantial Harm Report for Q3 2024 was also presented. The purpose of this report is to identify 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 grievances Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability issues, and they are ranked by		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	severity level. Eighteen (18) cases were submitted to the Peer Review Committee in Q3 2024. There was one (1) incident found involving appointment availability issues without significant harm to a member. Two (2) cases were determined to be related to significant harm to a member but without appointment availability issues. No cases (0) were related to behavioral health issues. There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2024. Quarter 3, 2024 Peer Count Report was presented at the meeting with a total of eighteen (18) cases reviewed. There were eleven (11) cases closed and cleared. There were three (3) cases tabled for further information. Two (2) cases were pending closure for CAP compliance and one (1) case was deferred. One (1) case with CAP outstanding/continued monitoring. There were no (0) cases closed/terminated. Follow up will be initiated to obtain additional information for tabled cases and ongoing monitoring and reporting will continue. **Executive Report** <u>Executive Dashboard</u> Enrollment as of September 2024 is 435,615. Kaiser enrollment as of November is approximately 9,000 and is approaching what their membership was at the time CVH had a relationship with them in 2017. In 2025, Kaiser will accept Auto Assignment activity up to 5,900 members; however, Kaiser will not take on auto assignments in Fresno, Kings, or Madera counties. Regarding Information Technology Communications & Systems, the average age of workstations is decreasing as older workstations are being updated. The cybersecurity assessment is in progress with the final report to follow.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding the Call Center and CVH Website, efforts remain ongoing to allow Members a self-service option to gain access to their Member ID Card through the CalViva Health Website. Scheduled implementation by Q1 2025. Regarding Provider Activities, Claims Processing, and Provider Disputes, there are no significant issues or concerns.		
#8 Final Comments from Commission Members and Staff	None.		
#9 Announcements	None.		
#10 Public Comment	None.		
#11 Adjourn	The meeting adjourned at 3:10 pm. The next Commission meeting is scheduled for February 20, 2025, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

October 17, 2024

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

	Finance Committee Members in Attendance		CalViva Health Staff in Attendance
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Director, HR/Office
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
	Paulo Soares	✓	Hector Torres, Sr. Accountant & MIS Analyst
✓	Joe Neves		
✓	Supervisor 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 11:30 am, a quorum was present.		
#2 Finance Committee Minutes dated September 19, 2024 Attachment 2.A Action, D. Maychen, Chair	The minutes from September 19, 2024, Finance meeting were approved as read.		Motion: *Minutes were approved* *5 – 0 – 0 – 2* *(Frye / Neves)*
#3 Moss Adams presentation of Fiscal Year 2024 Audit Results	Rianne Suico, and Eleanor Garibaldi, representatives of Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an unmodified opinion on the financial statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	were discussed. The required communications and the organization's accounting policies are in compliance with GAAP. After completing the work, it was found that the financial statements do not need to be adjusted, and no issues were encountered when completing the work.		
#4 Financials – as of August 31, 2024 Action D. Maychen, Chair	As of August 31, 2024, total current assets recorded were approximately $536.1M; total current liabilities were approximately $381.5M. Current ratio is approximately 1.41. Total net equity as of the end of August 2024 was approximately $164.4M, which is approximately 748% above the minimum DMHC required TNE amount. For the first two months of fiscal year 2025 interest earned actual recorded was approximately $1.9M, which is approximately $863K more than budgeted due to market projection of the first federal rate cut in March and five to six rate cuts in 2024 however, in actuality the first rate cut occurred in September 2024 and the Plan's money markets mainly consists of T-Bills and those are closely tied to the Federal reserve rate. Premium capitation income actual recorded was approximately $335.7M which is approximately $27.2M more than budgeted due to enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $9.6M, which is approximately $432K more than budgeted due to enrollment being higher than projected. License expense actual recorded was approximately $249K which is approximately $11K more than budgeted due to DMHC's license fee assessment rate was higher than projected which DMHC cited higher labor costs as the reason for the higher license fee. Recruitment expense shows negative $549 and is due to the timing of a refund related to a job posting. Net income for the first two months of FY 2025 actual recorded was approximately $2.75M, which is approximately $1.9M more than budgeted primarily due to interest income being approximately $863K higher than projected and enrollment being higher than projected.		Motion: *Financials as August 31, 2024, were approved* *5 – 0 – 0 – 2* *(Rogers / Neves)*
#5 Announcements	Daniel thanked his Finance team for the work performed on the audit.		
#6 Adjourn	Meeting was adjourned at 11:49 am		

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

Dated: 11-21-24

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 11/21/24

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

October 17th, 2024

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

Committee Members in Attendance			CalViva Health Staff in Attendance
✓	**Patrick Marabella, M.D.**, Emergency Medicine, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Senior Director of Medical Management Services
✓	**David Cardona, M.D.,** Family Medicine, Fresno County At-large Appointee, Family Care Providers	✓	**Mary Lourdes Leone,** Chief Compliance Officer
✓*	**Christian Faulkenberry-Miranda, M.D.,** Pediatrics, University of California, San Francisco	✓	**Sia Xiong-Lopez,** Equity Officer
	Ana-Liza Pascual, M.D., Obstetrics/Gynecology, Central Valley Obstetrics/Gynecology Medical Group	✓	**Maria Sanchez**, Senior Compliance Manager
✓	**Carolina Quezada, M.D.,** Internal Medicine/Pediatrics, Family Health Care Network	✓	**Patricia Gomez,** Senior Compliance Analyst
	Joel Ramirez, M.D., Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Nicole Foss, RN**, Medical Management Services Manager
✓*	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Zaman Jennaty, RN**, Medical Management Nurse Analyst
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA (**Alternate)**	✓**	**Norell Naoe,** Medical Management Administrative Coordinator
	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 10:06 am. The meeting began with the informational section of the meeting, see section **#9 Compliance Update** until a quorum was reached at 10:09 A.M. with the arrival of Dr. Waugh.	
#2 **Approve Consent Agenda** Committee Minutes: September	The September 19th, 2024, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out	**Motion**: *Approve* Consent Agenda

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
17, 2024 - Standing Referrals Report (Q2 2024) - Specialty Referrals Report- HN (Q2 2024) - Provider Preventable Conditions (Q2 2024) - TurningPoint Musculoskeletal Utilization Review (Q2 2024) - SPD HRA Outreach Report (Q2 2024) - QIUM Committee Meeting Calendar 2025 (Revised) (Attachments A-G) **Action** Patrick Marabella, M.D Chair	for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Quezada) 4-0-0-3
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (August 2024) (Attachments H) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard and Turnaround Time Report** through August 2024 were presented. The total Grievances received for August 2024 was 190, and July was 197. • There were 161 Quality of Service Grievances: 23 Prior Authorizations; 39 Administrative; 11 where the PPG and the PCPs were reassigned due to changes in contracting; and nine Transportation Access with six being No Shows. • There were 20 Quality of Care Grievances. • There were 219 Exempt Grievances, with only one Transportation No Show, and 22 Balanced Billing. There were 42 total Appeals received in August. • There were 21 Advanced Imaging: mostly cardiac. • The uphold rate was 33.3% and the overturn rate was 62.5%. ○ The Plan is working to improve the prior authorization process for imaging based on the Corrective Action Plan.	**Motion**: *Approve* - A&G Dashboard and Turnaround Time Report (August 2024) (Waugh/Cardona) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	There was one Turn Around Time Acknowledgement Letter out of compliance relating to transportation.	
#3 **QI Business** - Behavioral Health Performance Indicator Report (Q2 2024) (Attachment I) **Action** Patrick Marabella, M.D Chair	The **Behavioral Health Performance Indicator Report Q2 2024** provides a summary to evaluate some elements of the behavioral health services provided to CalViva members. The behavioral health potential quality issues, provider disputes, and network availability and adequacy metrics were previously included in this report but are now included in other reports as part of an organizational change that resulted in the integration of behavioral health into the Plan effective 01/01/2024: In Q2 2024, all five metrics met or exceeded their targets. The non-ABA review timeliness metric met the 100% target. Therefore, a barrier analysis and an improvement plan were not required. • CalViva overall membership for Q2 2024 was 436,457 (a 0.1 % decrease from Q1 2024). • The Q2 2024 behavioral health utilization rate (# of unique members with at least one behavioral health claim) was 3%. (This metric has a 1-quarter lag.) • There were zero Life-Threatening Emergent cases. • There were zero Non-Life-Threatening Emergent cases. • There was one Urgent case. • There were 52 non-ABA reviews in Q2 2024, and all were compliant with timeliness standards. • There were 803 ABA reviews in Q2 2024, 802 were compliant with the timeliness standards resulting in a 99.9% compliance rate. • Q2 2024 accuracy results for CVH ABA approvals were 100%. *Dr. Faulkenberry arrived at 10:27 to hear this full report.*	**Motion**: *Approve* - Behavioral Health Performance Indicator Report (Q2 2024) (Waugh/Cardona) 5-0-0-2
#3 **QI Business** - Health Equity 2024 Language Assistance Program Report (Semi-Annual) (Attachment J) **Action**	The **Health Equity 2024 Language Assistance Program Report (Semi-Annual)** provides information on the language service utilization by CalViva Health members from January 1st to June 30th, 2024, as well as updates on the Language Assistance Program (LAP) areas. This report also incorporates Behavioral Health language utilization by CalViva Health members for the same reporting period. Member Services Department representatives handled a total of 77,218 calls across all languages during this reporting period. Of these, 22% (16,912) were handled in Spanish and Hmong languages. • A total of 5,743 interpreter requests were fulfilled for CalViva Health members, 88% (5,036) of these requests were fulfilled utilizing telephonic interpreter services with 11% (630) for in-person, 1% (77) for sign language interpretation, and no requests for video remote	**Motion**: *Approve* -Health Equity 2024 Language Assistance Program Report (Semi-Annual) (Faulkenberry/ Quezada)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	interpreting. • Behavioral Health's (BH) Member Services Department representatives handled a total of 1,804 calls across all languages and 16% (294) calls handled in a language other than English (Arabic, Armenian, Mandarin, Punjabi, and Russian) with 95% (278) handled in Spanish and 0.3% (1) handled in Hmong. • One-hundred-twenty requests for interpreter services were fulfilled with BH. Of these 120 requests, 84% (101) were fulfilled for in-person, 3% (4) for sign language interpretation, 9% (11) for telephone interpretation, and 3% (4) for Video Remote Interpretation. • One alternate format request was received from CalViva Health members during this reporting period. • A total of 28 English material reviews were completed for CalViva Health documents/materials, including the member newsletter. • A total of 20 grievance cases were received and reviewed by the Health Equity Department. • As of June 30, 2024, CalViva Health membership totaled 434,7601 members with 69% Latino/Hispanic, 11% White/Caucasian, 9% Asian/Pacific Islander, and 5% African American/Black. • Of the 158,171 members with Limited English Proficiency (LEP), 54% (84,847) identified as female and make up 36.4% of the overall membership. There is a total of 46% (73,324) who are identified as male, they make up 36.5% of the overall membership. The majority of members with LEP are female, while both males and females with LEP make up a nearly equal part of the overall membership. • The Member Services Department ensures that bilingual representatives and/or interpreters are available to speak with members in their own language. Spanish calls accounted for 95% (12,097) and Hmong calls accounted for 5% (661). • A total of 20 grievance cases were received and reviewed by the Health Equity Department. Of these, 8 were coded as "culture perceived discrimination", 4 were coded as "culture non-discriminatory", none were coded as "linguistic perceived discrimination", 8 were coded as "linguistic non-discriminatory". These cases were reviewed and adjudicated through the Appeals and Grievances process. • The Heath Equity's language assistance program updates are mostly consistent with previous reporting periods except for the utilization volume. Interpreter requests and call volume for CalViva Health increased significantly compared to the same reporting period in	5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2023. A factor that may contribute to this increase in utilization is the number of members with LEP, the volume has increased by roughly 8,000 since the end of 2023. ***Discussion:*** *Dr. Cardona asked who can initiate the use of an interpreter?* *Dr. Marabella stated that anyone could initiate the use of interpreter services. The patient or the provider. When obtaining consent or other high-risk communications, it is best to use the health plan interpreter services rather than office staff from a risk management perspective.*	
#3 **QI Business** - Facility Site & Medical Records and PARS Review Report (Q1 and Q2 2024) (Attachment K) Action Patrick Marabella, M.D Chair	The **Facility Site & Medical Records and PARS Reviews (Q1 and Q2 2024) report** displays completed activity and results of the DHCS-required PCP Facility Site (FSR) and Medical Record Reviews (MRR). All CalViva counties are using the New FSR/MRR tools and standards. The results of Physical Accessibility Review Survey (PARS) assessments of providers are also provided. The results are analyzed for monitoring and improving the performance of PCPs against DHCS and CalViva Health standards. • Eleven FSRs and six MRRs were completed during the 1st and 2nd Quarters of 2024. o The FSR mean rate for Q1-Q2 2024 was 97%. o The MRR mean rate for Q1-Q2 2024 was 91%. ▪ The Adult Preventive Care mean score over all counties for Q1-Q2 was 90%. ▪ The Pediatric Preventive Care mean score over all counties for Q1-Q2 was 84%. • Interim Review is a DHCS-required monitoring activity to evaluate the PCP site between the 3-year periodic FSR cycle. In Q1 and Q2 2024, 11 interim reviews were completed in the 3 CalViva counties. All 11 interim reviews were completed as fax backs. • There was one "dirty office" complaint received. The FSR department conducts a site visit for provider sites that have three complaints in a rolling six-month period per FSR and Credentialing policies. • For the table on page 3, 60 records were reviewed for this reporting period but the numbers represented in parentheses did not equal the number of cases that qualified for each measure (denominator). In the future, the number in parentheses will reflect the true denominator for each measure. • Corrective Action Plans (CAPs) have three components, FSR Critical Element (CE) CAP, FSR CAP and MRR CAP. CE CAPs are due in 10 business days from the date of the FSR. FSR and MRR CAPs are due in 30 calendar days from the date of the review. PCPs with FSR scores greater than or equal to 90% with no Critical Element (CE) deficiencies and MRRs greater than or equal	**Motion: Approve** - Facility Site & Medical Records and PARS Review Report (Q1 and Q2 2024) (Waugh/ Faulkenberry) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	to 90% do not have to submit a CAP (exempt pass). • Eight PARS were completed in Q1 and Q2 2024 with all eight PARS having Basic level access. • Certified Site Review Nurses provide educational training prior to the actual FSR/MRR evaluation. Educational Trainings allow provider sites to become familiar with the DHCS regulations and FSR/MRR processes and can be done on site if requested. There were seven onsite educational trainings completed in the 1st and 2nd Quarters 2024.	
#4 **Key Presentations** - Health Equity 2024 Work Plan Mid-Year Evaluation & Executive Summary (Attachment L) Action Patrick Marabella, M.D Chair	The **Health Equity 2024 Work Plan Mid-Year Evaluation & Executive** Summary was presented and reviewed. The Plan is working towards NCQA accreditation for Health Equity and must show the specific activities completed by CVH Health Equity staff to meet NCQA standards. By June 30th all activities were on target for end-of-year completion with some already completed. All the Work Plan activities are on target for completion by the end of the calendar year 2024. Will continue to assess circumstances to modify plans as needed in order to continue to implement, monitor, and track Health Equity-related services and activities. **The 2024 Work Plan is divided into four Categories:** • Language Assistance Program • Compliance Monitoring • Communication, Training, and Education • Health Literacy, Cultural Competency & Health Equity **Some Completed Activities Include:** • Completed audit requirements for Behavioral Health and Health Equity Oversight. LAP Annual Assessment was completed. • Amended three language vendors' contracts to include tactile and CART services. • One hundred forty-five staff completed bilingual assessments or were reassessed. • Twenty grievance cases reviewed with no interventions and four interpreter complaints. • Eight hundred-seventy-one CVH referrals made in Findhelp, 147 members received help, and 584 new programs were added to the entire platform. • Provider materials available in the provider's library including the LAP program and "Findhelp How-To" guide. • Training completed: Readability, EMR Database in Q2 2024 with 93 attendees Cultural Competency & Implicit Bias Training on track to complete in Q3-4 2024 for staff and Providers. • Key informant interviews and focus groups completed for W30-6+ and MH/SUD PIP.	**Motion**: *Approve* - Health Equity 2024 Work Plan Mid-Year Evaluation & Executive Summary (Quezada/Waugh) 5-0-0-2

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	CalViva Health Equity Activities Include: • Enhancing DEI for CVH through Surveys and practices (Planned to start November 2024) • DEI training for all staff (Cultural Competency, Implicit bias, Historical trauma and how it influences modern medical practices, CVH members and how they are impacted) Planned for November 1, 2024 • Community engagement: o NIC (Network Improvement Committee) o Assisting MH/SUDs PIP working with trusted CBO- Binational There were no questions or comments from committee members. *Dr. Cardona left the meeting at 10:47 A.M. and returned at 10:49 A.M.*	
#4 **Key Presentations** - Quality Improvement and Health Equity Transformation Program (QIHETP) 2024 (Attachment M) Action Patrick Marabella, M.D Chair	The **Quality Improvement and Health Equity Transformation Program (QIHETP) 2024** was presented and reviewed. The Program was created in 2023 because it was required for the 2024 DHCS Contract to address the integration of Health Equity into Quality Improvement in Medi-Cal Managed Care Plans. It provides guidelines on integrating health equity practices throughout the health plan, among providers, and with Members. **In keeping with NCQA Accreditation Standards, CalViva'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 and with providers, and other key stakeholders. • Improve individual & household-level social needs & networks, by improving access, quality, and value of services for our members. **Quality Improvement and Health Equity 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. **Enhancing Current Processes and Practices:** Already in Place:	**Motion**: *Approve* - Quality Improvement and Health Equity Transformation Program (QIHETP) 2024 (Waugh/ Faulkenberry) 5-0-0-2

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	○ Quality Improvement Program & Work Plan ○ Health Equity Program & Work Plan ○ Performance Improvement Projects (PIPs, Lean Projects and Collaboratives) ▪ Examples of cultural projects include Breast Cancer Screenings with the Hmong population; Hispanic Educational Awareness training with ED Staff for our current FUM/FUA Non-Clinical PIP & Lean Projects ○ Population Needs Assessment The QIHETP further integrates the two programs by utilizing the Health Equity Model to reduce Disparities. Leadership is charged with monitoring the health equity activities, medical management, and quality of care and services provided to members to promote equity through: • Encounter Data • Grievances and Appeals • Utilization Data • Satisfaction Surveys (CAHPS) With an Emphasis on: • Member & Family Engagement • Community Engagement • Reducing Disparities Updates for 2024: • Updated Dates throughout from 2023 to 2024 • Section 4.1B. (page 5) Quality Improvement Activities: revised the eight categories included to assess performance to be consistent with the 2024 QI & Health Ed Work Plan. • Section 7.1 (page 10) Health Equity Model: revised list of demographic elements used in data analysis to reduce disparities to be consistent with NCQA terminology. (Race/ethnicity, language, gender identity, and sexual orientation are analyzed to develop targets for disparity reduction efforts and specific interventions to address the disparities and the barriers associated with that.) • Updated (page 6 & page 13) to indicate that CalViva has obtained NCQA Health Plan Accreditation rather than planning to obtain accreditation.	

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	There were no questions or comments from committee members.	
#5 **UM/CM/PHM Business** - Key Indicator Report and Turnaround Time Report (August 2024) - Medical Policies (August 2024) (Attachments N - O) Action Patrick Marabella, M.D Chair	The **Key Indicator Report and Turnaround Time Report** through August 2024 were presented. • Overall, Membership levels have stabilized. • Utilization has fluctuated over the previous months. Expansion utilization has been on a downward trend, and SPD has an upward trend. • Acute Admissions, Bed Days, and Acute Length of Stay (all adjusted PTMPY), for all categories have decreased. This may indicate that the acuity or the burden of illness of members being admitted is not as great as it was immediately after COVID-19. o Hospital stays are shorter, which may be a result of CalAIM activities as well as a robust case management or Transitional Care Services (TCS) program to help people transition out of the hospital and connect to other services. • The turnaround times were 100% except for Preservice Urgent which was 98%. • Perinatal Case Management referrals have an 84% engagement rate for 137 referrals. • Physical Health Case Management referrals have a 46% engagement rate for 274 referrals. • Transitional Care Services' (TCS) engagement rate is back up to 68%. Referral numbers have steadily increased from the beginning of the year to 610 for August. TCS receives all the Care Management cases initially and then refers to the different departments accordingly. • Behavioral Health Case Management referrals have a 74% engagement rate with 121 referrals. • First Year of Life Case Management referrals have demonstrated variation, but they have a 100% engagement rate for the 34 referrals for August. *Discussion:* *Dr. Cardona asked if it could be determined which activity has been the most fruitful in reducing hospital utilization.* *Dr. Marabella indicated that it is likely multifactorial, but he feels that the TCS program with staff in the hospital and case managers telephonically to coordinate post-discharge services that has had the biggest impact on reducing ALOS and readmission rates. All members receive a TCS case manager prior to discharge from the hospital.* The **Medical Policies** (August) were presented to the committee. Dr. Marabella recommended that committee members review the new Medical Policies and updates for their awareness, especially those specific to each practitioner's specialty, and provide any comments or feedback.	Motion: *Approve* - Key Indicator Report and Turnaround Time Report (August 2024) - Medical Policies (August 2024) (Cardona/Quezada) 5-0-0-2

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	Medical Policies are compiled based on a national review by physicians and sent monthly to providers featuring new, updated, or retired medical policies for the Plan. Updated policies for August 2024 include but are not limited to: • CP.BH.300 – Biofeedback for Behavioral Health Disorders • CP.MP.203 – Diaphragmatic/Phrenic Nerve Stimulation • CP.MP.194 – Osteogenic Stimulation • CP.MP. 165 – Selective Nerve Root Blocks and Transforaminal Epidural Steroid Injections • CP.MP.169 – Trigger Point Injections for Pain Management New Policies include: • Sleep Studies, Adult • Sleep Studies, Pediatric	
#6 Policy & Procedure Business - Public Health Policy & Procedure Annual Review (Attachments P) Action Patrick Marabella, M.D Chair	The **Public Health Policy & Procedure Annual Review** was presented to the committee. The following policies were presented for annual review with no changes made: • PH-001 Electronic Visit Verification • PH-003 Adult Preventive Services • PH-010 Dental Care • PH-014 Immunization Program • PH-016 Local Education Agency (LEA) • PH-018 Access to Certified Nurse Practitioners • PH-019 Minor Consent • PH-020 Mental Health Services • PH-021 Mental Health Dispute Resolution • PH-023 Non-Specialty Mental Health Services • PH-024 Eating Disorder Treatment Services • PH-026 MHN Behavioral Health • PH-028 Responsibilities for Behavioral Health Treatment Coverage for Members under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits • PH-041 Department of Developmental Services (DDS) Administered Home and Community Based Waiver Program • PH-053 In-home Supportive Services Program Waiver (IHHS) • PH-062 Non-Emergency, Non-Medical Transportation Assistance and Coordination	Motion: Approve - Public Health Policy & Procedure Annual Review (Waugh/Quezada) 5-0-0-2

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	• PH-089 Community Health Worker Guidelines • PH-101 Perinatal Care • PH-102 Doula Services The following policies were presented for annual review and were approved with minor edits: • PH-002 In-Home Operations Waiver and Home and Community-Based Alternatives (HCBA) Waiver • PH-004 Pediatric Preventive Care Services • PH-006 Vision Care • PH-009 School-Based Health Programs • PH-013 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services • PH-017 Communicable Disease Reporting • PH-025 Behavioral Health Treatment Services autism spectrum disorder • PH-042 HIV Testing and Counseling • PH-043 Sexually Transmitted Diseases (STD) Services • PH-048 Regional Centers Coordination • PH-050 California Children's Services (CCS) • PH-051 Genetically Handicapped Persons Program (GHPP) • PH-052 Children with Special Health Care Needs (CSHCN) • PH-088 Public Health Coordination • PH-103 Access to Freestanding Birth Centers and the Provision of Midwife Services • PH-104 Family Planning Services • PH-105 Pregnancy Termination The following policies were presented for annual review and were approved with the following changes: • PH-008 Early Start Program: Added information about LEA and CHW. • PH-015 Sensitive Services: Added confidentiality section. • PH-022 Alcohol and Drug Treatment Services: Additions to policy section for members 16 years and younger. • PH-027 Dyadic Services and Family Therapy: Removed reference and information about Family Therapy. Updated benefits and eligibility of family members. The following is a new policy that was approved:	

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	• PH-029 Behavioral Health Screening, Assessment, Care Coordination, and Exchange of Information. This policy was created to facilitate effective communication and exchange of information between the physical and mental health care of a member as now required by the State. The full policy can be referenced in the packet.	
#7 Oversight Audits - Appeals and Grievances Oversight Audit (Attachment Q) Action Patrick Marabella, M.D Chair	The **Appeals and Grievances Oversight Audit** was presented and reviewed. The overall compliance rate for HNCS for the Appeal and Grievance function is 91% based upon the number of compliant standards divided by those reviewed in the audit grid 20/22 including positive overall file review results of 97% compliance. Following the 8/30 rule a review of 106 randomly selected digital and audio cases was completed from the audit period of January 2023 to December 2023. The breakdown of cases is as follows: • Thirty Standard Appeal & Grievance Cases • Eight Exempt Grievance Cases – Customer Contact Center (CCC) • Eight Exempt HIPAA compliance verification audio files • Eight Exempt Grievance Cases – ModivCare • Seventeen Exempt Grievance Cases- MHN • Thirty Expedited Appeal & Grievance Cases • Four State Fair Hearing (SFH) Cases • One Independent Medical Review (IMR) Overturn Cases A total of four State Fair Hearing cases were completed in MY2023. CalViva Health noted 42 potential cases overall for the calendar year (including withdrawn cases) while Health Net identified 39 cases during the same period identifying an opportunity for improvement. Additional opportunities for improvement were identified related to the forwarding of Proof of Service Certificates to CalViva Health in a timely manner. Because Proof of Service Certificates were not provided CalViva could not confirm the timeliness of services for any of three cases with one case not applicable due to no jurisdiction. CAP required. A list of all Independent Medical Review (IMR) Overturn cases for CalViva during the audit period (January 1, 2023, through December 31, 2023) was requested from Health Net; yielding a total of one case, which was found to be 100% compliant. The overall file review compliance rate is 97% (102/105). Corrective Action Plan (Review Element/Standard 9A-2 State Fair Hearing): • Complete documentation and Proof of Service Certificates are not consistently being sent to	Motion: Approve - Appeals and Grievances Oversight Audit (Cardona/ Faulkenberry) 5-0-0-2

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	CalViva Health. Specifically, we were unable to verify if SOPs were mailed within two working days prior to the scheduled hearing date. Also, the reconciliation of potential SFH cases does not match from HN (39) to CVH (42). • Additional findings are under review.	
#8 **Access Business** - Provider Appointment Availability & After-Hours Access Survey Results (2023) (Provider Update) - Access Workgroup Quarterly Report (Q4 2024) - Access Workgroup Minutes 07/30/2024 (Attachment R-T) Action Patrick Marabella, M.D Chair	The **Provider Appointment Availability & After-Hours Access Survey Results 2023 (Provider Update)** were presented and reviewed. The results are used to monitor physicians' and other providers' compliance with timely access and after-hours regulations and to evaluate the effectiveness of the network to meet the needs and preferences of CalViva Health members. The results of the 2023 PAAS survey for DMHC and the DHCS appointment access standards indicated that the Plan met all standards except for the following: •Urgent care appointment with a psychiatrist. •Non-urgent care appointment with a psychiatrist. •Urgent care appointment with a specialist -- that requires prior authorization -- within 96 hours. •Non-urgent appointment with a specialist within 15 business days. Failure to meet one or more timely appointments and after-hours access standards, as indicated, will result in a corrective action plan (CAP). The **Access Work Group Quarterly Report (Q4 2024)** was presented and reviewed. This report is to provide the QI/UM Committee with an update on the CalViva Health Access Workgroup activities since the last report to the QI/UM Committee. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. On 7/30/24, the following **MY 2023 DMHC Timely Access Reports (TAR)** were approved: • MY2023 Availability Report • MY2023 Accessibility Report • MY2023 Access & After-Hours CAP • MY2023 PQI Access to Care Report • MY2022 Behavioral Health Member Experience Report CalViva Health Medi-Cal (ECHO) • MY2023 Behavioral Health Provider Satisfaction Survey Report • MY2023 Provider Satisfaction Survey with Access and Availability for Medical Providers • MY 2023 Member Satisfaction Survey with Access Report - Medical Providers	Motion: *Approve* - Provider Appointment Availability & After-Hours Access Survey Results (2023) (Provider Update) - Access Workgroup Quarterly Report (Q4 2024) - Access Workgroup Minutes 07/30/2024 (Quezada/ Waugh) 5-0-0-2

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	See summary above for results of the **Provider Appointment Availability & After-Hours Access Survey Results 2023.** Regarding PQIs related to access to care, a thorough review of all measurement year 2023 PQI/QOC cases indicated there were no cases related to appointment availability incidents of non-compliance resulting in substantial harm. The following are some of the key standing reports/matters approved: • Member Services Call Center Metrics Report (HN & MHN) – (Q2 2024) • Telehealth Program (April Data) • PPG Dashboard & Access Narrative – (Q1 2024) • 274 Monthly Provider Data Quality Check – May-June • MY2023 Alternate Access Network Adequacy • 2023 Subnetwork Certification Summary Report **Access Work Group Minutes from 07/30/2024,** lists reports that the Access Work Group routinely reviews, and key reports were presented with additional detail to the QI/UM Committee in the **Access Work Group Quarterly Report (Q4 2024).** *Dr. Cardona left the meeting at 11:20 A.M. and returned at 11:21 A.M.*	
#9 **Compliance Update** - Compliance Regulatory Report (Attachment U)	Mary Lourdes Leone presented the **Compliance Report** at the beginning of the meeting as the quorum was not yet met. **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, ER, Provider Network, Claims, FWA, Call Center, Health Education, COC, and Privacy and Security. The following annual	

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	audits have been completed since the last Commission report: PDR (CAP Required), A&G (CAP Required) **Fraud, Waste & Abuse Activity.** Since the 9/19/2024 Compliance Report to the Committee, there have not been any new MC609 filings. **Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation.** On 9/6/24, the Plan received DHCS's final Report findings and formal CAP request. There were nine deficiencies in total (four for behavioral health and five for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. All corrective actions must be implemented within 6 months from the date of the CAP request. **Department of Health Care Services ("DHCS") 2024 Medical Audit.** On 9/16/2024, the Plan had the Exit Conference with DHCS. On 10/3/2024 DHCS sent out the Final Audit Report and CAP request. There were two findings: • The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive. • The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within 10 working days. The Plan's first response to the CAP is due by November 2, 2024. **2024 Network Adequacy Validation (NAV) Audit.** On 9/30/2024 the Plan received notice that HSAG has officially closed out the audit noting all items have been resolved. HSAG is working with DHCS on finalizing plan-specific validation rating determinations, which will be shared in late November 2024. **California Advancing and Innovating Medi-Cal (CalAIM)** On 10/9/2024, the Plan submitted an updated Community Supports Provider Capacity and Final Elections report to confirm that the Plan will be able to provide the following additional CS services in Kings and Madera counties: • Kings County o Recuperative Care: CityServe (Services on track to go live 1/1/2025)	

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	• Madera County o Recuperative Care: SOUL Housing (Services on track to go live 7/1/2025) ▪ Short-Term Post Hospitalization: RH Builders (Services on track to go live 1/1/2025) o Sobering Center: RH Builders went live earlier for this service **Memorandum of Understanding (MOU):** Since the last Commission Meeting the Plan has not executed any additional MOUs. **Annual Network Certifications:** • **2023 Subnetwork Certification (SNC) –** On 9/25/2024, the Plan received the 2024 SNC Landscape Analysis request. The Plan must submit a response by 10/25/2024. • **2023 Annual Network Certification (ANC) –** The Plan is awaiting final DHCS approval of its AAS request as revised and submitted on 9/18/2024. **Timely Access and Annual Network Reporting (TAR):** • **RY 2023 MY 2022**- The Plan is still awaiting the Department's response to the Plan's response to the Network Findings Report which was submitted on 8/1/2024. • **RY2024 MY 2023 –** Results of the 2023 DMHC Timely Access Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Survey (PAHAS). See the results above. **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. **Public Policy Committee (PPC):** The next Public Policy Committee meeting will be held December 4, 2024, 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.	
#11 **Old Business**	None.	
#12 **Announcements**	The next meeting is November 21st, 2024.	
#13 **Public Comment**	None.	
#14 **Adjourn**	The meeting adjourned at 11:21 p.m.	

NEXT MEETING: November 21st, 2024

Submitted this Day: November 21, 2024

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

Acknowledgment of Committee Approval:

X
Patrick Marabella, MD Committee Chair

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of DHCS Filings													
Administrative/ Operational	35	8											43
Member Materials Filed for Approval;	4	1											5
Provider Materials Reviewed & Distributed	11	2											13
# of DMHC Filings	6	1											7

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	4	3											7
High-Risk	0	1											1

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of New MC609 Cases Submitted to DHCS	1												1
# of Cases Open for Investigation (Active Number)	29												

Report Date 2/20/2025

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 1/16/2025 Compliance Regulatory Report to the Commission, there was one new MC609 filing. This is a provider specializing in internal medicine who allegedly billed for services for a deceased member whose date of death was 7/18/2022.

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: Credentialing The following annual audits have been completed since the last Commission report: UMCM (CAP Required), Access and Availability (No CAP) and Call Center (No CAP).
Regulatory Reviews/Audits and CAPS:	**Status**
Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation	As a reminder, on 9/6/24, the Plan received DHCS' Final Report findings and formal CAP request. There were nine deficiencies in total (4 for behavioral health and 5 for transportation). The Plan submitted the initial CAP response on October 7, 2024. The Plan is required to submit monthly updates on all CAP activities. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 3/10/25.
Department of Health Care Services ("DHCS") 2024 Medical Audit	As a reminder, on 10/3/2024, DHCS sent out the Final Audit Report and CAP request. There were two findings: • The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive. • The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days. The Plan is on track for completing its stated corrective actions and will provide its next monthly update on 3/1/25.
Department of Managed Health Care (DMHC) 2025 Medical Follow-Up Audit	On 1/6/25, the Plan received written notice from the DMHC of their intent to conduct a "Follow-Up" Audit of the outstanding deficiencies from the 4/18/24 Final Report of the 2022 Routine Medical Survey. The deficiencies concerned the Plan failing to identify potential quality issues (PQIs) in exempt grievances, and inappropriately denying payment of post-stabilization care. All requested documents were submitted on 2/5/25.

Department of Health Care Services ("DHCS") 2025 Medical Audit	On 2/10/2025, DHCS proposed 6/2/2025-6/13/2025 time period for the virtual onsite 2025 audit and the Plan has accepted. The Entrance Conference will begin on 6/2/25 @ 10:00am
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
Memoranda of Understanding (MOUs)	Since the last Commission Meeting, the Plan has executed and submitted to DMHC & DHCS the following MOU, which has been posted to CalViva's website: • Madera County WIC MOU
Annual Network Certifications	➢ 2024 Subnetwork Certification (SNC) Landscape Analysis – On 9/25/2024, the Plan received the 2024 SNC preliminary request for the Landscape Analysis and submitted a response on 10/25/2024. On 1/3/2025, the Plan submitted the 2024 SNC deliverable. DHCS has followed up requesting additional information. The Plan has submitted all additional documents and is awaiting approval.
Transgender, Gender Diverse, or Intersex (TGI) Training	➢ DHCS APL 24-017 and DMHC APL 24-018 are requiring Plans to conduct TGI training to staff who are in direct contact with Members. By March 2025, Plans are required to submit evidence of training along with the curriculum. The Plan will also be working on deliverables associated with these APLs, such as updating its provider directory to show which providers are offering gender affirming care, monitoring and tracking grievances as they relate to gender affirming care, and updating the Plan's policies and procedures.
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 2025.
Committee Report:	**Status**
Public Policy Committee (PPC)	The next PPC meeting will be held on March 5, 32025, 11:30am-1:30pm, CalViva Health Conference Room, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711.

APPENDIX A

2025 DHCS All Plan Letters:

- APL 25-002 SNF WQIP
- APL 25-004 Community Reinvestment Requirements
- APL 25-005 Threshold Languages

2025 DMHC All Plan Letters:

- APL 25-001 - Southern California Fires and Enrollees' Continued Access to Health Care Services (1.9.2025).pdf

Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
MLLeone@calvivahealth.org
Phone: 559-540-7856

Table of Contents

I. CalViva Health Overview:

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

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

II. Purpose:

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

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

III. Elements:

The following provisions of the CalViva Health Code of Conduct are intended to guide

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

1. Member Services and Rights:

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Provider/Vendor Relations and Contracts:

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

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

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

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

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

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

4. For services that are not reasonable and necessary.

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

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

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

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

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

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

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

3. Business Operations and Accounting:

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

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

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

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

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

guidelines.

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

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

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

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

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

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

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

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

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

O. CalViva Health prohibits the solicitation or acceptance of gifts, gratuities, favors or other benefits from persons or entities that do business with CalViva Health. Notwithstanding the foregoing, acceptance of common business hospitality, such as occasional meals, entertainment or nominal gifts with a value of $50.00 or less,

are not considered a violation of this paragraph.

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

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

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

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

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

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

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

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

U. CalViva Health, in cooperation with subcontractors and regulators, will make all

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

4. Medical Records:

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

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

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

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

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

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

C. CalViva Health retains records in accordance with a written policy which incorporates Medicaid and all federal, state and local regulatory guidelines.

5. Medical Management and Claims:

A. CalViva Health monitors the claims submitted by providers to ensure honest, fair and accurate claim practices. All entities providing claims functions on behalf of

CalViva Health are required to demonstrate experience and knowledge in performing such functions in accordance with federal, state and local law.

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

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

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

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

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

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

6. Employee Relations:

A. CalViva Health encourages all employees and contractors to respect the rights and cultural differences of other individuals.

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

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

7. Avoiding Potential Conflict of Interest or Retribution

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

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

APPROVAL:

February 2015, 20254

_____ Date: _____

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

February 2015, 20254

_____ Date: _____

Name: Jeffery Nkansah
Title: Chief Executive Officer

February 2015, 20254

_____ Date: _____

Name: David S. Hodge
Title: RHA Commission Chairperson

Item #6

CLOSED SESSION

No attachments

Item #7

Annual Administration

7.A BL 25-003
7.B Form 700

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

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

DATE: February 20, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Annual Administration

BL #: 25-003
Agenda Item 7
Attachment 7.A

Discussion Points:

Ethics Training:

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

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

Form 700:

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

Please complete and return to the Clerk, Cheryl Hurley, by April 1, 2025.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

STATEMENT OF ECONOMIC INTERESTS
COVER PAGE
A PUBLIC DOCUMENT

Date Initial Filing Received
Filing Official Use Only

Please type or print in ink.

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

1. Office, Agency, or Court

Agency Name *(Do not use acronyms)*

Division, Board, Department, District, if applicable

Your Position

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

Agency: Position:

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

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

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

☐ **Annual:** The period covered is January 1, 2024, through December 31, 2024.

-or-

The period covered is _____/_____/_____, through December 31, 2024.

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

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

- ☐ The period covered is January 1, 2024, through the date of leaving office.

-or-

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

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

4. Schedule Summary (required)

► ***Total number of pages including this cover page:*** _____

Schedules attached

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

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

5. Verification

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

DAYTIME TELEPHONE NUMBER
( )

EMAIL ADDRESS

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

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

Date Signed *(month, day, year)*

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

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

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

Comments: ____________

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

Check one

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

GENERAL DESCRIPTION OF THIS BUSINESS

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

NATURE OF INVESTMENT

☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

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

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

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

☐ None or ☐ Names listed below

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

Check one box:

☐ INVESTMENT ☐ REAL PROPERTY

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

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

NATURE OF INTEREST

☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership

☐ Leasehold _____ Yrs. remaining ☐ Other _____

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

---

► 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

Check one

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

GENERAL DESCRIPTION OF THIS BUSINESS

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

NATURE OF INVESTMENT

☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

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

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

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

☐ None or ☐ Names listed below

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

Check one box:

☐ INVESTMENT ☐ REAL PROPERTY

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

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

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

IF APPLICABLE, LIST DATE:

___/___/**24** ACQUIRED ___/___/**24** DISPOSED

NATURE OF INTEREST

☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership

☐ Leasehold _____ Yrs. remaining ☐ Other _____

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

Comments: _____

CALIFORNIA FORM **700**
FAIR POLITICAL PRACTICES COMMISSION

Name

SCHEDULE B
Interests in Real Property
(Including Rental Income)

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

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

IF APPLICABLE, LIST DATE:
__/__/24 ACQUIRED __/__/24 DISPOSED

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

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

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

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

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

IF APPLICABLE, LIST DATE:
__/__/24 ACQUIRED __/__/24 DISPOSED

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

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

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

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

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE TERM (Months/Years)

_____% ☐ None _____

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

☐ Guarantor, if applicable

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE TERM (Months/Years)

_____% ☐ None _____

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

☐ Guarantor, if applicable

Comments: _____

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name _____

► 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

_____

ADDRESS *(Business Address Acceptable)*

_____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

_____

YOUR BUSINESS POSITION

_____

GROSS INCOME RECEIVED

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

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

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

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

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

☐ Loan repayment

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

_____ *(Describe)*

☐ Other _____ *(Describe)*

► 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

_____

ADDRESS *(Business Address Acceptable)*

_____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

_____

YOUR BUSINESS POSITION

_____

GROSS INCOME RECEIVED

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

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

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

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

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

☐ Loan repayment

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

_____ *(Describe)*

☐ Other _____ *(Describe)*

► 2. LOANS RECEIVED OR OUTSTANDING DURING THE REPORTING PERIOD

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

NAME OF LENDER*

_____

ADDRESS *(Business Address Acceptable)*

_____

BUSINESS ACTIVITY, IF ANY, OF LENDER

_____

HIGHEST BALANCE DURING REPORTING PERIOD

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

INTEREST RATE

_____% ☐ None

TERM (Months/Years)

_____

SECURITY FOR LOAN

☐ None ☐ Personal residence

☐ Real Property _____ *Street address*

_____ *City*

☐ Guarantor _____

☐ Other _____ *(Describe)*

Comments: _____

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name ______________________________

SCHEDULE D
Income – Gifts

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$__________	____________________
____/____/____	$__________	____________________
____/____/____	$__________	____________________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$__________	____________________
____/____/____	$__________	____________________
____/____/____	$__________	____________________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$__________	____________________
____/____/____	$__________	____________________
____/____/____	$__________	____________________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$__________	____________________
____/____/____	$__________	____________________
____/____/____	$__________	____________________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$__________	____________________
____/____/____	$__________	____________________
____/____/____	$__________	____________________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$__________	____________________
____/____/____	$__________	____________________
____/____/____	$__________	____________________

Comments: ____

CALIFORNIA FORM **700**
FAIR POLITICAL PRACTICES COMMISSION

Name

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

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

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

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

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

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

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

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

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

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

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description

► If Gift, Provide Travel Destination

Comments:

Item #8

Attachment 8.A

8.A Community Support
Policy & Procedure

POLICIES AND PROCEDURES	**Title**: Requirements for RHA Funding of Community Support & Community Reinvestment Programs
	Procedure #: AD-103
	Page: 1 of 7
Department: Administration	**Effective Date**: 6/1/2017
Region: Fresno, Kings, Madera	**Last Review and/or Revision Dates**: ~~5/19/2022~~2/20/2025
	LOB: Medi-Cal Managed Care

I. Purpose

A. The Fresno-Kings-Madera Regional Health Authority dba CalViva Health (the "Plan" or "CalViva") Commission has established a process to review and consider funding for project initiative/program requests ~~in excess of twenty thousand dollars ($20,000.00)~~ per CalViva fiscal year (July 1 through June 30) in a consistent, organized and fair manner.

~~A.~~B. This policy also includes the~~a~~ processes and guidelines to fulfill the Plan's contractual requirement to reinvest a minimum level of its net income ("base community reinvestment") into its local communities and an additional investment if it does not meet quality outcome metrics ("quality achievement community reinvestment"). ~~for provider recruitment/incentives, community based organization grants, enrollment support, youth recreation fund, and education scholarships that will serve the growing Medi-Cal population in the counties of Fresno, Kings and Madera.~~

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II. Policy

A. CalViva Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability. Review and consideration of funding requests will be performed in compliance with federal and state laws.

B. Community support ~~A CalViva Health budget item for outside p~~project initiative(s)/program(s), DHCS community reinvestments, and/or provider network expansion funding ~~funding requests and for a provider network expansion fund will be included in~~ will be within the annual budget limits ~~for Commission approval~~approved by the Commission.

C. All requests for funding must be submitted in writing a minimum of 90 days prior to the anticipated initial funding date.

D. DHCS contractual community reinvestment activities will be conducted in accordance with this Plan policy and procedure and any applicable contractual and/or DHCS All Plan Letter ("APL") community reinvestment requirements (i.e. DHCS APL 25-004). Any required implementation plan, reporting, etc. will adhere to those aforementioned requirements.

~~C.~~1. If applicable, the Plan will also ensure any qualifying subcontractors as defined in DHCS APL 25-004 also fulfill their obligation to make a base community reinvestment in accordance with the applicable contractual and/or DHCS All Plan Letter community reinvestment requirements (i.e. DHCS APL 25-004). The quality achievement community reinvestment requirement does not apply to qualifying subcontractors and the qualifying subcontractor is permitted, but not required, to transfer their obligation amount to the Plan to administer their reinvestments on their behalf in accordance with requirements.

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III. Definitions

A. **Commission** - the 17-member Commission appointed according to the provisions of the Joint Exercise of Powers Agreement under which the Fresno-Kings-Madera Regional Health Authority "(RHA") dba CalViva Health is governed.

B. **Fresno-Kings-Madera Regional Health Authority (RHA)** – the multi-county health authority established through a Joint Exercise of Powers Agreement between the counties of Fresno, Kings, and Madera to provide services to eligible Medi-Cal beneficiaries within the jurisdiction of the counties.

C. **Ad-Hoc Funding Review Committee** – An Ad-Hoc committee appointed by the Commission to review ~~-~~ budgeted recommendations and / or funding requests in excess of $25,000~~submitted during the Plan's next fiscal year~~. The Ad-Hoc Committee will include a minimum of three (3) Commissioners, the Chief Executive Officer, ~~and~~ Chief Financial Officer, and Equity Officer.

IV. Procedure

A. ~~Application~~ **Requirements for Community Supports ~~Funding~~ Project Initiatives/Programs**

~~A.~~

~~1.~~ Requesting organization(s) must submit a completed application for Provider ~~Recruitment~~Infrastructure Grants, or a formal written request for Community Support Funding and any applicable supporting documentation for review ~~by the~~

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~~designated Ad-Hoc Committee~~. ~~Provider Recruitment Grants requests must include, but are not limited to the following information:~~

~~1.1. Description of the project initiative/program~~
~~1.2. Project initiative/program goals and time frames for implementation and key milestones~~
~~1.3. Budget for the project initiative/program funding being requested.~~
~~1.4. Sponsoring/requesting organization's most recent financials and the previous year financials (i.e. income statement and balance sheet, for Provider Recruitment Grants only,~~
~~1.5. Specific information on how funds provided by the Plan will be used~~
~~1.6. Information about any matching funds/grants/other funding the organization has obtained or is pursuing~~
~~1.7. Targeted beneficiaries of the funding~~
~~1.8.~~1.~~A list of persons who will be responsible for administering the funds and project initiative/program.~~

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2. The requesting organization if requested by CalViva Health, must indemnify CalViva Health for any claims or legal action related to the funded project initiative/program. ~~-~~The indemnification document will be provided by the Plan's legal counsel and executed prior to the initial funding date.

3. The Ad-Hoc Funding Review Committee will review budgeted recommendations and evaluate any ~~the~~ funding requests in excess of $25,000 and make a recommendation to the Commission. ~~-~~The review and evaluation will include but not be limited to consideration of the following criteria:
   - 3.1. CalViva Health Mission and Principles
   - 3.2. Provider access impact
   - 3.3. Benefit to Plan members
   - 3.4. Improve Quality of Care
   - 3.5. Impact on current CalViva Health budgeted funds available
   - 3.6 Information from Plan staff research and input

4. Upon completion of the review, the Ad-Hoc Funding Review Committee will prepare a recommendation for the Commission. ~~-~~The recommendation will include at a minimum:
   - 4.1. The recommended total amount to be funded
   - 4.2. The length of time for funding and any incremental time periods for the funding payments
   - 4.3. Any conditions or other qualifications imposed on the funding

5. The Commission will review the funding requests and approve/deny/modify the recommendation and identify any specific conditions or other qualifications that must be met by the requesting organization.

5.1. Subsequent to the Commission decision, the requesting organization will be notified of the decision in writing and, if approved, informed of any specific conditions/requirements and other instructions.

6. Funded project initiatives/programs and organizations must submit paid invoices, if required, and provide periodic (e.g. semi-annual, annual, etc.) reports to the Commission that include use of funds and progress toward stated goals. -The frequency of reporting will be determined by the Plan based on the type of project initiative/program funded.
   6.1. Failure to submit required invoices and/or quarterly reports may result in the Commission making a decision to cease funding.
   6.2. Unsatisfactory periodic reports may also result in the Commission making a decision to cease funding.

B. **Additional Requirements for DHCS Community Reinvestment Activities**

1. Any funded DHCS community reinvestment activities shall include the requirements mentioned in Procedure, Section IV, A, 1-6 above and the following guiding principles:

   1.1. Health Outcomes and Equity – The Plan's Equity Officer will help inform community reinvestment activities. Investments will be targeted toward reducing existing health disparities and/or promoting improved health outcomes for Medi-Cal populations.
   1.2. Engage with the Community – The Plan's Public Policy Committee will be consulted and funded activities will be directly informed by Community Health Assessment(s), Local Health Jurisdiction(s), and County Behavioral Health.
   1.3. Target Non-Contract Activities – Funding will be directed toward activities that are not otherwise included in the Plan's Medi-Cal contract or services carved out of the Plan's Medi-Cal contract but covered under Medi-Cal.

2. Any funded DHCS community reinvestment activities will fit within the following five DHCS community reinvestment categories:

   2.1. Cultivating neighborhoods and built environment – investments that create neighborhoods and environments that promote health, well-being and safety.
   2.2. Cultivating a health care workforce – investments that build the next generation of health care workers including, for example, addressing workforce shortages and establishing a health career pipeline for youth and young adults.
   2.3. Cultivating well-being for priority populations – investments that address community-specific needs through tailored supports and services

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not covered under the Plan's Medi-Cal contract to priority populations such as those identified through the CHA / CHIP process or an ECM population of focus (e.g. children and youth receiving foster care, justice involved populations, children and families.)

2.4. Cultivating local communities – investments that bolster the lives of individuals and contribute to the advancement and well-being of a community such as through education initiatives, employment and training programs, programs to eradicate poverty, and initiatives that address social isolation.

2.5. Cultivating improved health – investments targeted toward upstream root causes of poor health that address immediate and long term health-related needs as defined by the community.

3. Any funded DHCS community reinvestment activities will be identified within the Plan's community reinvestment plan (initial and/or subsequent):

3.1. The community reinvestment plan(s) and report(s) will be submitted to DHCS in accordance with any applicable templates for review and approval and include all of the details required in accordance with applicable contractual and/or DHCS All Plan Letter Community Reinvestment requirements (i.e. DHCS APL 25-004).

3.2. The community reinvestment plan(s) and community investment report(s) will be posted on the Plan's website.

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~~A.~~C. Additional Requirements for Provider Network Expansion Funding

1. The Plan will work with contracted network participating provider groups ("PPGs") or other contracted organizations to promote increased provider capacity and access by providing funds for initial costs related to recruitment of new providers to the Plan's network.

2. Funding available for recruitment of primary care physicians ("PCP"), mid-level and specialist subsidies will be determined on an annual basis as part of the annual budget planning for the Plan's upcoming fiscal year. The Commission reviews and approves the annual budget.
   2.1. Depending on the budget, provider network needs and Plan goals, the subsidies may only be available for PCP recruitment and/or mid-level recruitment and/or specialist recruitment in any given year.
   2.2. Subsidies will identify the specific cost elements to be covered and a defined percentage and maximum of the total costs of the recruited individual.

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3. Interested PPGs/organizations currently contracted in the Plan's provider network must submit an application and any applicable supporting documentation for review by the designated Ad-Hoc Committee.

4. The Ad-Hoc Funding Review Committee will review and evaluate the provider network expansion funding requests and make a recommendation to the Commission. The review and evaluation will include but not be limited to consideration of the following criteria:
   - 4.1. CalViva Health Mission and Principles
   - 4.2. Provider access impact
   - 4.3. Benefit to Plan members
   - 4.4. Quality of Care
   - 4.5. Impact on current CalViva Health budgeted funds available
   - 4.6 Information from Plan staff research and input
   - 4.7. The contracted entity's relationship with the Plan, track record and stability
   - 4.8 Geographic region (need for PCPs, mid-levels, specialists)
   - 4.9. Type of PCP (Family Practice, Internal Medicine, Pediatrics) or specialist
   - 4.10. Practice Setting - organized clinic, small group, etc.
   - 4.11. Number of provider positions subsidies are being requested for

5. Once approved for the subsidy funding, the requesting PPG/organization must meet the following requirements:
   - 5.1. Physicians must have an unrestricted California license and be actively Board Certified in the appropriate medical specialty. Mid-levels must have unrestricted California licensure or certification as applicable.
   - 5.2. Physicians must have an EMR/EHR or be in the process of implementing an EMR/EHR and cooperate with the Plan in providing access to transmission of data to and from the Plan for CalViva Health members.
   - 5.3. Physician must be open to the Plan's Medi-Cal business, with no member limit for a minimum of eighteen months.
   - 5.4. Physician must be new to the Plan and preference is to be new to the Fresno, Kings and Madera counties medical community.
   - 5.5. The contracting or employment entity will have to pay a pro-rated amount back to the Plan if the provider leaves the practice before two full years of participation.

6. Exceptions can be made to selection criteria and/or requirements if clinical needs outweigh either the criteria or requirements.

7. If the contracted PPG/organization is unable to hire the provider within 6 months from the signing of the agreement with the Plan; then the funding opportunity may be withdrawn and an alternate site, entity and physician type may be selected.

8. The Plan reserves the right to unilaterally withdraw the funding opportunity at any point in the process

V. Authority

A. RHA Joint Powers of Authority and Bylaws
~~A.~~B. DHCS Community Reinvestment Contractual and APL Requirements (25-004)

VI. References

A. None

APPROVAL:

Officer/Committee Chair Person David S. Hodge **Date:** ~~**May 19, 2022**~~**February 20, 2025**

Name: David S. Hodge, MD
Title: Commission Chair

Date	Department	Comment(s)
6/1/2017	Finance	New Policy
5/19/2022	Administration	This policy replaces in its entirety the previous policy approved by the Commission. Policy was updated to change departments from Finance to Administration. Edits were made to reflect current operational practices for the Community Support Programs.
2/20/2025	Administration	Policy was updated to address the new 2024 DHCS Contractual Requirements surrounding Community Reinvestments and DHCS All Plan Letter 25-004

Item #9
Attachment 9.A-B

Annual Delegation
Oversight of Health Net

9.A BL 25-004
9.B Executive Summary 2024 Annual Delegation Oversight & Monitoring Plan of Health Net community Solutions Report

Jeffrey Nkansah
Chief Executive Officer

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

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

DATE: February 20, 2025

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: 2024 Annual Delegation Oversight and Monitoring Report of Health Net

BL #: **25-004**
Agenda Item **9**
Attachment **9.A**

RHA Commissioners received and reviewed the full Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions, Inc. (Health Net) Calendar Year 2023 Report in Closed Session. A summary of the scoring and report is being provided to the public.

Scoring

- Pass (P) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is acceptable to CalViva.
- Fail (F) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is not acceptable to CalViva.
- Not Scored (NS) = CalViva has determined that based on its oversight and monitoring review(s) conducted, there is not enough data available to score performance.

Oversight and Monitoring Reviews Conducted	Score
Quality Assurance	P
Performance Standards	P
Reporting Completeness, Timeliness, & Accuracy	P
Oversight Audits	F

RECOMMENDED ACTION:

1. Approve the 2024 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report.

2. Approve Health Net Community Solutions, Inc. to continue their delegated functions for another year.

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority ("RHA") Commission

FROM: Jeffrey Nkansah, Chief Executive Officer

COMMITTEE DATE: February 20, 2025

SUBJECT: Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions – Calendar Year ("CY") 2024 Report & Executive Summary

Executive Summary

PURPOSE:

This report describes CalViva Health's delegation model and its processes for overseeing compliance of the activities delegated to ensure compliance with CalViva Health's contract with delegated entities, the Department of Health Care Services ("DHCS"), Department of Managed Health Care ("DMHC") contractual and regulatory requirements as well as the National Committee of Quality Assurance ("NCQA") accreditation requirements.

SUMMARY OF THE DELEGATION MODEL:

CalViva Health ("CalViva") has an Administrative Services Agreement ("ASA") with Health Net Community Solutions, Inc. ("Health Net") to provide certain administrative services on CalViva's behalf. Health Net is CalViva's Subcontractor/Plan Administrator.

CalViva also has a Capitated Provider Services Agreement ("CPSA") with Health Net for the provision of health care services to CalViva members through Health Net's network of contracted providers. Under the terms of the ASA and CPSA, Health Net has been delegated responsibility for performing a wide variety of administrative, clinical and provider network activities on CalViva's behalf.

CalViva oversees activities performed by Health Net through a variety of mechanisms including adherence to CalViva's performance standards, review of applicable Health Net policies and procedures, marketing materials, monthly, quarterly, semi-annual, and annual data or summary activity reports. Comprehensive report schedules listing all reports and

due dates are monitored by CalViva to ensure receipt and review of the required reports.

Periodic oversight audits of functions delegated to Health Net are also done throughout the year. All discussion(s) on reports, audit finding(s), corrective action(s) are presented to one or more of the Plan's oversight committees (i.e. Compliance Committee, QI/UM Committee, Finance Committee) and the Commission, as applicable.

Through the monitoring and oversight auditing processes discussed above, this report conveys CalViva's annual Compliance Assessment of Health Net and whether it is recommended for delegation to be continued.

SCORING:

- Pass (P) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is acceptable to CalViva.
- Fail (F) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is not acceptable to CalViva.
- Not Scored (NS) = CalViva has determined that based on its oversight and monitoring review(s) conducted, there is not enough data available to CalViva to score performance.

Oversight and Monitoring Reviews Conducted	Score
Quality Assurance	P
Performance Standards	P
Reporting Completeness, Timeliness, & Accuracy	P
Oversight Audits	F

NEXT STEPS:

Engage Health Net in the areas where the performance is not acceptable to CalViva and continue to perform oversight and monitoring of functions handled by Health Net on the Plan's behalf. CalViva recommends Health Net continue their delegated functions for another year during the engagement.

OVERSIGHT AND MONITORING REVIEW(S):

Quality Assurance:

Accreditation Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Review and confirm NCQA Health Plan Accreditation Status	➢ Review Accreditation Certificate & NCQA website o Screenshot of NCQA website o Copy of HN Accreditation Certificate Received	No
Review and confirm NCQA Health Equity Accreditation Status	➢ Review Accreditation Certificate & NCQA website o Screenshot of NCQA website o Copy of HN Accreditation Certificate Received	No
Quality Improvement (QI) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual Review of QI Program	➢ Reporting – o QI/UM 56 Annual Program Description, o QI/UM 57 Annual Work Plan, o QI/UM 59 QI Work Plan End of Year Evaluation o Calendar Year 2024 QI/UM Report Matrix o Calendar Year 2024 QI/UM Committee/Workgroup Meeting Minutes ➢ Audit – o QI Oversight Audit ▪ Calendar Year 2024 Completion of QI Oversight Audit (Audit Tool and Summary)	No Yes

Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 26 Blood Screening Performance ○ QI/UM 36 IHA Quarterly Audit Report ○ QI/UM 58 Work Plan Mid-Year Evaluation and Executive Summary ○ QI/UM 59 Work Plan End of Year Evaluation and Executive Summary ○ QI/UM 65 Continuity and Coordination of Medical Care (Analysis and Opportunities Report) ○ QI/UM 67 Continuity & Coordination b/w Medical and Behavioral Healthcare Report ○ Calendar Year 2024 QI/UM Report Matrix & Calendar Year ○ 2024 QI/UM Committee/Workgroup Meeting Minutes	No
Population Health Management (PHM) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual review of PHM Program	➢ Reporting – ○ QI/UM 79 PHM Program Strategy Description ○ QI/UM 80 Care Management Program Description ○ QI/UM 84 Care Management Program Evaluation ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar Year 2024 QI/UM Committee/Workgroup Meeting Minutes	No

Annual audit of complex case management files and continuity of care/transitions of care	➢ Audit – ○ UM Oversight Audit ▪ Calendar Year 2024 Completion of UM/CM Oversight Audit (Audit Tool and Summary Findings) ○ Continuity of Care Audit ▪ Calendar Year 2024 Completion of COC Oversight Audit (Audit Tool and Summary Findings)	Yes No
Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 16 Case Management and CCM Report ○ QI/UM 36 IHA Quarterly Audit Report ○ QI/UM 50 Enhanced Care Management (“ECM”) and Community Supports (“CS”) Performance Report ○ QI/UM 75 PHM Assessment Report ○ QI/UM 76 PHM Segmentation Report ○ QI/UM 77 PHM Effective Analysis Report ○ QI/UM 84 Case Management Program Evaluation ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar Year 2024 QI/UM Committee/Workgroup Meeting Minutes	No

Network Management (NET) Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Annual review of Network Management Program	➢ Reporting – ○ QI/UM 9 / Access 9 Geo Access Report ○ Access 27 Practitioner Availability Report ○ Access 28 Primary Care Accessibility Report ○ Access 29 Behavioral Health Accessibility Report ○ Access 30 Specialty Care Accessibility Report ○ Access 31 Non-Behavioral Health Network Adequacy Report ○ Access 32 Behavioral Health Network Adequacy Report ○ Access 33 Physician Directory Accuracy Report ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar Year 2024 QI/UM Committee Workgroup Meeting Minutes ○ Calendar Year 2024 Access Report Matrix ○ Calendar Year 2024 Access Workgroup Meeting Minutes ➢ Audit – ○ Access and Availability Oversight Audit ○ Provider Network Oversight Audit ▪ Calendar Year 2024 Completion of Provider Network Oversight Audit (Audit Tool and Summary Findings)	No Yes
Annual review of Network Management Procedures	➢ Access 16 P&P Review Access, Availability, Telehealth	No

Member Experience (ME) Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 1 A&G Dashboard & TAT Report ○ QI/UM 2 A&G Executive Summary ○ QI/UM 3 A&G IRR ○ QI/UM 4 A&G Member Report ○ QI/UM 5 A&G Audit Report ○ QI/UM 6 A&G Member Letter Monitoring Report ○ QI/UM 7 CCC Expedited Grievance Report ○ QI/UM 8 A&G Validation Audit Summary Report ○ QI/UM 9 / Access 9 Geo Access Report ○ QI/UM 57 QI Annual Workplan ○ QI/UM 58 QI Mid-Year Evaluation ○ QI/UM 59 QI End of Year Evaluation ○ QI/UM 78 Provider Appointment / After Hours Access Survey Results ○ Access 3 Member Satisfaction Survey with Access Report ○ Access 13 Member Satisfaction with Behavioral Health Care ○ Access 38 Quality and Accuracy of Member Calls ○ Access 39 Accuracy of Prior Auth and Referrals Information ○ Calendar Year 2024 QI/UM Report Matrix & Calendar Year 2024 QI/UM Committee/Workgroup Meeting Minutes, Calendar Year 2024 Access Report Matrix & Calendar Year 2024 Access Workgroup Meeting Minutes	No

Credentialing (CR) Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Annual review of credentialing policies and procedures.	➢ Reporting – o Medical Management 6 Health Net Credentialing Policies and Procedures ➢ Audit – o Credentialing Oversight Audit ▪ Calendar Year 2024 Completion of Credentialing Oversight Audit (Audit Tool and Summary Findings)	No Yes
Annual audit of credentialing and recredentialing files	➢ Audit – o Credentialing Oversight Audit ▪ Calendar Year 2024 Completion of Credentialing Oversight Audit (Audit Tool and Summary Findings)	Yes
Semi-Annually Evaluates Regular Reports	➢ Reporting – o QI/UM 29 Adverse Events Report o QI/UM 41 System Controls Oversight Report o Calendar Year 2024 QI/UM Report Matrix o Calendar Year 2024 Credentialing Sub-Committee Meeting Minutes	No

At least annually monitor Health Net's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with Health Net's policies and procedures at least annually. If necessary, Act on all findings from Factor 5 and implement a quarterly monitoring process until Health Net demonstrates improvement for one finding over three consecutive quarters	➢ Reporting – ○ QI/UM 41 System Controls Oversight Report	No
Utilization Management (UM) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual review of UM Program.	➢ Reporting – ○ QI/UM 69 UM/CM Work Plan ○ QI/UM 72 UM/CM Program Description ○ QI/UM 71 UM/CM Work Plan End of Year Evaluation ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar Year 2024 QI/UM Committee Workgroup/Meeting	No
Annual audit of UM denials and appeals	➢ Audit – ○ UM/CM Oversight Audit ▪ Calendar Year 2024 Completion of UM Oversight Audit (Audit Tool and Summary Findings)	Yes

Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 3 A&G IRR ○ QI/UM 42 Pharmacy IRR, ○ QI/UM 45 System Controls Denials ○ QI/UM 63 KIR TAT Report ○ QI/UM 70 UM/CM Mid-Year Evaluation Report ○ QI/UM 71 UM/CM End of Year Evaluation Report ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar Year 2024 QI/UM Committee Workgroup Meeting Minutes	No
At least annually monitor Health Net's UM denial and appeals system security controls to ensure that Health Net monitors its compliance with the delegation agreement or with Health Net's policies and procedures at least annually. If necessary, Act on all findings from Factor 5 and implement a quarterly monitoring process until Health Net demonstrates improvement for one finding over three consecutive quarters	➢ Reporting – ○ QI/UM 45 System Controls Denials Report ○ QI/UM 48 System Controls Appeals Report	No
Health Equity (HE) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual review of Health Equity Program	➢ Reporting – ○ QI/UM 11 Health Equity Program Description ○ QI/UM 12 Health Equity Work Plan ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar 2024 QI/UM Committee/Workgroup Meeting Minutes	No

Annual evaluation of performance	➢ Audit – ○ Health Equity Oversight Audit ▪ Calendar Year 2024 Completion of Health Equity Oversight Audit (Audit Tool and Summary Findings)	NO
Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 9 / Access 9 Geo Access Report ○ QI/UM 10 Language Assistance Program Report ○ QI/UM 13 Health Equity Mid-Year Work Plan Evaluation ○ QI/UM 14 Health Equity Work Plan End of Year Evaluation ○ QI/UM 86 Disparities Analysis and Actions Report ○ Calendar Year 2024 QI/UM Report Matrix ○ Calendar 2024 QI/UM Committee/Workgroup Meeting Minutes	No

HEALTH NET'S ADHERENCE TO CALVIVA's PERFORMANCE STANDARDS CY 2024:

MEASUREMENT	DEFICIENT	DESCRIPTION OF DEFICIENCY	CAP REQUESTED	MONETARY PAYMENT ASSESSED
HEDIS / MCAS	YES	Sanction Notice – HEDIS/MCAS Measures below MPL.	TBD	TBD
Encounters	NO	N/A	N/A	N/A
Provider Network	NO	N/A	N/A	N/A

Regulatory Audits	TBD	Repeated and uncorrected deficiency identified in a regulatory audit due to a CAP not being implemented or not effectively implemented to achieve and sustain compliance.	TBD	TBD
Reporting	NO	N/A	N/A	N/A

1. Section 2.05 of the ASA describes Health Net's obligation to comply with the CalViva Performance Standards set forth in Exhibit B of the Agreement.

2. Section 2.05 also describes CalViva's obligation to evaluate the specific Performance Standards Health Net failed along with the amount of Performance Penalty CalViva intends to assess against Health Net's Administrative Fees.

HEALTH NET'S REPORTING COMPLETENESS, TIMELINESS & ACCURACY TO CALVIVA:

Health Net's Reporting to CalViva have been categorized by function, requesting agency, or workgroup in which they are presented (See Table below). Comprehensive report schedules listing all reports and due dates are monitored by CalViva to ensure receipt and review of the required reports.

Management Oversight Meeting (MOM) reports	DMHC_DHCS Regulatory reports
Quality Improvement /Utilization Management (QI/UM) reports	OPERATIONAL reports
ACCESS reports	FINANCE reports
ENCOUNTERS reports	COMPLIANCE reports
DHCS Regulatory reports	MEDICAL MANAGEMENT reports
DMHC Regulatory reports	Ad-Hoc Reports

Health Net reports were received for oversight and if applicable reviewed/approved/adopted during CY 2024 at one or more of the Plan's oversight meeting forums with accompanying meeting

minutes (i.e. QI/UM Committee, Peer Review Sub-Committee, Credentialing Sub-Committee, QI/UM Workgroup, Appeals and Grievances Workgroup, Access Workgroup/Committee,) and the Commission, as applicable.

CALVIVA OVERSIGHT AUDIT(S) OF HEALTH NET:

CalViva employs both "desk review" and "on-site" audit methods. Various types of evidence are requested to confirm compliance with DHCS/DMHC contractual requirements and regulations, NCQA Accreditation Requirements, and Health Net Administrative/Capitated Provider Service Agreement contractual obligations to CalViva.

Evidentiary materials include but are not limited to a comprehensive oversight audit report schedule listing all oversight audits, look back period(s), schedules, statuses, and corrective actions is monitored and available by CalViva.

The schedule is reviewed, and discussed at least quarterly at the Plan's Compliance Committee oversight meeting forum with accompanying meeting minutes during CY 2024. The table below identities the functional areas audited by CalViva for compliance and the respective agency/entity/standard being assessed for compliance.

Functional Area Audited	CalViva Contract	DHCS Contract	DMHC Knox Keene	NCQA Standards
Appeals and Grievances	X	X	X	UM, ME
Access and Availability	X	X	X	NET
Behavioral Health	X	X	X	QI, PHM, UM, NET, CR, ME
Call Center / Member Services	X	X	X	ME
Claims	X	X	X	
Continuity of Care	X	X	X	PHM
Credentialing	X	X	X	CR
Emergency Room Services	X	X	X	
Fraud, Waste, Abuse	X	X	X	
Health Education	X	X	X	
Health Equity	X	X	X	ME, HE
Marketing	X	X	X	ME

Member Rights – Member Experience	X	X	X	ME
Pharmacy*	X	X	X	PHM, UM, ME
Privacy and Security	X	X	X	ME, HE
Provider Network	X	X	X	NET, ME
Provider Dispute Resolutions	X	X	X	
Quality Improvement	X	X	X	QI, PHM, HE, ME
Utilization Management / Care Management	X	X	X	UM, PHM

* Statewide policy. Medicaid/Medi-Cal members pharmacy benefit is under Medi-Cal RX administered directly by the State.

CY 2024 AUDIT OVERSIGHT AUDIT RESULTS & ANALYSIS

The following table below will identify the Oversight Audits **that were completed** in CY 2024.

Functional Area Audited	Completion Date	CAP
Access and Availability		
Appeals and Grievance	9/23/2024	YES
Behavioral Health	5/1/2024	NO
Call Center / Member Services		
Claims	10/31/2024	YES
Continuity of Care	11/26/2024	NO
Credentialing	4/26/2024	YES
Emergency Room Services	12/18/2024	YES
Fraud, Waste, & Abuse	11/1/2024	NO
Health Education	12/3/24	NO
Health Equity	8/2/2024	NO
Marketing	8/20/2024	NO
Member Rights – Member Experience	8/6/2024	NO
Pharmacy		

Privacy and Security	10/1/2024	YES
Provider Network	10/11/2024	YES
Provider Disputes	10/28/2024	YES
Quality Improvement	4/17/2024	YES
Utilization Management / Care Management	4/26/2024	YES

Item #10
Attachment 10.A

New Ad-Hoc Committee Regarding
Conference Report Involving Trade Secret

10.A BL 25-005

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Garry Bredefeld
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D., 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

Jeffrey Nkansah
Chief Executive Officer
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DATE: **February 20, 2025**

TO: **Fresno-Kings-Madera Regional Health Authority Commission**

FROM: Jeffrey Nkansah, Chief Executive Officer

RE: **New Ad-Hoc Committee regarding Conference Report Involving Trade Secret—Discussion of Service, Program, or Facility with an Estimated Date of Public Disclosure of January 2028**

BL #: **25-005**
Agenda Item **10**
Attachment **10.A**

BACKGROUND:

On May 16, 2024, RHA Commissioners in Closed Session agendized:

- Conference Report Involving Trade Secret—Discussion of Service, Program, or Facility in accordance with Government Code Section 54954.5 with an Estimated Date of Public Disclosure: January 2028.

On January 16, 2025, RHA Commissioners once again in Closed Session agendized:

- Conference Report Involving Trade Secret—Discussion of Service, Program, or Facility in accordance with Government Code Section 54954.5 with an Estimated Date of Public Disclosure: January 2028.

DISCUSSION:

Establish an Ad-Hoc Committee appointed by the RHA Commission. The Ad-Hoc Committee will include a minimum of three (3) Commissioners, the Chief Executive Officer, and Chief Financial Officer. The Ad-Hoc Committee will review and evaluate and make recommendations to Commission for Action.

RECOMMENDED ACTION:

1) Grant authority for CalViva CEO to contract an organization/individual who can assist in navigating the California political and policy making environment and 2) Appoint the following RHA Commissioners to a New Ad-Hoc Committee regarding Conference Report Involving Trade Secret—Discussion of Service, Program, or Facility with an Estimated Date of Public Disclosure of January 2028:

1. Mr. Paulo Soares, At-Large, Madera County
2. Ms. Rose Mary Rahn, Director, Public Health Department, Kings County
3. Mr. David Luchini, Director, Public Health Department, Fresno County

Item #11
Attachment 11.A-B

2024 Annual Quality Improvement & Health Education Work Plan Evaluation

11.A Executive Summary
11.B Year End Evaluation

EXECUTIVE SUMMARY REPORT TO COMMITTEE

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

FROM: Patrick Marabella, MD, Chief Medical Officer
Amy Schneider, RN, Senior Director Medical Management

COMMITTEE DATE: February 20, 2025

SUBJECT: CalViva Quality Improvement (QI) and Health Education Program Evaluation Executive Summary 2024 – Year-End

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Summary:

CalViva Health (CalViva) annually assesses the overall effectiveness of its Quality Improvement (QI) and Health Education (QIHEd) Program at improving network-wide clinical and service practices. CalViva has an Administrative Services Agreement with Health Net to provide capitated provider, network, and administrative services. Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for both Health Plan (HPA) Health Equity (HEA) and Health Equity Plus Accreditation. As part of the CalAIM strategy to be "NCQA accredited" by January 1, 2026, CalViva obtained HP Accreditation in July 2024 and plans to obtain HEA in Q2 2025. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

The Quality Improvement (QI) and Health Education Program Evaluation Executive Summary 2024 Year-End includes:

- Summary of Overall effectiveness of QIHEd Program
- Goals and Quality Indicators
- Overall Effectiveness of QIHEd Work Plan Initiatives
- QIHEd Reporting
- Summary of Key Accomplishments
- Annual QIHEd Program Changes

Quality Improvement (QI) and Health Education Program Evaluation Executive Summary 2024 – Year-End

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Section 1: Summary of Overall Effectiveness of QIHEd Program

CalViva Health ("CalViva") is a National Committee for Quality Assurance (NCQA) accredited health plan and plans to obtain Health Equity Accreditation in Q2 2025. Annually CalViva assesses the overall effectiveness of its Quality Improvement (QI) and Health Education Program at improving network-wide clinical and service practices to improve health outcomes and reduce disparities. CalViva has an Administrative Services Agreement with Health Net Community Solutions to provide provider, network, and administrative services Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for Health Plan (HPA), Health Equity (HEA) and Health Equity Plus Accreditation.

Health Net and CalViva collaboratively and continually strive to incorporate a culture of quality across their organizations, conduct operations to improve service and satisfaction for CalViva members as well as support and oversee the provider network to improve provider quality outcomes using measurement systems including Healthcare Effectiveness Data and Information Set (HEDIS®), provider access, availability, and satisfaction surveys, the Experience of Care and Health Outcomes (ECHO) Survey and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) rates. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

Health Equity Accreditation (HEA) recognizes organizations that lead the market in providing culturally and linguistically responsive services, and work to reduce health care disparities. The NCQA HEA Plus Standards, are an additional add-on option to HEA, and help provide a roadmap to improve and refine initiatives focused on providing high quality health care and connecting social and community support services to the communities we serve. Health Net was awarded HEA and HEA Plus status in September 2022 and both renewed in September 2024. As part of the CalAIM strategy to be "NCQA accredited" by January 1, 2026, CalViva plans to obtain HEA in Q2 2025, with the HEA Plus option.

QI Committee Structure

CalViva's QIHEd Program was successfully supported by the CalViva QI/UM Committee which met seven times in 2024. The committee oversaw the QIHEd Program, provided feedback, decision support, and recommendations for the QIHEd Program throughout the year. The QI/UM Committee reported to the CalViva Regional Health Authority (RHA) Commission six times in 2024.

CalViva's Credentialing and Peer-Review Subcommittees also successfully supported CalViva's QI Program, as demonstrated in the organizational chart below. These subcommittees met four times each in 2024. Additionally, QI/UM Workgroup, Appeals and Grievance Workgroup, and Access Workgroup meetings were held in 2024 to develop, monitor, and evaluate activities supporting the QI Program.

The QI/UM Workgroup supported the efforts of the QI/UM Committee by scheduling, receiving, reviewing, editing, and approving reports for presentation at the QI/UM Committee. QI Workgroup aided in the identification and pursuit of opportunities to improve health outcomes, safety, access and member and provider satisfaction.

The QI/UM Workgroup met thirty-one times in 2024 and was chaired by CalViva's Chief Medical Officer. Members of the Workgroup consisted of CalViva staff including Senior Director of

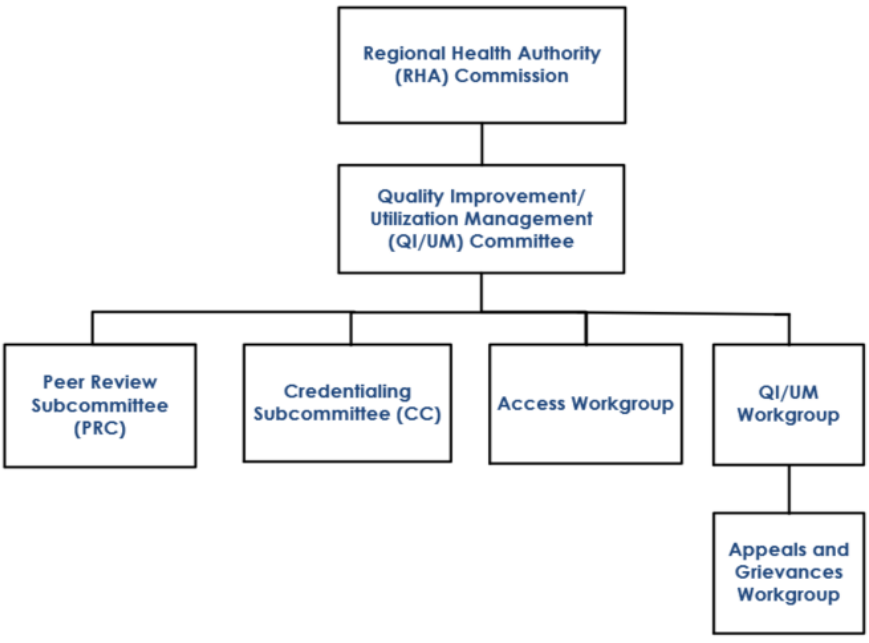
Medical Management (Registered Nurse) and a Manager of Medical Management Services (also a Registered Nurse); and Health Net staff from Quality Improvement/Health Education/Wellness, Appeals and Grievances, Health Equity, Pharmacy, Credentialing, Customer Contact Center, Population Health Management, Provider Network Management, and Provider Relations. The Workgroup conducted performance improvement reviews and discussions of monitoring of QI/UM activities, findings, barriers, and interventions to develop and implement actions. Significant findings and follow-up were reported to the QIUM Committee and RHA Commission.

CalViva's Access Workgroup met seven times in 2024. The CalViva Health Access Workgroup included representatives from CalViva Health and Health Net departments with access and network adequacy related functions. The Workgroup reviewed findings from ongoing monitoring of access to plan services, identified gaps, and developed and evaluated activities that addressed those gaps in access to care. The Workgroup submitted issues that required escalation to the Management Oversight Meeting ("MOM"), QI/UM Committee and/or RHA Commission for final decision and approval of recommended actions.

The Appeal and Grievance Workgroup reported to the QI/UM Workgroup and supported the QI Program through the review and analysis of appeal and grievance data. The Appeals and Grievances Workgroup met seven times in 2024. The workgroup processed, tracked, and trended member grievances and appeals at the provider and plan level. The Workgroup submitted reports to the Peer Review Subcommittee to review, act on and follow-up on identified significant events or trends.

Please refer to the 2024 Quality Improvement and Health Education Program Description for more information on the sub-committees.

CalViva's Quality Improvement Committee Organizational Chart



Practitioner Participation and Leadership Involvement in the QIHEd Program
The committee structures for CalViva ensured that external and internal physicians with various specialties participated in the planning, design, implementation, and review of the QIHEd Program. Six external providers were participants in the QIUM Committee and both the Credentialing and Peer Review Sub-Committees with specialties in Pediatrics, Behavioral Health, Internal Medicine, Family Medicine, Obstetrics and Gynecology, and General Surgery. CalViva's Chief Medical Officer chaired the committees and invited external practitioners to participate.

Practitioner involvement in 2024 included: reviewing and approving the 2023 QI Work Plan Year-End Evaluation, and the 2024 QIHEd Program Description and Work Plan. Practitioners discussed opportunities for improvement based on Reporting Year (RY) 2024 HEDIS© results and performance. Practitioners were also involved in performance improvement projects to address underperforming measures. In 2024, CalViva worked with high volume, low performing providers, and clinics in Fresno County. CalViva and Health Net established multidisciplinary improvement teams, including local providers and practitioners, that worked collaboratively to determine the current processes, identify potential barriers, and establish plans for improvement to address potential barriers with work plan projects and outcomes. This included projects on Well-child Visits and Behavioral Health.

In 2024 CalViva Medical Management Team reinstituted Annual Clinic Visits focused on high volume FQHC's/Clinics throughout Fresno, Kings, and Madera counties. During these 90-minute clinic site visits, the Medical Management Team presents provider specific HEDIS® results, discusses barriers to meeting the measures, and shares successful strategies and lessons learned from current and previous quality improvement projects. In Q4 two Annual Clinic Visits were conducted, one at United Health Centers in Fresno County and one at Adventist Health in Kings County. Both visits were very successful, engaging clinic leadership and quality improvement staff in productive dialogue regarding future activities and collaborative efforts.

Adequacy of QIHEd Program Resources
In 2024, CalViva's QI Team included a Chief Medical Officer, a Senior Director of Medical Management, a Manager, a Nurse Analyst, and an Administrative Coordinator. The Chief Medical Officer (CMO), who oversaw the QIHEd Program, chaired all QI/UM Committee meetings in 2024. Along with the Senior Director of Medical Management, he reviewed and approved all QI policies and procedures during the annual policy review and when updates/edits were made throughout the year. The CMO reported at least quarterly to the RHA Commission on the status and activities of the QIHEd program. The CMO and Senior Director of Medical Management co-chaired bi-weekly multi-disciplinary team meetings for all PIP, Quality Management Improvement Projects (QMIP)and regulatory projects in 2024. These teams were the focal point for evaluating current results and processes, identifying and testing potential interventions, monitoring and evaluating results, and modifying interventions or spreading lessons learned and best practices to other providers and counties. Finally, reports were shared with appropriate regulatory agencies.

The CalViva QIHEd Program was led by the Senior Director of Medical Management who worked in collaboration with the Health Net Quality Management Departments and teams to implement QIHEd programs and activities to address and improve quality of care and service, patient safety, and member and provider satisfaction. Monthly QI Leadership Meetings occurred between the CalViva QI Team and the Health Net departments to provide high level updates from Quality Improvement, Provider Engagement, and Medical Affairs teams and discuss any issues that may require follow up.

In 2024, the delegated Quality Management Department at Health Net led by the Vice President of Quality Management, remained a centralized, interdisciplinary team working to support members in a coordinated manner, resulting in focused efforts to improve HEDIS and CAHPS performance. Participating provider groups (PPGs) could access HEDIS report cards, highlighting their performance on key measures compared to national benchmarks, as well as care gap reports including member and practitioner-level information for PPGs to determine actionable approaches to close care gaps. Five departments comprised Quality Management, each with a separate leadership structure: 1) Quality Improvement and Health Education, 2) Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review, 3) Program Accreditation and CAHPS, 4) Health Equity, and 5) HEDIS and Quality Analytics. The Quality Improvement Analytics team supported data needs across all Quality Management teams and departments. Based upon the results of the 2024 monitoring activities noted below and within the attached full Work Plan, CalViva has determined that program resources met the needs of CalViva membership and providers. Planned activities were consistently completed (110/129 overall) and within expected timeframes. HEDIS® measures demonstrated compliance in fifty-eight percent of objectives met.

Quality Improvement Department and Health Education System
Under the direction of the Medi-Cal QI Director, and in collaboration with the Senior QI Manager, the Program Owners and Drivers (PODs) lead each program/measure strategy. Program Managers lead the Measure Specific PODs and drove strategy by measure/area of focus as well as drove long-term strategy for their geographic or topical areas to address health education and quality outcomes improvement. The PODs generally consisted of Program Manager IIIs, Senior QI Specialists, QI Specialists, Health Educators, and Project Managers who ensured compliance and implementation for all required activities. The Health Education POD was led by two Directors that managed a team implementing health education programs, compliance activities and comprised of Senior Health Education Specialists, Health Education Specialists, and Program Manager IIs. As needed, external providers, clinics and clinic staff were brought in as guest partners on formal QI projects.

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review Department

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site review was led by a QI Director of Clinical Services and included two Senior Managers of Provider Data Management and Credentialing, and a QI Manager of Clinical Grievance for PCPs for Medi-Cal.

The Facility Site Review (FSR) team collaborated with other Medi-Cal Managed Care plans throughout the state to maintain and refine a standardized system-wide process for conducting reviews of primary care physician facility sites, along with Medical Record Review (MRR) and Physical Accessibility Review Surveys (PARS). This process minimized duplication and supported consolidation of FSR surveys. The process incorporated evaluation criteria and standards in compliance with DHCS contractual requirements and was applicable to all Medi-Cal Managed Care plans. The FSR department also conducted provider education, provider outreach, and other QI activities. The FSR QI Director provided regular updates of FSR, MRR, and PARS activity via reports to the Quality Improvement Committee. These evaluation reports identified overarching areas of noncompliance by sections and selected elements, reported at the regional level with year-over-year (YOY) comparison. This detailed analysis allowed for monitoring and identification of improvement opportunities. The FSR team collaborated with the Regional Medical Directors and Credentialing, Provider Network, Clinical Grievances, Health Education, Health Equity, and Provider Relations departments to implement process improvements.

Program Accreditation Team
The QI Senior Director led the Program Accreditation team. The Program Accreditation team included a Manager of Accreditation, two Compliance Specialists, and a Compliance Analyst. This team led activities to ensure ongoing organization-wide compliance with requirements of accrediting bodies for Health Plan Accreditation (HPA), Health Equity Accreditation (HEA), and external and internal audit readiness; including completion of HPA for CalViva in Q2 2024. At year end, in review of staff resources and support, the Quality department transitioned Quality EDGE to the Program Accreditation team. As a result, a Compliance Analyst and Compliance Specialist were promoted to Project Manager II positions, a Quality Improvement Specialist I was added to the team, and a Quality Program Specialist transferred from the Quality Medi-Cal team.

CAHPS Team
The QI Sr. Director also led the CAHPS team that included two Program Manager IIIs focused on implementing the CAHPS member experience survey. The team also led improvement strategies including root cause analysis of member pain points, CAHPS exposure and training, mock CAHPS implementation, and improvement initiatives in partnership with operations and provider-facing teams.

Health Equity Team
The Health Equity team was unique in its cross-functional support structure. The Health Equity team had representation throughout the State and was staffed by a Vice President of Quality Management, a Manager of Health Equity, one Program Manager III, five Senior Health Equity Specialists, two Health Equity Specialists, and one supplemental staff position. There was a strong governance structure to oversee and provide support to cultural and linguistic/health equity services. The Health Equity team had a breadth of knowledge as it related to the integration of cultural and linguistic services within the health plan and across operational areas of cultural competency, health literacy, language assistance services, addressing health disparities and compliance. The Health Equity team analyzed, designed, and implemented strategies to support the reduction of health disparities and facilitate the Health Equity

workgroups, which were responsible for developing and implementing an action plan to reduce health disparities in targeted HEDIS measures.

CalViva adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards represented 15 different standards that served as the foundation for the development of the Health Equity Department strategic plans. To ensure that the plan was continually striving to be responsive to the membership, the Health Equity Team conducted data analysis and designed and implemented services to meet the needs of CalViva members. Internally, the Health Equity Team surveyed new employees to determine staff diversity and cultural and linguistic, and supported and trained bilingual associates. In 2024, there were 202 certified bilingual staff members who supported the CalViva service area. Externally, the Health Equity team conducted a biennial Geo Access report, which used member zip code data and correlated it with member language preference. These data were further overloaded with provider network language capabilities and a gap analysis was conducted to target network expansion. The Human Resources Department and Diversity and Inclusion team were responsible for the overall coordination to ensure a diverse leadership and workforce.

HEDIS Department

A Senior Director of HEDIS Reporting and Business Analytics led the HEDIS Department. There were one Director, two Senior Managers, two Managers, three Supervisors, and four HEDIS Program Managers, along with Medical Record Abstractors, Analysts and Customer Service Advocates that comprised the team. The HEDIS team was responsible for HEDIS measurement and reporting annual rates, creating provider report cards/care gaps, provider incentive programs and outward-facing provider and member outreach to support data and care gap closure.

The HEDIS team also had a QI Director of Data Analysis who oversaw the QI Research and Analysis (QIRA) team within the department and was responsible for ensuring the production of detailed reporting and analytics. The QIRA team reported directly to the QI Director of Data Analysis and was responsible for providing data and analytical support for QI projects and is comprised of seven analysts (six Biostatistician I and one Biostatistician II) and three Quality Analytics Program Managers (QAPMs) who supported CalViva.

Section 2: Goals and Quality Indicators

The Quality Improvement 2024 Work Plan included eight categories. To determine CalViva's success in achieving specified goals, the plan calculated the number and percentage of activities completed and objectives met per category (**Tables 2.1 and 2.2**) and outlined RY 2024 performance against the goals in the Appendix.

Table 2.1 Activities Completed by Category

Work Plan Programs	Year-End Activities Completed	Rate (%)
1. BEHAVIORAL HEALTH	5/6	83.33%
2. CHRONIC CONDITIONS	24/30	80%
3. HOSPITAL QUALITY/ PATIENT SAFETY	9/9	100%
4. MEMBER ENGAGEMENT AND EXPERIENCE	2/2	100%
5. PEDIATRIC/PERINATAL/DENTAL	36/40	90%
6. PHARMACY	7/8	87.5%
7. PREVENTIVE HEALTH	14/16	87.5%
8. PROVIDER COMMUNICATION/ ENGAGEMENT	13/18	72.22%
Total	**110/129**	**85.27%**

Table 2.2 Objectives Met

Category	2024 Objectives Met	Rate (%)
1. BEHAVIORAL HEALTH	0/6	0%
2. CHRONIC CONDITIONS	6/6	100%
3. HOSPITAL QUALITY/ PATIENT SAFETY	9/11	81.82%
4. MEMBER ENGAGEMENT AND EXPERIENCE	0/1	0%
5. PEDIATRIC/PERINATAL/DENTAL	15/30	50%
6. PHARMACY	1/3	33.33%
7. PREVENTIVE HEALTH	12/12	100%
8. PROVIDER COMMUNICATION/ ENGAGEMENT	5/9	55.56%
Total Rate	**49/78**	**62.82%**

As shown in **Table 2.1**, 85.27% of the total 2024 work plan activities were completed as planned. Overall, CalViva met 62.82% of the total year work plan objectives **(Table 2.2)**.

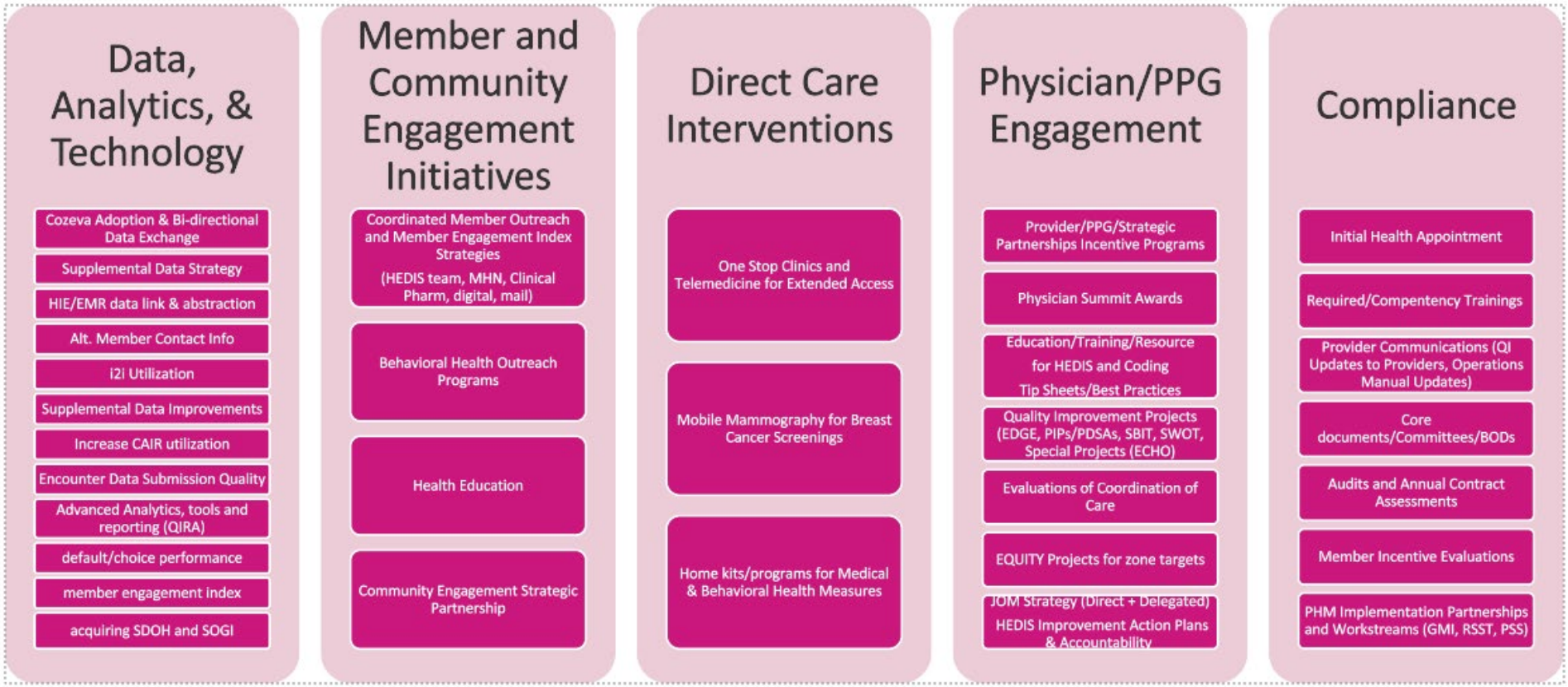
Quality goals follow regulatory and accreditation standards, which can change annually. **Appendix Table A-1** provides the performance goals of the plan. These goals were the overall percentiles that CalViva seeks to achieve. Additionally, the objectives were tied to how much of the goals were accomplished within the year, which can include meeting directional improvement (e.g., improved performance year-over-year, **Appendix Table A-5 to Table A-19**).

As set by DHCS, all MCAS measure rates must exceed the minimum performance level (MPL) of 50th percentile. CalViva's performance goal for CAHPS was to meet the NCQA 25th percentile national benchmark. The goal for provider surveys was to meet the 70% or 90% performance rate for provider access or satisfaction survey measures. The outcomes tables in the Appendix provide detailed measure-level progress toward goals.

To meet or exceed the MPL, CalViva carried out numerous targeted programs and performance improvement projects to close care gaps. The team continued to prioritize interventions along

the strategic tracks noted in **Chart 1**. Critical interventions that address data and targeted analysis, member supportive and direct care services, provider engagement and compliance, all worked cohesively to support goal achievement.

Chart 1 Quality Improvement Strategic Tracks



In addition, the QI Team collaborated with the Provider Engagement Team to continue implementation of Quality EDGE (Evaluating Data to Generate Excellence). Quality EDGE is a systematic five step change management cycle that integrates quality improvement tools, focused measure sets and provider engagement strategic assessments to drive providers to rapid improvements in HEDIS outcomes. The mission of Quality EDGE is to outperform all market competitors on quality metrics by providing unparalleled consultative services, innovative programs and actionable reports while improving health equity. The Vision: We are the partner of choice, collaborating internally and with our providers to deliver the highest quality of care to the most vulnerable population. The team collaborated to identify the following goals for 2024:

1. Complete and deploy action plans for priority providers (specific targets in development).
2. Continually measure, evaluate, and improve processes to ensure efficacy of Quality EDGE and full engagement among the staff.
3. Improve results for "voice of the provider" (specific target in development).

Goals Met:

Quality of Care: MCAS

Overall, CalViva achieved 59% of MCAS measures above the MPL for Measurement Year (MY) 2023. **Appendix Table A-2** provides a breakdown of the percent of required MCAS measures above MPL for each of the three CalViva Medi-Cal counties. Fresno County met 50% of its objectives. Kings County met 39% of its objectives. Madera County met 89% of its objectives. Refer to **Section 5** for a summary of key accomplishments by county and measure category.

Hospital Quality/Patient Safety

Hospital quality performance was measured across CalViva's network based on facilities with sufficient publicly available data across priority metrics (5 facilities total). CalViva hospitals largely showed either appropriate performance or improvement, and continued avoidance of outlier performance for hospital-acquired infection metrics. The network showed directional improvement for hospitals meeting the standardized infection ratio of 1.0 or lower for *catheter-associated urinary tract infections* (CAUTI) and *Methicillin-resistant Staphylococcus aureus* (MRSA), while all hospitals continued to meet the goal for *Clostridioides difficile* (C.Diff). The proportion of hospitals meeting the goal for *central line-associated bloodstream infection* (CLABSI) and *Surgical site infection following colorectal surgery* (SSI-Colon) declined from last year's performance due to one fewer hospital meeting the goal for each infection. The network successfully avoided outliers for all five infections. Hospitals meeting the NTSV C-section rate standard of 23.6% or lower showed directional improvement, with three out of five facilities (60%) meeting the goal compared to just one hospital (20%) the previous year.

Behavioral Health

For 2024, the focus was on improving timely follow up care after an emergency department (ED) visit for either a principle mental health or substance use diagnosis, or the FUM and FUA HEDIS® metrics, for CalViva members. For all three CalViva counties, the National 50th percentile Quality Compass goal was not achieved and all metrics showed decreases from the prior measurement year. There is an ongoing focus on improving both the FUM and FUA metrics moving forward, including an ongoing regulatory Performance Improvement Project and a Lean process improvement project. (**Appendix Table A-6)**.

Health Services Advisory Group (HSAG) CAHPS Survey

In 2024, the annual CAHPS survey was conducted for CalViva by the state (HSAG). Results showed 3/8 measures met the Outcome Quality Compass (QC) 25th percentile goal: Rating of

All Health Care, Rating Personal Doctor, and Rating of Health Plan. Three out of the eight measures had non-reportable data due to small sample size (N<100). (**Appendix Table A-7)**.

Provider Access, Availability, Satisfaction Survey Measures

Results from provider surveys showed directional YOY improvement achievement or met the 70 (PAAS) or 90% (PSS, PAHAS) rate objectives in 69.08% (105/152) of total measures. CalViva met the following goals:

- 50.82% (68/88) of PAAS measures (**Appendix Tables A-8 to A-12**).
- 66.67% (4/6) of the Telephone Access Survey measures (**Appendix Table A-13**).
- 64% (22/32) of Provider Satisfaction Survey (PSS) measures and 50% of BH PSS measures (**Appendix Tables A-14, A-15, and A-16**).
- 66.67% (4/6) of Provider After-Hours Survey measures (**Appendix Table A-17**).
- 27.78% (5/18) of ECHO survey measures (**Appendix Table A-18**).
- 100% (2/2) of Behavioral Health PAAS by Risk Rating measures (**Appendix Tables A-19**).

*Refer to the **Appendix Tables A-3 and A-5** for the summary of goal attainment by program category for RY 2024.*

As the tables demonstrate, there is still progress needed to reach the goals set for each county/category, for example Kings County is at 39% where Fresno and Madera Counties are at 50 and 89%,respectively. Despite meeting a majority of the MCAS objectives, meeting directional improvement on CAHPS measures, and reaching the 70 or 90% performance goal rate for provider survey measures. There also remains an opportunity to reach the goals set for CalViva. Opportunities by category are found in **Appendix Table A-4:** Summary of Barriers and Opportunities.

Barriers to Achieving Goals and Objectives:

MCAS

- Initial outreach calls to members resulted in a low reach rate. A portion of members who were contacted were not successfully reached after three (3) phone attempts and thus remained noncompliant for their chronic illness.
- A portion of members who were reached lacked the understanding/desire to learn about how to manage their chronic illness through basic education, lifestyle changes, medication management, etc.
- Members reported transportation issues, such as only having one car to transport all family members to their activities, broken down vehicles and/or unexpected family emergencies.
- Members stated they could not commit to attending the classes because they work long varied hours, needed more advance notice, have to arrange for childcare, and encountered family emergencies.
- Many of these members reported that a standard classroom setting during regular business hours may not be feasible and expressed interest through a virtual or hybrid class model.

Measure Barriers.

- *Breast Cancer Screening* (BCS):
    - Disparities in BCS in the Hmong population.

- Language barriers and low health literacy may take several attempts to explain a mammogram. The Healthy Equity Team, Health Education and Provider Engagement must work together for successful outreach, education, and events with on-site mammograms.
- Unable to reach members due to disconnected phone numbers, no voice mail set-up, and wrong numbers.
- Members often do not arrive at their scheduled time and adjustments may be required to fit them in the schedule.
- Inadequate access to screening mammography and there is a limited volume of mobile mammography vendors. Further, regulatory requirements for DHCS provider contracting has delayed implementation with available vendors.
- Variable provider referral and follow-up practices.
- Appointment availability at high traffic radiology facilities.

- *Childhood Immunization Status – Combination 10* (CIS-10) :
  - Lack of member understanding of the importance of immunizations.
  - The complicated and time-bound immunization schedule – immunizations completed out of timeframe.
  - Parent refusals for vaccines during office visits.
  - Lack of strong recommendations from providers for immunizations.
  - Missing one or both flu vaccines. Parent's viewing the flu vaccine as optional.
  - Missing Hep B vaccines from hospitals.
  - Members not completing the vaccine series after turning one year.
  - Language barriers.

- *Developmental Screening in the First Three Years of Life* (DEV)
  - Incorrect modifiers used by providers billing for developmental screenings.

- *Immunizations for Adolescents – Combination 2* (IMA-2)
  - Missing HPV vaccines.
  - Member vaccine hesitancy for the HPV vaccine.
  - Providers not starting HPV vaccine series at age 9.

- *Well-Child Visits in the First 30 Months of Life - 0 to 15 Months* (W30-15)
  - Members did not understand the importance of infant well-care checkups, the periodicity schedule and what to expect in infant well-care checkups.
  - Lack of connection of pregnant members to pediatricians to get the parent established with the pediatrician so the parent knows when to bring in the newborn after discharge from the hospital.
  - Data gap of W30-6+ visits. Completed W30-6+ visits are not getting to the health plan primarily due to the lack of a link between the birthing parent and the newborn.
  - Lack of access to infant well-care visits. It could take weeks or months to get well-care appointments, putting the infant behind on visits according to periodicity schedule. Lack of dedicated provider time to well-care visits.

- *Well-Child Visits in the First 30 Months of Life - 15 to 30 Months* (W30-30)
  - Members did not complete infant well-care after babies turn one year.
  - Parents were not able to bring children to well-care appointments during regular business hours.

- Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.

- *Child and Adolescent Well-Care Visits* (WCV):
  - Lack of provider outreach to members to complete WCV.
  - Lack of member engagement with child and adolescent well-care.
  - Parents were unable to bring children to well-care appointments during regular business hours.
  - Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.

- *Cervical Cancer Screening* (CCS):
  - Members could not be reached by phone.
  - Members refused the CCS screening.
  - Lack of knowledge regarding the test.
  - Members are not yet educated on the self-test.
  - Providers are not aware of the self tests as it is a new update.
  - Fears related to the service.
  - Staff turnover.
  - Stigma around the topic within certain populations.

- *Controlling Blood Pressure* (CBP)
  - Lack of champion at the PPG/Provider level to promote the measure; increased workload and limited provider time impact availability.
  - Home digital blood pressure cuffs are a covered Medi-Cal benefit; lack of awareness around the benefit impacts access to the BP monitoring devices..
  - Poor medication adherence.
  - Lack of follow-up.
  - Fear of side effects.
  - Knowledge gap on self-measured blood pressure monitoring (SMBP); lack of awareness about the benefits of SMBP monitoring.
  - Inaccurate home BP monitoring.
  - Unable to reach members due to outdated or inaccurate contact information.

- *Hemoglobin A1c Control for Patients with Diabetes* (HBD)
  - Poor medication adherence.
  - Lack of follow-up or clear communication regarding treatment goals, medication use/adjustments, and lifestyle modifications.
  - Knowledge gap: some providers may not be updated on the latest diabetes management guidelines.
  - Unable to reach members due to outdated or inaccurate contact information.
  - Lack of regular monitoring of A1c levels to achieve optimal glycemic control.
  - Medi-Cal regulatory approval timelines impact availability of mass A1c kit mailing to targeted population.

- *Asthma Medication Ratio* (AMR)
  - Poor medication adherence.
  - Unable to reach members due to outdated or inaccurate contact information.
  - Low awareness of CalAIM Asthma Remediation Services by providers.

Hospital Quality/ Patient Safety

- Hospital leadership may not assign quality performance sufficient importance among other institutional priorities.
- Hospital Acquired Infections and C-section rates reflect all-payer data. Limited influence as a single plan on all-payer scores.

Behavioral Health

- Difficulty reaching Medi-Cal population by phone because of unreliable and highly variable contact information.
- Lack of education about behavioral health treatment & address the stigma of diagnosis.
- Timely access to Admit, Discharge, and Transfer (ADT) data.
- ADT data may not include 100% of the eligible populations because of internal facility limitations on data sharing.
- Timeliness of referrals and follow-ups.
- Plan limitations and restrictions on data sharing with providers for substance use disorders impacts timeliness of follow up.
- Not all providers leverage Cozeva platform on a daily basis to prioritize behavioral health outreach and gap closures.
- Members in ADT reports may not ultimately end up in the eligible population because of the lack of a principle mental health or substance use diagnosis.

Member Experience/CAHPS

- All patient interaction has the potential to impact CAHPS scores.
- CAHPS results were often based on patient perception and patient recall.
- Any negative experience will stay with members regardless of the look-back period.
- Staff shortages and turnover due to minimum wage increases.
- Operational issues that impact member experience/CAHPS:
    - Prior authorization delays for care.
    - PCP and specialist referral delays.
    - Attitude and service issues related to customer service.

Provider Access and Availability Surveys

- Providers not complying with timely appointments standard.
- Provider offices were having difficulty responding accurately to the survey calls due to the volume of providers requiring appointment availability responses, busy with patients during normal office hours.
- Health Plan to understand barriers that practices have in meeting timely access to better assist providers.
- Members did not have access to or information for urgent care services.
- Specialty access issues in certain geographies.
- Provider practices may be closed to new patients, leading to access issues.
- Ineligibility rates from PAAS.
- PAAS non-responders.
- Providers non-compliance with access standards year-over-year.

Provider Engagement Oversight

- Plan encounters challenges in navigating relationships between Provider Group and when ownership of provider group changes are frequent.
- Insufficient Plan program or processes to assist clinics with physician shortages.

- Plan provider incentives are not adequate alone to improve provider performance and PPGs prioritize other plan's programs.
- Lack of consistent payment or oversight models in place that incentivize providers to accommodate member's needs (after work/school hours, multi appointment family member scheduling, one-stop visits, etc.).
- Lack of consistent and effective engagement with providers and clear method of accountability of internal teams.

Section 3: Overall Effectiveness of QIHEd Work Plan Initiatives

3.1. Behavioral Health

Improve Behavioral Health Measures

Health Net continued providing behavioral health (BH) oversight through attendance and participation in QI/UM and Access Workgroup Meetings and submitting BH Performance Indicator Reports timely. There were no corrective actions required.

Follow Up After Emergency Department (ED) Visits for Mental Illness or Substance Use (FUM/FUA)

The Behavioral Health Population Health Clinical Operations continued live outreach to CalViva members in Fresno and Madera counties for follow-up after mental health or substance use disorder emergency department visits, or FUM and FUA. Kings County was excluded from this live phone intervention outreach because it had already achieved the minimum performance level the prior measurement year.

Results: The final FUA-30-day follow-up rate for MY 2023 was 15.66%. The final FUM-30-day follow up rate for MY 2023 was 17.55%. These rates reflect Fresno, Kings, and Madera county performance combined (Accreditation Rate) does not meet benchmarks.

Improving rates for FUM and FUA will continue in MY 2025. CalViva saw rate increases over time during MY 2024, primarily due to the Legacy MHN phone outreach calls that were taking place. As part of the Non-Clinical PIP and a Lean Project for Madera County, CalViva is implementing a Coding Education training and a Cultural Competency training for hospital staff.
.

For both FUM and FUA measures across all three CalViva Health Counties, rates showed a downward trend from the prior measurement year and therefore didn't achieve the National 50th Percentile benchmark goal for any metric component. Some of the significant decreases were seen in the FUM30 metric. Fresno County decreased from 25.47% to 14.17%, Kings County decreased from 70.07% to 38.25%, and Madera County decreased from 52% to 22.47%. Rate decreases were also seen for FUA30, but to a lesser degree; dropping from 18.48% to 15.01% in Fresno County, 31.79% to 21.66% in Kings County, and 18.32% to 16.84% in Madera County.

Non-Clinical Performance Improvement Project (PIP) Behavioral Health

Target Population: Individuals who have had an ED Visit for Substance Use (FUA) or Mental Health (FUM) and received follow-up care within 7 days of an ED visit in Fresno and Madera Counties.

The California Department of Health Care Services (DHCS) updated the required PIP process in 2023. Each health plan is required to initiate one Clinical PIP and one Non-Clinical PIP to run from 2023 through December 31st, 2026. The initial submission of Steps 1-8 of the PIP process and two Intervention Worksheets were submitted to HSAG/DHCS in September and December 2024 and CalViva Health received 100% validation in January 2025 for the Non-Clinical PIP.

The PIP had two Aim Statements:

- During the measurement period, CalViva Health will carry out targeted interventions*that will result in improvement in the percentage of provider notifications for CalViva Health members with substance use disorder (SUD)/ mental health (MH) diagnoses following or within 7 days of an emergency department visit in Fresno and Madera Counties.

For the non-clinical PIP, CalViva leveraged dedicated hospital staff to notify providers of eligible members visiting the emergency department for SUD/MH diagnoses. Timely provider notifications could support follow-up care for members who had an ED visit for mental illness or substance use. Two interventions are currently being implemented:

1. Educate the Substance Use Professionals and MH Liaisons/Social Workers regarding the use of codes to accurately and completely document services and referrals provided.
2. Culturally Appropriate Education Strategies for Mental Health/Substance Use Disorder to Increase Follow-up Care.

CalViva completed a Lean Quality Improvement & Health Equity Project for Madera County. CalViva submitted a completed A3 QI tool for the Coding and Cultural Competency training. Too few CalViva members in Madera were having follow-up care after a mental health or substance use disorder emergency department event. CalViva' s Madera rates did not meet minimum performance levels for FUA or FUM. The completion rate for FUA and FUM was 9.84% combined, when the MPL for FUA and FUM were 24.51% and 40.59%, respectively. The majority of Madera members in the FUA/FUM population were Hispanic (at 62%) so there may have been cultural drivers negatively impacting follow-up care rates. The FUA & FUM member outreach was conducted in 2024 and resulted in an engagement rate of 17% due to lack of accurate member contact information (e.g., phone numbers) and member reluctance. Outreach was also impacted by privacy issues in sharing admission, discharge and transfer (ADT) data, and only identified approximately 35% of BH ED Visits.

CalViva will continue to monitor the effectiveness of the interventions in 2025, and with timelier follow up by PCPs for FUA should positively contribute to better rates for 2025.

3.2. Chronic Conditions/Chronic Disease

Improve Chronic Conditions

Chronic diseases are complex and influenced by multiple risk factors such as genetics or age which cannot be changed, and by modifiable risk factors like diet, physical activity and tobacco use that can be changed. Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities. Hypertension or high blood pressure increases the

risk of heart disease and stroke. Individuals with asthma experience frequent disease state symptoms, hospitalizations, and emergency room visits related to uncontrolled asthma which can then lead to miss work and school. The burden of chronic disease can be reduced by focusing on strategies in primary prevention, early detection and interventions, and disease management. Implementing evidence-based approaches to prevent chronic disease can improve the quality of care.

2024 improvement activities included:

- The multi-gap HEDIS calls identified 70,932 CalViva members for the outreach, with 49,394 total attempts made and 11,763 CalViva members reached. Live outreach to close multiple gaps in care including those with controlling blood pressure and diabetes care gap yielded a reach rate of 23.8%. The reach rate exceeded goal rate of 20%.
- Outcomes Medication Therapy Management (MTM) is a pharmacist-based intervention launched in late Q2 to close A1c and CBP care gaps for Medi-Cal members, YTD results show 78 members compliant for CBP, and 28 members compliant for HBD.
- Community Health Worker (CHW) interventions targeting 397 CalViva members, around CBP and A1c control yielded to date 21 self-reported BP readings, of which 13 were compliant and 20 members identified for chart chase for recent A1c screening.
- Direct, bulk mailing of in-home A1c kits to CalViva members was delayed in 2024 due to shifting timelines for vendor regulatory review process. However, vendor received DHCS approval early December 2024, allowing for with member collateral submission and contract execution to impact direct gap closure of HBD measure for MY 2025.
- Provider targeted interventions for Medi-Cal members included live calls (53% reach rate), digital service alert and targeted e-mail blasts to encourage providers to get members screened for BP prior to year end, and to aim for compliant reading of < 139/89.
- Members who had an Asthma Medication Ratio (AMR) gap were outreached to by a pharmacist to address barriers to asthma medication adherence using motivational interviewing techniques and encouraged to discuss action plans with their providers. Fresno and Madera counties improved rates YOY and Madera exceeded the MPL.
- The plan partnered with Central California Asthma Collaborative (CCAC), a Community Support Provider, to provide Asthma Remediation and Education Services to qualifying members with asthma in Fresno County. Members enrolled in the program learned how to reduce asthma triggers in their home and received resources to help remove allergens and other indoor triggers. CCAC outreached to a total of 200 members, of which 44 agreed to a home assessment, making this a 22% enrollment rate.
- CalViva will continue to promote CalAIM Asthma Remediation services by partnering with providers and making the program available to qualifying members with asthma.

The multigap HEDIS calls to CalViva members, targeted provider calls and e-mail blasts, and direct bulk mailing of A1c Kits to members will continue in MY 2025 to impact care gap closure. CalViva to explore opportunities in MY 2025 to collaborate between CHWs and provider groups targeting CalViva members to enhance engagement, promote care coordination and address social needs by connecting members to appropriate resources. Due to the low yield of compliant Medi-Cal members for Outcomes MTM, this intervention will not continue in MY 2025.

3.3. Hospital Quality/Patient Safety

Improve Hospital Quality/Patient Safety

CalViva's hospital quality initiatives focused on raising awareness among hospitals about performance expectations for specific metrics and connecting facilities with the organizations and QI resources that they may need to drive improvements.

These programs include collaboration with external organizations that report outcomes and/or provide the technical quality improvement guidance that hospitals may need, such as: Cal Hospital Compare and its sister organization Convergence Health, and the Health Services Advisory Group (HSAG) (both participants in the CMS-funded Hospital Quality Improvement Contract (HQIC) program); The Leapfrog Group, including as co-chair of Leapfrog Partners Advisory Committee; the California Health Care Foundation; the California Maternal Quality Care Collaborative (CMQCC); and other health plans.

Three of CalViva's hospitals identified as poor performers (Clovis Community Hospital, Community Regional Medical Center, and Saint Agnes Medical Center), received enhanced outreach to the hospital's Quality leadership to convey our concerns about the status of low performing priority metrics and to obtain information about their efforts to improve.

While CalViva hospitals showed good performance and continued avoidance of outlier performance for 3 hospital-acquired infection metrics (CAUTI, MRSA, and C.Diff), 2 infections warrant more attention. CLABSI and SSI-Colon declined in the number of hospitals meeting the target of an SIR <= 1.0. Focus on these metrics is needed to reduce the risk to patients of preventable complications. C-section performance improved, with 3 in 5 hospitals meeting the target of an NTSV C-section rate of 23.6% or below, compared to just 1 hospital previously. Continued engagement to drive excellence and to raise performance among network facilities is called for, as well as collaboration across stakeholders to support those goals.

CalViva's subcontractor, Health Net, collaborated with other key stakeholders in order to amplify our messaging and facilitate hospital access to QI tools and resources.

3.4. Member Engagement and Experience

Improve Satisfaction with Quality of Care/Service

<u>Member CAHPS Survey</u>
CalViva participated in the HSAG CAHPS survey, and it launched successfully in Q1 2024. The year over year rate increased for the following rating measures: Rating of Health Plan and Rating of All Health Care. Other findings were shared in the MY2023 ME7 report. Root cause analysis on appeals and grievances data was conducted on a quarterly basis to identify quarter over quarter and year over year trends in member pain points and areas for improvement. Findings were shared with appropriate internal stakeholders and teams. The CAHPS Team continues to meet regularly with departments to track progress of the various activities around CAHPS performance and general member experience. These meeting spaces were also a platform to brainstorm any new ideas or projects to address any member issues that come up during the year.

A few CAHPS related improvement activities in 2024 included:

- CAHPS Provider Webinar Training Series via Sullivan Group. The 3 topics included were:
    - Improving Service Excellence Through Successful Telephone Communication.

    - A Better Care Experience with A.I.M. (Assess, Improve, Manage) and
    - Managing Challenging Situations with Patients.
- CAHPS Best Practice Core Measure:
    - Provider Communication/Engagement – Provider Outreach: CAHPS. Created a one-page Best Practice Core Measure for Provider Engagement facing teams.
- CAHPS Playbook:
    - Provider Communication/Engagement – Provider Outreach: highlighted the importance of CAHPS and best practices around CAHPS provider influenced key measures.
- Provider Communication Update:
    - CAHPS article and measure rates.

Opportunities for 2025 include:

The CAHPS Team will attend the A&G Workgroups to discuss and plan efforts that may impact CAHPS and member experience at least quarterly and report to the QI/UM Committee.

- CAHPS and member experience awareness and education continue to be a focus since there are multiple stakeholder teams that are member-facing and have the potential to impact CAHPS scores.
- The CAHPS Team will continue to educate and collaborate with multiple stakeholder teams to promote CAHPS.
    - All patient interaction has the potential to impact CAHPS scores.
    - CAHPS results are often based on patient perception and patient recall.
    - Any negative experience will stay with the member regardless of a look-back period.

3.5. Pediatric/Children's Health Program

Improve Pediatric/Children's Health

<u>Clinical PIP: Well-Child Visits in the First 30 Months of Life – 0 – 15 months – Six or More Well-Child Visits (W30-6+)</u>

Target Population: Black or African American members in Fresno County.

The California Department of Health Care Services (DHCS) implemented a new PIP process in 2023. The initial submission of Steps 1-6 of the PIP process were submitted to HSAG/DHCS in September and November 2023 and CalViva received 100% validation in January 2024.

CalViva submitted Steps 1-8 and an intervention worksheet to HSAG/DHCS in September 2024 and resubmitted minor revisions to HSAG in early December 2024. Validation results may not be available until end of January 2025.

The PIP has two AIM statements:

- Do targeted interventions lead to statistically significant improvement in the percentage of Black or African American children 15 months of age in Fresno County that had six or more well-child visits during the remeasurement year. The baseline rate is 31.3%.
- Do targeted interventions lead to statistically significant improvement in the percentage of Black or African American children who complete three or more infant well-care visits within 120 days of life in Fresno County during the remeasurement year. The baseline rate is 41.5%.

CalViva partnered with Black Infant Health (BIH) in Fresno County and began referring identified Black or African American pregnant members and infants up to three months of age to BIH for the first intervention. In 2024, CalViva referred two lists of members and infants to BIH who outreached to members to enroll them into BIH. BIH reached 39.86% of members referred. Of the members reached, 20.34% enrolled in BIH. The referral lists continue to be sent to BIH approximately every two months.

CalViva also started planning additional interventions to implement in 2025, including incentivizing participants enrolled in BIH to complete the prenatal and postpartum classes and incentivizing participants to complete the 2-month infant well-child visit. Furthermore, CalViva will be promoting CDC's Milestone Tracker for the members enrolled in BIH by providing flyers, brochures, and posters with a QR code to encourage members to download the app on their phones. . A PowerPoint slide on CDC's Milestone Tracker will also be included in BIH's curriculum at members postpartum group session (week 2) that speaks on infant development and members will be guided to utilize the app for tracking doctor's appointments. Moreover, the CDC Milestone Tracker will be promoted at the Provider Webinar and a provider update or provider communication flyer will be launched in Q1.

Quality Monitoring Improvement Program

CalViva completed a Comprehensive Quality Improvement & Health Equity Process for the childhood domain in Fresno County in 2024. CalViva completed a fishbone diagram for the childhood domain in Fresno County and implemented two strategies to improve childhood domain measure rates. The first strategy targeted member engagement in increasing member access to evidence-based health educational resources through provider offices. CalViva distributed an email to providers containing a slide deck with QR codes and links to nationally recognized web-based resources. The slide deck was sent to 10 high volume pediatric providers and a total of 70 providers, including adult providers in Fresno County. Eighty-nine percent (89%) or more of the providers who completed a survey about the materials found the materials were relevant and easy to use and shared the resources with patients.

The second strategy addressed the data gap in W30-6+, W30-2+ and WCV. CalViva QI partnered with the HEDIS team and Provider Engagement to develop a desktop procedure for data reconciliation in order to standardize the data reconciliation process. CalViva created a desktop procedure and tested the data reconciliation process using Power Automate targeting 144 providers for W30 and 220 providers for WCV. For W30-6+, W30-2+ and WCV, 72% of providers targeted engaged in data reconciliation for W30 and 65% of providers engaged for WCV. Comparing rates to the same time last year, 71% of the engaged providers for W30-6+, 62% of the engaged providers for W30-2+ and 69% of the engaged providers for WCV showed improvements in their rates.

CalViva completed a Lean Quality Improvement & Health Equity Process for Kings County. CalViva submitted a completed A3 QI tool for the data reconciliation process in Kings County. The desktop procedure was created and the process tested in Kings County for W30-6+, W30-2+ and WCV. Sixty-five percent (65%) of the providers who engaged in the data reconciliation process for W30-6+ showed year over year improvements in their rates. Fifty-seven percent (57%) of the engaged providers for W30-2+ showed year over year improvements in their rates. Sixty-five percent (65%) of the engaged providers for WCV show improvements in their year over year rates.

Child Health Equity W30-6+ Collaborative Sprint (CHEC Sprint)

CalViva participated in the CHEC Sprint led by the Institute for Healthcare Improvement (IHI) and the California Department of Health Care Services (DHCS) since April 2024. While working with IHI and DHCS, CalViva engaged with a high volume low performing provider in Fresno County, Clinica Sierra Vista. CalViva and Clinica Sierra Vista- Elm Clinics implemented designed/suggested strategies throughout the CHEC Sprint to reduce equity gaps, improve access and build capacity in Fresno County. CalViva has been partnering and working closely with the CSV- Elm sites to implement best practices in children's preventive services to provide effective whole-person pediatric care. Some of the critical elements to achieve the project's aim included effective team-based care, automation, and effective use of technology, including electronic health records, population health management, and addressing social drivers of health. As of December 2024, CalViva and the pilot sites have completed three interventions designed by IHI and submitted all related deliverables to IHI and DHCS. Interventions 4 and 5 are expected to be completed by March 2025.

3.6. Perinatal Health/Reproductive Health

Improve Perinatal Health/ Reproductive Health

CalViva performed well in perinatal and reproductive health measures. All CalViva counties exceeded the 50th percentile for timely prenatal care (PPC-pre), postpartum care (PPC-post) and chlamydia screening (CHL). Kings County exceeded the 90th percentile and Fresno and Madera counties exceeded the 75th percentile for PPC-pre. Fresno and Kings counties exceeded the 75th percentile for PPC-post. Kings County also exceeded the 75th percentile for CHL. Despite the overall good performance for PPC, a disparity exists for Black or African American pregnant and postpartum members. CalViva is partnering with Black Infant Health (BIH) for the clinical W30-6+ PIP by directly referring pregnant and postpartum members to BIH. BIH reached 39.86% of the members referred and 20.34% of members reached enrolled into BIH, which has reported higher rates of prenatal and postpartum visits.

The Population Health Management team continued postpartum outreach calls to assist members in scheduling a postpartum visit and the first infant well care visit. The team reached an average of 85% of members. Of those reached, 35% self-report to have scheduled a postpartum visit and 46% self-report to have scheduled an infant well-care visit.

3.8. Preventive Health/Cancer Prevention

Improving Preventive Health/Cancer Screenings

Cancer screening programs aimed to improve the quality and accessibility of preventive health services, leading to an increased member participation in screenings. These programs were designed to raise awareness among both members and providers, address structural barriers, and offer training and process assessments to optimize clinic workflows. In 2024, efforts to improve preventive health screening performance included multi-gap member outreach, mobile mammography services with associated incentives, and comprehensive provider education paired with action planning.

CalViva members who had multiple gaps were outreached to schedule their appointments and address other barriers related to closing both breast and cervical cancer screening care gaps.

To complement these efforts, educational resources such as tip sheets for breast cancer, cervical cancer, and chlamydia screenings were made available through the Provider Library. Health Net partnered with the mobile mammography vendor, Alinea, to address access challenges for CalViva members. This partnership enabled the successful completion of 16 mobile mammography events, with two held in Kings County and 14 in Fresno County. These events resulted in 292 care gaps closed, 69 in Kings County and 223 in Fresno County. Furthermore, the multi-gap HEDIS calls identified 70,932 CalViva members, resulting in 29,392 contact attempts and successful engagement with 11,763 members.

Building on these initiatives, opportunities for 2025 include forming direct partnership with radiology facilities to address resource limitations and enhance service capacity. Another key area for growth involves collaborating with community-based organizations to deliver equitable and culturally sensitive care, ensuring that preventive health services are accessible and relevant to all members. These strategies reflect a commitment to addressing systemic challenges and fostering inclusive, effective preventive health care.

3.9. Provider Engagement

Quality EDGE

Quality EDGE continued to focus on the 18 Medi-Cal Accountability Set (MCAS) measures held to the minimum performance level (MPL). There was a special focus to align with DHCSs' bold goal of achieving the 50th percentile for all pediatric MCAS measures by 2025. Provider Engagement developed action plans to improve the MCAS measure rates for priority providers in Fresno, Kings, and Madera Counties. As of December 20, 2024, 112 Quality EDGE requests were approved. CalViva supported providers and members with over $660K in funds to sponsor initiatives such as point-of-care member incentive gift cards, mobile mammography events, one-stop clinic events, and equipment/supplies (lead screening machines and fluoride kits).

CalViva also implemented member outreach through the Family Unit HEDIS outreach calls. The team prioritized interventions along the strategic tracks of Data Analytics & Technology, Member and Community Engagement, Direct Care Interventions, Physician/PPG Engagement and Compliance and Operations to support goal achievement.

Provider Engagement increased operational oversight to allow the implementation of corrective action plans for non-compliant providers as appropriate. Some providers were encouraged to engage in the DHCS Equity and Practice Transformation Payments Program to provide additional practice transformation resources.

A standardized data reconciliation process was implemented, kicked off, and piloted in 2024 to help address the significant challenges that data workflow, provider use of codes, and other systems issues can impact the receipt of evidence of member care. Full implementation will be deployed in 2025.

3.10. Continuity/Coordination of Care (Behavioral and Nonbehavioral)

Improving continuity and coordination of care

Continuity and coordination of care between medical care and behavioral health care is an important aspect of care requiring focused and proactive assessment. A patient with a medical or surgical condition may have a behavioral complication or comorbidity. Similarly, a patient with

a behavioral disorder may have a medical comorbidity, or there may be a medical implication. The delivery system may or may not have a mechanism to ensure the seamless transfer of information between medical and behavioral care. This lack of structure, commonly found in the current industry, can cause members to experience discontinuity. The goals of the monitoring and evaluation process are to promote seamless, continuous, and appropriate care to members.

The CalViva Quality Improvement/Utilization Management (QI/UM) Committee provided oversight and guidance for CalViva's QI, Utilization Management (UM), and Credentialing Programs. The QI/UM Committee monitored the quality and safety of care and services rendered to members, identified clinical and administrative opportunities for improvement, recommended policy decisions, evaluated the results of QI and UM activities, and instituted needed actions.

Coordination of Care (Non-Medical):

CalViva used information at its disposal to facilitate continuity and coordination of medical care across its delivery system. CalViva utilized NCQA as a roadmap for improvement on 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. It provides a framework for implementing best practices to apply a QI process to improve key operational areas and is reported every two years for accreditation.

Opportunities for improvement identified included providing enhanced member and provider education, engaging both, and utilizing available resources. During RY 2024, CalViva Health monitored the following aspects of continuity and coordination of medical care:

- Timeliness of Perinatal Care – Postpartum Care (PPC)
- Eye Exam for Patients with Diabetes (EED)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Plan All-Cause Readmissions (PCR).

CalViva Health consistently achieved the NCQA 50th percentile across all measures, with the exception of the Pharmacotherapy for Opioid Use Disorder POD measure. This presents an opportunity to reassess and refine our strategies to drive improvement in this area.

Coordination of Care (Behavioral):

In an effort to improve care coordination and exchange of information between and amongst medical and behavioral providers, especially as it related to members visiting the ED for a mental health or substance use issue, an article was published in the September 2024 issue of CalViva's Provider Update. The article emphasized the importance of care coordination, its impact on member satisfaction, tips for improving care coordination, and when timely exchange of information is crucial for quality care. This information was also posted in the online Provider Library for on-demand access.

3.11. Access, Availability, and Service and Satisfaction

Improve Provider Access, Availability, Satisfaction and Service

CalViva is required to follow and monitor timely access standards set by regulators. The DMHC developed the Provider Appointment Availability Survey (PAAS) Methodology and survey tools

set for each measurement year. For MY 2023, CalViva administered the DMHC PAAS to randomly selected sample of in-network PCPs, specialists, and ancillary providers. CalViva adopted DMHC's regulatory compliance goals for Urgent and Non-Urgent Appointment Availability at 70% to align with health care industry standard performance goals for Provider Appointment Availability Survey (PAAS) goals for all appointment measures. For MY 2023, the new survey vendor QMetrics conducted the DMHC PAAS surveys between August through December for CalViva.

After-hours access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS) with performance goals of 90%. Results indicated a need for improvement in several areas. The DMHC PAAS was also administered to Health Net Behavioral Health (HNBH) psychiatrists and non-physician mental health providers who provided behavioral health services to CalViva members. The surveys were conducted via fax, telephone, and/or email between August through December 2023. Additionally, CalViva administered a separate Provider Appointment Availability Survey to capture appointment access among a wider group of PCPs and specialists, to monitor appointment access standards and fulfill reporting requirements (NCQA).

Corrective Action Plans (CAP)

For MY 2023 deficiencies were identified through analysis of the survey results and Corrective Action Plans (CAP) and educational packets were issued to PPGs and providers who failed in one or more of the timely access or after-hours measures. PPGs that received a CAP are required to complete an Improvement Plan (IP), submit a signed non-compliant providers notification attestation, and attend a Timely Access webinar. There were five PPGs and six Direct network providers who received CAP packets. Nine PPGs and four direct network providers received educational packets. PPGs that received a CAP have submitted Improvement Plans and supporting documentation and signed attestations. CAP Improvement Plan (IP) reviews were completed and closed. Two direct network providers who were unresponsive were issued 30-day termination letters, and have since been terminated.

- For 2024, the Access & Availability team have conducted ten provider training webinars from July to December. A total of 744 participants attended. The team continued to enhance training materials and provided some clarification on survey guidelines based on DMHC survey methodology. The team continued to recommend PPGs and provider offices to encourage their staff and coworkers to attend the training. A self-paced provider training is also available on Health Net's portal. Over 100 questions were answered during the webinar and copies of the presentation and Q&As were shared with all attendees.

Opportunities for 2025 include:

- Incentivize providers to improve and maintain access standards.

3.12. Health Education

Member Incentives

A total of 6,073 CalViva members participated in six-member incentive programs during 2024. These programs were aimed at increasing participation in Well Care Visit, Breast Cancer Screening, Cervical Cancer Screening, Childhood Immunization, and Well Child Visits. In total, $151,825 worth of gift cards were distributed to the members as awards. Of the recipients, 62%

were from Fresno County, 28% were from Madera, and 8% were from Kings.

Member Materials Management
A total of 12,780 pieces of member materials have been ordered for CalViva members. The pieces of member materials with the most orders were lead poisoning, diabetes, nutrition, and weight management/exercise. Providers were able to order materials using the online Health Education Material Order Form, while members can request for materials to be ordered from their provider or by calling Member Services.

Health Education Information Line
A total of ten calls have been made to the Health Education Information Line in the CalViva service area. One call inquired about the weight loss program for families and kids. Two calls inquired about diabetic services, one call inquired about provider information and six calls inquired about the health risk assessment form.

Section 4: QI Reporting

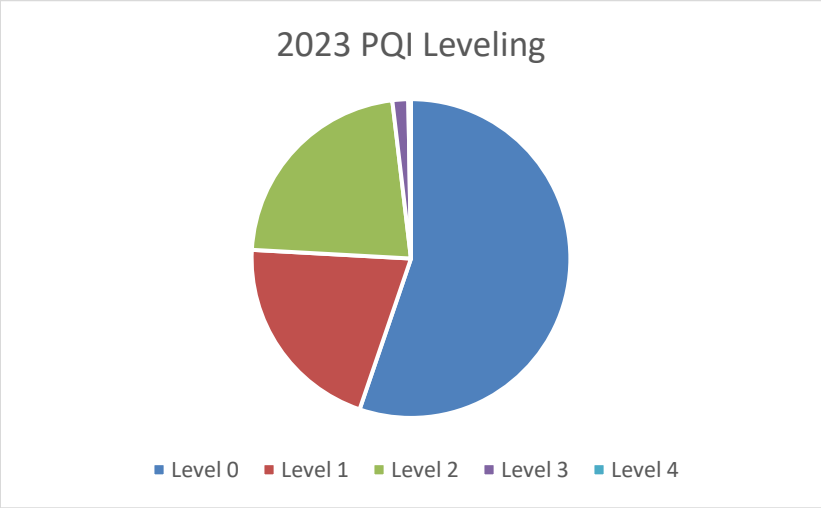
4.1 Safety Monitoring of Potential Quality Issues (PQIs) (Work Plan Section IV Crosswalk -QI Activity)

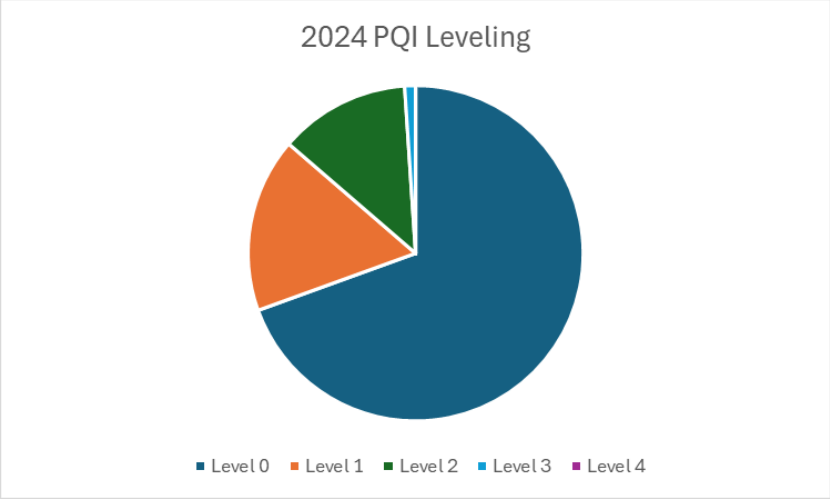
In 2024, CalViva received and closed 285 PQIs. All cases were completed within the regulatory turnaround time to maintain compliance with regulatory requirements. The following table shows the breakdown of leveling for cases. The plan used four severity levels for all PQIs:

- Level 0 – Investigation indicates no quality-of-care issue has occurred.
- Level 1 – Investigation indicates that a particular case demonstrated no potential for serious adverse effects.
- Level 2 – Investigation indicates that a particular case demonstrated a minimal potential for serious adverse effects.
- Level 3 – Investigation indicates that a particular case has demonstrated a moderate potential for serious adverse effects.
- Level 4 – Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects.

Table 4.1 2023-2024 PQI Cases

PQI Level	2023	2024
Level 0	206	198
Level 1	77	48
Level 2	83	36
Level 3	5	3
Level 4	1	0
Total Cases	**372**	**285**





4.2 Vendor Oversight

The Vendor Oversight team ensured delegated vendors supporting the plan were compliant with contractual and regulatory requirements. This was accomplished via ongoing monitoring and auditing.

2024 Delegated Vendor Auditing and Monitoring Activities
Delegated Utilization Management (UM) – American Specialty Health (ASH), TurningPoint and Evolent were delegated for UM.

- The Evolent audit resulted in UM findings for not consistently providing denial rationale written in layman terms. The ASH and TurningPoint annual audits have not been finalized.
- Transportation Program – The semi-annual scorecard evaluations of ModivCare resulted in non-compliance with the Physician Certification Statement (PCS) form process. ModivCare has an existing corrective action for this requirement and an active remediation plan. The annual audit has not been finalized. The health plan will be bringing the PCS form process in-house in 2025.

Delegated Vendor Auditing and Monitoring Summary

- Delegated Credentialing – American Specialty Health (ASH) and Centene Vision were delegated for Credentialing.
    - The Centene Vision audit demonstrated compliance with no findings. The ASH audit has not been finalized.
- Delegated Utilization Management (UM) – American Specialty Health (ASH), TurningPoint and Evolent were delegated for UM.
    - The Evolent audit resulted in UM findings for not consistently providing denial rationale written in layman terms. The ASH and TurningPoint annual audits have not been finalized.
    - Transportation Program – The semi-annual scorecard evaluations of ModivCare resulted in non-compliance with the PCS form process. ModivCare has an existing corrective action for this requirement and an active remediation plan. The annual audit has not been finalized. The health plan will be bringing the PCS form process in-house in 2025.

<u>2025 Delegated Vendor Auditing and Monitoring Plan</u>
For 2025, the plan will continue to perform transportation monitoring via scorecard evaluations, quarterly JOCs, monthly ModivCare VOCs and perform annual audits of delegated services.

Delegated Vendor	Description of Services	Proposed Audit & Monitoring Schedule
Evolent Specialty Services	Advanced Radiology Services	Annual Audit: June
American Specialty Health (ASH)	Acupuncture Network	Annual Audit: June
ModivCare	Transportation Services: Non-Medical & Non-Emergency (NMT & NEMT)	Annual Audit: June Scorecard reviews, March and October
TurningPoint Healthcare Solutions	Musculoskeletal Surgical, Cardiac Procedures	Annual Audit: May
Centene Management Company	Utilization Management, Claims, Member Services	Annual Audit: December
Centene Vision Services (Envolve Vision)	Vision Benefits Manager (Optometry & Ophthalmology)	Annual Audit: May

Section 5: Summary of Key Accomplishments

The 2024 reporting year was a productive year for CalViva's Quality Improvement Program. The following is a summary of some of the key QI interventions and accomplishments for this period.

Health Education:

- The Plan promoted a newly developed digital resource which included QR codes and links to health education resources for members.

- The Plan worked with Member Services to inform members of available health education materials and programs available to CalViva members.
- The Plan reviewed and updated health education materials as needed, following DHCS guidelines, and promoted digital ordering and print distribution of required and high-volume topic articles.
- Completed the emergency room (ER) visit analysis in September 2024 for the Central California Asthma Collaborative (CCAC) asthma project. There were 59 ER visits (59/134) among program participants who completed the program compared to 73 ER visits (73/141) among program participants before the program began. In addition, among members who completed the program, the AMR gap closure rate was 16%, which was slightly higher than members who did not complete the program.
- Continue partnership and promotion of BCS and CCS screenings via partnerships with community based organizations such as Every Woman Counts.,
- Promoted Kick It California tobacco cessation program in the member newsletter and at various meetings.
- Awaiting DHCS approval of new Diabetes Prevention Program (DPP) with new DPP provider.
- Developed 2-member outreach campaigns to promote new DPP once approved by DHCS.
- Developed 1-provider outreach campaign to promote new DPP once approved by DHCS.
- Weight Management Fit Families For Life (FFFL): 1 request received and fulfilled for this resource in 2024.
- Received DHCS and DMHC approval for the myStrength Program transition to Teladoc Mental Health (Digital Program).
- Completed a member material assessment and converted the material to Krames content and the Staywell Library.

Quality Indicators and Ratings for MY 2023

- Fresno, Kings, and Madera counties all met 100% of the Chronic Conditions measures MPL – 50th percentile (CBP and Diabetes Poor Control).
- Fresno, Kings and Madera Counties met 100% of the Adult Preventive Care/Cancer Prevention Measures MPL - 50th percentile (CHL, BCS, and CCS, and AISE Flu).
- Madera County met 100% of the Children's Health and Pharmacy Measures MPL – 50th percentile as well as met all measures (16) except two (2) behavioral health measures
- Fresno, Kings, and Madera counties all met 100% of the Perinatal/Reproductive Care measures MPL – 50th percentile (PPC).
- CalViva scored 100% for BH PAAS by Risk Rating measures.

Regulatory Requirements and Submissions

- High Volume Physical Accessibility Review Survey (PARS) report was submitted to DHCS in January 2024.
- The Clinical Improving Infant Well-Child Visits (W30-6+) Among Black or African American Infants in Fresno County PIP Steps 1-8 were submitted to HSAG in Q3 2024 with an Intervention Worksheet. Minor revisions were submitted in early December 2024. Awaiting validation from HSAG.
- The Kings County Lean Quality Improvement & Health Equity Process A3 initial plan was submitted to DHCS in May 2024 and the Progress report submitted in September2024.

- The Madera County Lean Quality Improvement & Health Equity Process A-3 Initial plan was submitted to DHCS in May 2024 and the Progress report was submitted in September 2024.
- The Fresno County Comprehensive Quality Improvement & Health Equity Process Fishbone Diagram was submitted to DHCS in May 2024. The two strategies and action items were submitted to DHCS in June 2024 and the Progress Report was submitted to DHCS in October 2024.
- The Child Health Equity Collaborative Sprint deliverables (3 storyboards and 3 post-intervention reports) were submitted to the Institute for Healthcare Improvement (IHI) in June, August, and November 2024.
- The Non-Clinical Behavioral Health PIP SUD/SMH Steps 1-8 were submitted to HSAG in Q4 2024; currently awaiting final validation.

Quality Improvement Initiatives

- Continued pilot of tracking high volume, low performing providers for Initial Health Appointments (IHA) with Provider Engagement team on a quarterly cadence. The performance overall YTD for High Volume low performing providers increased by 2.86%.
-
- Provided 27 POC lead analyzers with one year supply of test strips to provider offices in the CalViva Health service area.
- Completed 21 PARS in Fresno, Kings, and Madera counties.
- Results from annual HSAG CAHPS Survey (2023 results): YOY rate increased for the following rating measures: Rating of Health Plan and Rating of All Health Care.
- Successfully prepared and coordinated all needed requirements for CalViva to launch regulatory CAHPS in Q1 2024. 2025 will be the last year that HSAG will be conducting adult and child CAHPS surveys. Starting in 2026, the health plan will be responsible for conducting its own adult and child CAHPS survey.
- Conducted a total of 10 provider Timely Access webinars sessions in 2024 statewide, with a total of 744 attendees participated.
- For Pediatric/Children's Health, CVH developed a partnership with Black Infant Health (BIH). CVH referred a total of 208 members during the initial intervention cycles combined (76 prenatal and 132 postpartum members) to BIH Fresno and 15 CVH members total were enrolled in the BIH program from the June, July and August CVH list of referrals. The total reach rates for the prenatal members were 46.05% and the total reach rates for the postpartum members was 36.13%.
- CalViva is currently engaged in a plan wide Provider Training on IHA Best Practices that includes IHA visit compliance requirements. Year to Date (YTD), 557 provider trainings have been completed, resulting in a 14% increase YTD for IHA visit compliance completion rates within 120 days of enrollment.
- In Quarter 1, the Plan trained Provider Engagement on LSC requirements including anticipatory guidance documentation and provided California Department of Public Health resources and materials to be shared with providers and members. In Quarter 2 the Anticipatory Guidance Compliance Rates increased by 1.06%.
- DHCS approval of vendor to administer in-home A1c kits to Medi-Cal members allows for targeted outreaches in 2025 for direct care gap close; all Medi-Cal collateral have been approved prior to contract execution.

Quality Improvement Department and Program

- Implemented Quality EDGE through Provider Engagement and Medical Affairs targeting priority providers and PPGs in Fresno, Kings, and Madera Counties.

- Quality EDGE funding supported 117 activities to close care gaps in CalViva counties in 2024. Activities include community events, equipment for providers, blood pressure and lead screening resources, technology support, direct care services (one-stops and mobile mammography), and member and provider staff incentives.

Section 6: Annual QIHEd Program Changes

Based on this evaluation, the QIHEd Program effectively meets safe clinical practice goals, has adequate resources, and a strong QI Committee structure, which includes productive practitioner participation and effective leadership. Program and Drivers (PODs) continue to gain efficiency across various teams, streamline operations, and reduce duplication within and across teams and programs. The purpose of the team PODs is to improve the design and group of programs to achieve strategic outcomes and goals, foster collaboration and align teams, and create more opportunities for innovation and growth. Quality Management will continue to leverage health plan materials, activities, and reporting along with its internal processes to improve care and services for CalViva members..

Appendix

Table A-1. Performance Goals

Standard	Goal
DHCS Managed Care Accountability Set (MCAS) HEDIS Measures	NCQA QC National 50th Percentile
Behavioral Health MCAS HEDIS Measures	NCQA QC National 50th Percentile
Hospital Care/Patient Safety	YOY Directional improvement for % network hospitals meeting Hospital-Acquired Infections and Nulliparous, Term, Singleton, Vertex C-section rate targets
CAHPS	YOY Improvement and/or NCQA QC National 25th Percentile (stretch goal)
Provider Access and Availability and Satisfaction Surveys	70 or 90 Percentage Rate (%) or directional YOY improvement.

Table A-2. MY 2023 MCAS Measures Above 50th Percentile by County

CalViva Counties	Fresno	50%	**Overall 59%**
	Kings	39%	
	Madera	89%	

Table A-3. Summary of RY 2024 Outcomes by Category

Category	Medi-Cal	
	N	Rate %
Adult Chronic Care	6/6	100%
Adult Preventive Care/Cancer Prevention	6/6	100%
Adult Survey (CAHPS)^	3/5	50%
Behavioral Health	0/12	0%
Children's Health	7/18	38.89%
Hospital Care/Patient Safety	9/9	100%
Pharmacy*	7/8	87.5%
Provider Access and Availability and Satisfaction Surveys	105/152	69.08%
Reproductive Health	9/9	100%
Total	**152/225**	**67.56%**

^ In 2024, HSAG conducted the annual CAHPS survey for CalViva Health.

Table A-4. Summary of Opportunities

Based on results, the following performance measures are areas of focus for improvement for CalViva.

Adult Health Opportunities	Reproductive Health Opportunities
Chronic Care: • Controlling High Blood Pressure • Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control **Pharmacy:** • Asthma Medication Ratio **Preventive Health/Cancer Prevention:** • Cervical Cancer Screening	• N/A
	Children's Health Opportunities
	• Childhood Immunization Status - Combo 10 • Immunizations for Adolescents - Combo 2 • Well-Child Visits in the First 30 Months of Life - 0 to 15 Months • Well-Child Visits in the First 30 Months of Life - 15 to 30 Months • Child and Adolescent Well-Care Visits • Lead Screening in Children • Developmental Screenings in the First 3 Years of Life
Behavioral Health Opportunities	

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

New opportunities identified by DHCS (currently not being held to the MPL):
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Hospital Care/Patient Safety Opportunities

- Hospital performance on HAIs: Central Line Associated Bloodstream Infection and Surgical Site Infection – Colon

Member Experience – CAHPS Opportunities

CAHPS Measures:
- Customer Service Composite
- Getting Needed Care Composite
- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Coordination of Care
- Overall Rating Measures (Personal Doctor, Specialist)

Provider Survey Opportunities

PAAS Survey Measures:
- Access to PCPs,
- Access to Specialists
- Access to Ancillaries
- Access to Psychiatry and Non-Physician Mental Health
- Telephone Access: Provider call-back for non-urgent issues during normal business hours

PAHAS Survey Measures:
- Appropriate After-Hours Emergency Instructions
- Ability to Contact On-Call Physicians After-Hours

Provider Satisfaction Survey:
- All Provider Satisfaction Survey Access Measures
- Behavioral Health Practitioners Survey Access Measures: Routine Care, Urgent Care, Non-Life-Threatening Emergent Care, and Coordination of appointments with an interpreter Standards.
- All BH Experience of Care and Health Outcomes (ECHO) measures

Table A-5. County Level MCAS HEDIS Outcomes for MY 2022 – MY 2023

Fresno	HEDIS Measure	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	*QC MY 2023 Nat'l 50th Percentile	Outcome Met (Y/N)
Adult Chronic Care						
CBP	Controlling High Blood Pressure	61.73%	64.29%	↑	61.31%	Y

CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control (<8%) **(inverted)**	37.47%	35.31 %	↑	37.96%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	52.14%	57.87 %	↑	52.20%	Y
BCS-E	Breast Cancer Screening-E	N/R	N/R	-	52.60%	N/R
CCS	Cervical Cancer Screening	57.08%	60.55 %	↑	57.11%	Y
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	27.49%	27.74%	↑	30.90%	N
IMA-2	Immunizations for Adolescents - Combo 2	37.23%	36.06 %	↓	34.31%	Y
LSC	Lead Screening in Children	49.88%	56.69%	↑	62.79%	N
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	50.01%	56.65%	↑	58.38%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	62.69%	65.01%	↑	66.76%	N
WCV	Child and Adolescent Well-Care Visits	48.14%	51.57 %	↑	48.07%	Y
Pharmacy						
AMR*	Asthma Medication Ratio	62.15%	63.66 %	↑	65.61%	N
Reproductive Health						
CHL	Chlamydia Screening in Women	58.86%	61.35%	↑	56.04%	Y
PPC	Prenatal and Postpartum Care – Postpartum Care	84.23%	82.10%	↓	78.10%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	89.62%	90.39%	↑	84.23%	Y
Kings	**HEDIS Measure**	**MY 2022 (%)**	**MY 2023 (%)**	**^ Rate Trend**	***QC 2023 Nat'l 50th Percentile**	**Outcome Met (Y/N)**
Adult Chronic Care						
CBP	Controlling High Blood Pressure	71.81%	72.81%	↑	61.31%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (<8%) **(inverted)**	30.05%	25.42%	↑	37.96%	Y
Adult Preventive Care/Cancer Prevention						

BCS	Breast Cancer Screening	58.61%	61.90	↑	52.20%	Y
BCS-E	Breast Cancer Screening	N/R	N/R	-	52.60%	N/R
CCS	Cervical Cancer Screening	58.95%	61.10	↑	57.11%	Y
Children's Health						
CIS-10	Childhood Immunizations Status – Combo 10	23.84%	19.83%	↓	30.90%	N
IMA-2	Immunizations for Adolescents - Combo 2	29.68%	31.39 %	↑	34.41%	N
LSC	Lead Screening in Children	53.77%	58.64%	↑	62.79%	N
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	53.48%	57.44%	↑	66.76%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	55.59%	53.74 %	↓	66.76%	N
WCV	Child and Adolescent Well-Care Visits	39.56%	41.79 %	↑	48.07%	N
Pharmacy						
AMR*	Asthma Medication Ratio	64.37%	59.29 %	↓	65.61%	N
Reproductive Health						
CHL	Chlamydia Screening in Women	62.15%	64.11 %	↑	56.04%	Y
PPC	Prenatal and Postpartum Care - Postpartum Care	84.18%	83.84%	↓	78.10%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	87.76%	91.27 %	↑	84.23%	Y
Madera	**HEDIS Measure**	**MY 2022 (%)**	**MY 2023 (%)**	**^ Rate Trend**	***QC 2023 Nat'l 50th Percentile**	**Outcome Met (Y/N)**
CBP	Controlling High Blood Pressure	67.49%	71.04%	↑	61.31%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control (<8%) **(inverted)**	35.93%	30.79 %	↑	37.96%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	61.03%	63.15%	↑	52.20%	Y
BCS-E	Breast Cancer Screening-E	N/R	N/R	-	52.60%	N/R
CCS	Cervical Cancer Screening	61.58%	68.37%	↑	57.11%	Y
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	48.42%	47.45%	↓	30.90%	Y

IMA-2	Immunizations for Adolescents - Combo 2	53.53%	47.32%	↓	34.41%	Y
LSC	Lead Screening in Children	66.42%	78.10%	↑	62.79%	Y
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	56.71%	63.70%	↑	66.76%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	75.65%	79.19%	↑	66.76%	Y
WCV	Child and Adolescent Well-Care Visits	57.71%	65.02%	↑	48.07%	Y
Pharmacy						
AMR*	Asthma Medication Ratio	72.93%	72.20%	↓	65.61%	Y
Reproductive Health						
CHL	Chlamydia Screening in Women	59.38%	62.08%	↑	56.04%	Y
PPC	Prenatal and Postpartum Care - Postpartum Care	87.04%	80.10 %	↓	78.10%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	90.37%	90.82 %	↑	84.23%	Y

*Percentile based on Quality Compass (QC) 2023 National HMO benchmarks for MY 2023 MCAS. Outcomes met for regional performance are based on the DHCS MPL at the 50th percentile.
^ rate trend based on directional changes to rates year over year.
NT Not trendable year over year due to significant differences in NCQA technical specifications.
N/R Not reported.
^Administrative rate only
*These measures are not current MY 2024 MCAS measures but are upcoming MY 2024 MCAS measures.

Table A-6. Progress to MY 2023 Goals – Behavioral Health Outcomes (HEDIS)

Fresno	HEDIS Measure	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	*QC 2023 Nat'l 50 Percentile Rate	Outcome Met (Y/N)
~FUM7	Follow-Up Within 7 Days After Emergency Department Visit for Mental Illness	14.98%	6.65%	↓	40.59%	N
~FUM30	Follow-Up Within 30 Days After Emergency Department Visit for Mental Illness	25.47%	14.17%	↓	54.87%	N
~FUA7	Follow-Up Within 7 Days After Emergency Department Visit for Substance Use	10.84%	8.52%	↓	24.51%	N
~FUA30	Follow-Up Within 30 Days After Emergency Department Visit for Substance Use	18.48%	15.01%	↓	36.34%	N

Kings	HEDIS Measure	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	*QC 2023 Nat'l 50 Percentile Rate	Outcome Met (Y/N)
~FUM7	Follow-Up Within 7 Days After Emergency Department Visit for Mental Illness	58.50%	26.78%	↓	40.59%	N
~FUM30	Follow-Up Within 30 Days After Emergency Department Visit for Mental Illness	70.07%	38.25%	↓	54.87%	N
~FUA7	Follow-Up Within 7 Days After Emergency Department Visit for Substance Use	21.85%	16.56%	↓	24.51%	N
~FUA30	Follow-Up Within 30 Days After Emergency Department Visit for Substance Use	31.79%	21.66%	↓	36.34%	N
Madera	**HEDIS Measure**	**MY 2022 (%)**	**MY 2023 (%)**	**^ Rate Trend**	***QC 2023 Nat'l 50 Percentile Rate**	**Outcome Met (Y/N)**
~FUM7	Follow-Up Within 7 Days After Emergency Department Visit for Mental Illness	36.80%	10.11%	↓	40.59%	N
~FUM30	Follow-Up Within 30 Days After Emergency Department Visit for Mental Illness	52.00%	22.47%	↓	54.87%	N
~FUA7	Follow-Up Within 7 Days After Emergency Department Visit for Substance Use	11.45%	9.47%	↓	24.51%	N
~FUA30	Follow-Up Within 30 Days After Emergency Department Visit for Substance Use	18.32%	16.84%	↓	36.34%	N

*Percentile based on Quality Compass (QC) 2023 National HMO benchmarks for MY 2023 MCAS. Outcomes met for regional performance are based on the DHCS MPL at the 50th percentile.
^ rate trend based on directional changes to rates year over year.
[NT]Not trendable year over year due to significant differences in NCQA technical specifications.
[N/R] Not reported.
^Administrative rate only
~ MY23 rates reflect work that took place starting in Q4 2023

Table A-7. Regulatory CAHPS Survey administered by HSAG

CAHPS Measures	MY 2022 (%)	MY 2023 (%)	^ Rate Trend	Baseline Source (Source: For 2023 - Quality Compass MY 2023 25th Percentile)	**Outcomes Met (Y/N)
Getting Needed Care	76.7%	73.50	↓	77.83%	N
Getting Care Quickly	81.8%	N/R	-	76.01%	N/R
How Well Doctors Communicate	93.5%	90.2%	↓	91.44%	N
Customer Service	86.3%	N/R	-	88.1%	N/R
Coordination of Care	81.8%	N/R	-	82.18%	N/R
Rating of All Health Care	74.7%	76.87%	↑	72.32%	Y
Rating of Personal Doctor	85.7%	81.38%	↓	80.4%	Y
Rating of Health Plan	71.9%	81.98%	↑	74.71%	Y
Rating of Specialist	80.4%	N/R	-	78.63%	N/R

^ In 2024, HSAG conducted the annual CAHPS survey for CalViva Health, with final results available in May 2024.
N/R Non-reportable data due to small sample size (n<100).
** Outcome met Y/N based on Quality Compass MY 2023 25th Percentile.

Provider Appointment Availability Survey (PAAS)

Table A-8. PAAS (DMHC PAAS + Non-DMHC Medi-Cal Questions) – Access to PCPs

PAAS (DMHC + Non-DMHC Medi-Cal)										
Access Measure and Standard (Performance Goal = 70%)										
County	Urgent Care Appointment within 48 hours of request (PCP)		Non-Urgent Appointment within 10 business days of request (PCP)		Access to Preventive Health Check-Up/Well-Child Appointment within 10 business days of request (PCP)		Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP)		Access to First Prenatal Appointment within 2 weeks of request (PCP)	
	(Rate %)									
	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	50.2	79.7↑	76.8	89.5↑	62.9	87.5	81.7	92.3	71.9	80.5
Kings	62.7	80.0 ↑	77.2	87.0↑	69.8	70.6	84.6	85.3	82.1	75.01
Madera	60.0	80.0 ↑	73.2	78.7 ↑	68.6	91.4	84.8	94.1↑	90.0	100.0
Telehealth	42.2	N/A	70.3	N/A	56.7/A	N/A	76.0	N/A	66.7	N/A
Kern	N/A	75.6	N/A	80.2	N/A	77.2	N/A	92.3	N/A	91.3

PAAS (DMHC + Non-DMHC Medi-Cal)										
Access Measure and Standard (Performance Goal = 70%)										
	Urgent Care Appointment within 48 hours of request (PCP)		Non-Urgent Appointment within 10 business days of request (PCP)		Access to Preventive Health Check-Up/Well-Child Appointment within 10 business days of request (PCP)		Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP)		Access to First Prenatal Appointment within 2 weeks of request (PCP)	
	(Rate %)									
County	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Mariposa	N/A	100.0*	N/A	100.0*	N/A	100.0*	N/A	100.0	N/A	100.0
Merced	N/A	66.7*	N/A	10.0	N/A	20.0*	N/A	20.0	N/A	75.0
Overall	**49.0%**	**78.8 %↓**	**74.4%**	**85.3%**	**61.8%**	**83,9%**	**86.7%**	**91.1%**	**72.6%**	**83.1%**

Rate - Percent of total number of respondents surveyed who met the access standard.
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05).
* - Denominator less than 10,
^ Low response rates compared to MY 2021 and
therefore comparisons should be made with caution

Table A-9. PAAS (DMHC + CalViva) – Access to Specialists (All)

PAAS (DMHC + CALVIVA PAAS)						
Access Measure and Standard (Performance Goal = 70%)						
	Urgent Care Appointment within 96 hours of request (Specialists)		Non-Urgent Appointment within 15 business days of request (Specialists)		Access to First Prenatal Appointment within 2 weeks of request (Specialists)	
	(Rate %)					
County	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	39.3	55.3	60.1	64.8	63.9	83.3
Kings	47.1	41.2	82.4	52.6↓	100.0*	66.7*
Madera	32.3	61.1	48.6	62.5	0.0	100.0”
Telehealth	34.6	N/A	42.9	N/A	N/A	N/A
Kern	N/A	61.1	N/A	57.1	N/A	N/A
Merced	N/A	75.0*	N/A	75.0*	N/A	N/A
Monterey	N/A	33.3*	N/A	0.0*	N/A	N/A
San Luis Obispo	N/A	100.0*	N/A	100.0*	N/A	N/A
Overall	**37.6%**	**56.8%**	**56.1%**	**61.8%↓**	**67.4%**	**85.0%**
County	Urgent Care Appointment within 96 hours of request		Non-Urgent Appointment within 15 business days of request			

	(Specialists - Oncology)		(Specialists - Oncology)	
	(Rate%)			
	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	25	78.6	86	78.6
Kings	33*	33.3*	67*	100.0*
Madera	50*	100.0*	75*	100.0*
Kern	N/A	50.0*	N/A	50.0*
Merced	N/A	100.0*	N/A	100.0*
Overall	**35.8%**	**75.0%**	**81.5%**	**83.382**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-10 PAAS (DMHC ONLY)–SCPs (Cardiologists, Gastroenterologists, Endocrinologists)

PAAS (DMHC)				
Access Measure and Standard (Performance Goal = 90%)				
County	Urgent Care Appointment within 96 hours of request (Specialists)		Non-Urgent Appointment within 15 business days of request (Specialists)	
	(Rate %)			
	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	40.9	54.0	50.0	59.8
Kings	50.0	55.6	100.0	63.6
Madera	26.3	63.4	42.2	64.0
Telehealth	34.6	N/A	42.9	N/A
Kern	N/A	61.1	N/A	57.1
Merced	N/A	75.0*	N/A	75.0*
Monterey	N/A	33.3*	N/A	0.0*
San Luis Obispo	N/A	100.0*	N/A	100.0*
Overall	**35.4%**	**57.6%**	**46.3%**	**59.9%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant
difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-11. PAAS (DMHC) – Access to Ancillary

PAAS (DMHC)			
Access Measure and Standard		Non-Urgent Services within 15 business days of request (Ancillary)	
County	Performance Goal	MY 2022 (%)	MY 2023 (%)
Fresno	70%	92.3	85.7
Kings	70%	100.0*	66.7*
Madera	70%	75.0*	100.0*
Kern	70%	N/A	94.7
Merced	70%	N/A	N/A
Monterey	70%	N/A	N/A
San Luis Obispo	70%	N/A	100.0*
Overall	**70%**	**89.5%**	**89.4%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-12. PAAS (DMHC) – Access to Psychiatry and Non-Physician Mental Health

PAAS (DMHC)								
Access Measure and Standard (Performance Goal = 70%)								
	Urgent Care services within 96 hours of request (Psychiatrist)		Non-Urgent Appointment within 15 business days of request (Psychiatrist)		Urgent Care services within 96 hours of request (NPMH)		Non-Urgent Appointment within 10 business days of request (NPMH)	
	(Rate %)							
County	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023	MY 2022	MY 2023
Fresno	38.5	57.1*	50.0	50.0*	50.0	78.7	77.1	81.1
Kings	0.0	N/A	0.0*	N/A	33.3*	87.53*	66.7	77.8*
Madera	N/A	N/A	N/A	N/A	75.0*	83.3	100.0*	92.3
Telehealth	25.0*	66.7*	50.0*	66.7*	37.8	87.5	60.5	94.4
Overall	**33.3%**	**60.0%**	**47.4%**	**54.5%**	**47.4%**	**80.6%**	**73.4**	**83.3%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2022 PAAS vs MY 2023 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

CalViva Telephone Access Survey

Table A-13. CalViva Telephone Access Survey

Access Measure	Standard	Goal	County	MY 2022 (%)	MY 2023 (%)
Telephone Answer Time	Within 60 seconds	90%	Fresno	100	99.5
			Kings	100	100.0
			Madera	92.0	100.0

			Total	**99.0**	**99.6**
Provider Call-back for non-urgent issues during normal business hours	Within one business day	90%	Fresno	86.0	58.8
			Kings	87.0	64.7
			Madera	88.0	100.0
			Total	**87.0**	**63.6**

N - Total number of respondents to the survey question

Provider Satisfaction Survey - Satisfaction with Timely Access Regulations

Medical/Non-Behavioral Health

Table A-14. CalViva Provider Satisfaction Survey (PSS) Survey (% Satisfied/Very Satisfied) – Overall Results

Metric	MY 2022 (%)	MY 2023 (%)
Access and Availability (Composite)	69.7	78.1
Referral and/or prior authorization process necessary for your patients to access covered services	65.5	80.5
Access to Urgent Care	71.7	74.6
Access to non-urgent primary care	73.9	82.6
Access to non-urgent specialty services	68.0	73.6
Access to non-urgent ancillary diagnostic and treatment services	70.0	78.6
Access to current and accurate provider directory data	68.8	78.9

Table A-15. CalViva PSS Survey Results (% Satisfied/Very Satisfied) – by County

Access Measure	Source	Fresno		Kings		Madera	
		MY 2022 (%)	MY 2023 (%)	MY 2022 (%)	MY 2023 (%)	MY 2022 (%)	MY 2023 (%)
Referral and/or prior authorization process	CalViva Provider Satisfaction Survey	61	86	50*	40*	90	64
Access to urgent care		73	79	50*	50*	75	67
Access to non-urgent primary care		72	87	100*	50*	80	75
Access to non-urgent specialty services		68	76	50*	50*	71	75
Access to non-urgent ancillary diagnostic & treatment services		71	76	50*	50*	71	78
Access to current and accurate provider directory data		67	76	100*	60*	71	88

* Rates calculated with small denominator size (≤30), and therefore comparisons and conclusions should be made with caution.
N/A – Not Applicable for measurement year

Table A-16. CalViva PSS for Behavioral Health Practitioners Survey Results

Access Measure	Source	MY 2022 N (%)	MY 2023 N (%)
Perspective on or concerns with compliance with the Routine Care standard (*% usually/always able to meet standard)*	Behavioral Health Provider Satisfaction Survey (PSS)	29 (58.6)	36 (86.1)
Perspective on or concern with the time standard for routine follow up appointments with a non-physician behavioral health provider? *(% usually/always able to meet standard)*		No data	32 (90.6)
Perspective on or concerns with compliance with the Urgent Care standard *(% usually/always able to meet standard)*		28 (60.7)	30 (76.7)
Perspective on or concerns with compliance with the Non-Life-Threatening Emergent Care standard *(% usually/always able to meet standard)*		27 (70.4)	31 (51.6)
Perspective on or concerns with the coordination of appointments with an interpreter? *(% not used/no concern)*		25 (84.0)	40 (92.5)
Perspective on or concerns with the availability of an appropriate range of interpreters? *(% not used/no concern)*		24 (95.8)	40 (92.5)
Perspective on or concerns with compliance with the training and competency of available interpreters? *(% not used/no concern)*		24 (91.7)	40 (90.0)

CalViva Provider After-Hours Availability Survey (PAHAS)

Table A-17. Provider After-Hours Survey Results

		Appropriate After-Hours Emergency Instructions		Ability to contact on-call physician after-hours within 30 minutes	
County	Performance Goal	MY 2022 (%)	MY 2023 (%)	MY 2022 (%)	MY 2023 (%)
Fresno	90%	97.8	98.2	90.1	84.5↓
Kings	90%	100	98.5	94.3	83.1↓
Madera	90%	100	100	100	100
Overall	**90%**	**98.3%**	**98.4%**	**91.6%**	**85.9%**

N – Total number respondents to the question
Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2022 PAAS vs MY 2023 PAAS (p<0.05)

Table A-18. CalViva Health Experience of Care and Health Outcomes (ECHO)

Access Measure	Performance Goal	Source	FRESNO		KINGS		MADERA	
			MY 2022 N (%)	MY 2023 N (%)	MY 2022 (%)	MY 2022 N (%)	MY 2022 N (%)	MY 2023 N (%)
Non-urgent initial appointment with a psychiatrist within 15 days of request	90%	Experience of Care and Health Outcomes (ECHO)	61 (59.0)	55 (50.9)	7 (42.9)	3 (0.0)*	6 (66.7)	4 (50.0)*
Non-urgent initial appointment with psychiatrist within 10 days of request	90%		61 (37.7	55 (32.7)	7 (42.9)	3 (0.0)*	6 (33.3)*	4 (25.0)*
Non-urgent follow-up appointment with psychiatrist within 30 days of request	90%		89 (79.8)	76 (76.3)	7 (71.4)	4 (75.0)*	5 (80.0)*	5 (60.0)*
Non-urgent initial appointment with a non- physician within 10 days of request	90%		75 (45.3)	76 (46.1	8 (25.0)	4 (0.0)*	11 (36.4)	7 (42.9)*
Non-urgent follow-up appointment with non-physician behavioral health care provider within 10 days of request	90%		94 (51.1)	94 (44.7)	11 (27.3)	5 (20.0)*	9 (44.4)*	8 (37.5)*
Non-urgent follow-up appointment with non-physician behavioral health care provider within 30 days of request	90%		94 (84.0)	94 (84.0)	11 (45.5)	5 (20.0)*	9 (100)*	8 (87.5)*

* Rates calculated with small denominator size (≤30), and therefore comparisons and conclusions should be made with caution.
N - Represents the number of respondents who populated a response to that particular Access Measure

Table A-19. MHN BH Appointment Availability Results by Risk Rating

Access Measure	Performance Goal	Source	MY 2022 (%)	MY 2023 (%)
Access to Urgent care within 48 hours	90%	Behavioral Health Case Management System	100	100
Access to NLTE care within 6 hours			100	100

Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

Quality Improvement, Health Education, and Wellness 2024 Year-End Work Plan Evaluation

Purpose

The purpose of the CalViva Quality Improvement (QI), Health Education (HEd) and Wellness Program Work Plan is to integrate operational systems to both review clinical, service, access, and safety related outcomes against the priorities and objectives established by the Quality Improvement Program as well as provide a systematic plan of health education activities for the calendar year. It also documents the outcomes of proposed health education initiatives, programs and services. An assessment of critical barriers is made when objectives have not been met. The results of this Quality Improvement Program Evaluation provide evidence of the overall effectiveness of the QI Program and identify barriers and opportunities for improvement.

Mission

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

Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement and health education activities for 2024. The development of this document requires resources of multiple departments. Section I includes program objectives, monitoring and evaluation for the year. Section II includes ongoing monitoring of cross-functional activities across the organization. Section III lists Quality Improvement Tracking System activities that support meeting QI and HEd program objectives for the year.

Submitted by:

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

Glossary of Abbreviations/Acronyms

Acronym:	Description
A&G:	Appeals and Grievances
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CA:	California region
CAHPS®:	Consumer Assessment of Healthcare Providers and Systems
CAIR:	California Immunization Registry
CAP:	Corrective Action Plan
CHW:	Community Health Worker
CS:	Community Supports
CDI:	California Department of Insurance
CM:	Case Management
DHCS:	Department of Health Care Services
DMHC:	Department of Managed Health Care
DN:	Direct Network
DM:	Disease Management
ECHO:	Experience of Care and Health Outcomes survey
FFS:	Fee-for-Service
HEDIS®:	Healthcare Effectiveness Data and Information Set
HPL:	High Performance Level
HRQ:	Health Risk Questionnaire
IHA:	Initial Health Appointments
IVR:	Interactive Voice Response
LTSS:	Long Term Services and Supports
MCAS:	Managed Care Accountability Set

Acronym:	Description
MCL:	Medi-Cal
MPL:	Minimum Performance Level
MSSP:	Multipurpose Senior Services Program
MY:	Measurement Year
N/A:	Not Available
N/R:	Not Reportable due to small denominator (<30)
NCQA:	National Committee for Quality Assurance
PAS:	Patient Assessment Survey
PCP:	Primary Care Physician
PEPM:	Provider Engagement Performance Management
PIP:	Performance Improvement Project
PDSA:	Plan, Do, Study, Act Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
POD:	Program Owners and Drivers
PNM:	Provider Network Management
PPG:	Participating Provider Group
PTMPY:	Per Thousand Members Per Year
QC:	Quality Compass
QI:	Quality Improvement
QIP:	Quality Improvement Project
RY:	Reporting Year
SPD:	Special Persons with Disabilities
UM:	Utilization Management

Glossary of Abbreviations/Acronyms (Measure Specific)

Acronym:	Description
AMR	Asthma Medication Ratio
BCS	Breast Cancer Screening
CBP	Controlling Blood Pressure
CCS	Cervical Cancer Screening
C.Diff	Clostridioides difficile
CAUTI	Catheter-associated Urinary Tract Infection
CHL	Chlamydia Screening in Women
CIS-10	Childhood Immunization Status - Combination 10
CLABSI	Central line-associated bloodstream infection
DEV	Developmental Screening in the First Three Years of Life
FUA	Follow-Up After ED Visit for Substance Abuse – 30 days
FUM	Follow-Up After ED Visit for Mental Illness – 30 days
FVA	Flu Vaccinations for Adults
GSD	Glycemic Status Assessment for Patients with Diabetes (>9%)
HBD	Diabetes Care -Blood Sugar Controlled (>9%)
IMA-2	Immunizations for Adolescents – Combo 2
LSC	Lead Screening in Children
MRSA	Methicillin-resistant Staphylococcus aureus
NTSV	Nulliparous, Term, Singleton, Vertex
PCR	Plan All Cause Readmission
POD	Pharmacotherapy for Opioid Use Disorder
PPC-Pst	Postpartum Care
PPC-Pre	Prenatal and Postpartum Care: Prenatal Care
PCR	Plan All Cause Readmission
POD	Pharmacotherapy for Opioid Use Disorder
SSI-Colon	Surgical site infection following colorectal surgery

Acronym:	Description
TFL-CH	Topical Fluoride for Children
SSI-Colon	surgery
TFL-CH	Topical Fluoride for Children
W30	Well-Child Visits in the First 30 Months of Life
W30-6+	visits
W30-2+	visits
WCC	Nutrition and Physical Activity for
WCV	Child & Adolescent Well-Care Visits

Section I: Work Plan Initiatives

Goal: Implement activities to improve performance measures.

Section I includes program objectives, monitoring and evaluation for the year.

Program Details	Responsible Party	Objectives	MY 2022 Objectives Met (%, ratio):	MY 2023 Objectives Met (%, ratio):	2024 Mid-Year Activities Completed (%, ratio):	2024 Year-End Activities Completed (%, ratio):	Projected Mid-Year Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)2	Projected Year-End Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
1.Behavioral Health – Improving Behavioral Health (Mental Health and Substance Use) Outcomes Type of activity: •Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority area) Type of program: •Quality of Care •Safety	Kelli Lesser, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure (6 rates): FUA-30 (target 36.34), FUM-30 (target 54.87)	MY 2022: •FUA-30: (33%, 1/3) Fresno: 18.48% Kings: 31.79% Madera: 18.32% •FUM-30: (33%, 1/3) Fresno: 25.47% Kings: 70.07% Madera: 52%	MY 2023: •FUA-30: (0%, 0/3) Fresno: 15.01% Kings: 21.66% Madera: 16.84% •FUM-30: (0%, 0/3) Fresno: 14.17% Kings: 38.25% Madera: 22.47%	Mid-Year (Jan-Jun): 0%, (0/0) No activities were completed at mid-year. 3/3 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 83.33%, (5/6) of activities were completed at year-end.	Progress: On Track: 83.33% (5/6) of measures projected to meet objectives.	Progress: Off Track: 66.67% (4/6) of measures projected to meet objectives.	Continue Initiative with Modifications
2.A. Chronic Conditions – Diabetes (GSD >9) Type of activity: • Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MCAS MPL) Type of program: • Quality of Care • Quality of Service	Gigi Mathew, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	•MCL: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: GSD (new 2024 measure replaces HBD) **(inverted rate)**	MY 2022: •CDC > 9: (100%, 3/3) Fresno: 37.47% Kings: 30.05% Madera: 35.93%	MY 2023: •GSD >9: (100%, 3/3) Fresno: 35.31% Kings: 25.42% Madera: 30.79%	Mid-Year (Jan-Jun): 75%, (6/8) of activities were completed at mid-year. 8/10 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 66.67% (10/15) of activities were completed at year-end.	Progress: Off track: 66.67% (2/3) of measures projected to meet objectives. CalViva to leverage targeted vendor campaigns to non-compliant members by utilizing multi-modal approaches and collaborating with providers to promote completion of in-home A1c kits.	Progress: Off Track: 66.67% (2/3) of measures projected to meet objectives. Leverage vendors to facilitate direct care gap closure in conjunction with enhanced collaboration with providers to improve completion of in-home A1c kits. Share root cause analysis of A1c measure to help providers prioritize outreach.	Continue Initiative with Modifications
2.B. Chronic Conditions – Heart Health/Blood Pressure (CBP) Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MCAS MPL) Type of program: •Quality of Care •Quality of Service	Gigi Mathew, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: CBP at 50th percentile 61.31%.	MY 2022: •CBP: (100%, 3/3) Fresno: 61.73% Kings: 71.81% Madera: 67.49%	MY 2023: •CBP: (100%, 3/3) Fresno: 64.29% Kings: 72.81% Madera: 71.04%	Mid-Year (Jan-Jun): 80%, (4/5) of activities were completed at mid-year. 8/8 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 93.33%, (14/15) of activities were completed at year-end.	Progress: On Track: 100% (3/3) of measures projected to meet objectives.	Progress: On Track: 100% (3/3) of measures projected to meet objectives.	Continue Initiative with Modifications
3. Hospital Quality/Patient Safety Type of activity: • Ongoing activity – (monitoring of previously identified issue – address quality/ safety of care priority) Type of program: • Quality of Care • Safety	Barbara Wentworth, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	• Hospitals with sufficient reportable data: Directional improvement, based on appropriate scores (SIR=<1.0) or outliers (SIR>2) for target hospital acquired infections (HAIs) (CAUTI, CLABSI, C.Diff, MRSA, and SSI-Colon), if baseline is <90% (appropriate) / >5% (outlier). Otherwise, maintain =>90%/<5% status. • Maternity hospitals with reportable data: Directional improvement for the proportion of hospitals meeting the national standard (=<23.6%) for all-payer NTSV C-section rates.	HAIs for Measurement period 10/1/2021 to 9/30/2022, C-section for MY 2022; All CVH network hospitals with sufficient data: •CAUTI: SIR=<1.0: 50%; SIR>2.0: 0% •CLABSI:SIR=<1.0: 25%; SIR>2: 25% •C.Diff: SIR=<1.0: 100%; SIR>2: 0% •MRSA: SIR=<1.0: 50%; SIR>2: 0% •SSI-Colon: SIR=<1.0: 50%; SIR>2: 0% •NTSV C-sections: Rate=<23.6%: 20%	Met 9/11 (82%) of objectives for HAI and NTSV C-section performance in network hospitals with reported data. Objective is to improve (or sustain high performance) on the % of network hospitals that meet targets on 5 HAI's and on NTSV C-section rates. Meets objective if the % of hospitals meeting the target improves upon (or sustains high performance) compared to the % of hospitals last year). • HAIs: 3 out of 5 of the HAIs improved (or achieved 100%) in the percentage of CVH hospitals that met the target (SIR<=1.0); and 5 out of 5 HAIs improved on (or achieved 0%) in the percentage of CVH hospitals avoiding outliers (SIR>2.0). (See current % of CVH hospitals meeting the target and avoiding outliers below, for recent period of 7/1/22 - 6/30/23. Compare to previous period.) • CAUTI: SIR=<1.0: 75%; SIR>2.0: 0% • CLABSI:SIR=<1.0: 0%; SIR>2: 0% • C.Diff: SIR=<1.0: 100%; SIR>2: 0% • MRSA: SIR=<1.0: 75%; SIR>2: 0% • SSI-Colon: SIR=<1.0: 25%; SIR>2: 0% • NTSV C-sections (MY 2023): Improved on the % of CVH hospitals meeting the NTSV C-section rate target of <=23.6% (3 of 5 hosps, or 60%) compared to the % in the previous period (1 of 5 hosps, or 20%).	Mid-Year (Jan-Jun): 0%, (0/0) of activities were completed at mid-year. 9/9 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 100% (9/9) of activities were completed at year-end.	N/A	N/A	Continue Initiative Unchanged
4. Member Engagement and Experience – Initial Health Appointment Type of activity: •Ongoing activity – (monitoring of previously identified issue – DHCS regulatory activity, audit non-compliance) Type of program: •Quality of Care	Miriam Rosales, Program Manager III, QI Sia Xiong Lopez CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	•MCL: Meet directional improvement of 1-5% from prior year. IHA does not have HEDIS benchmark but is a DHCS compliance measure.	MY 2022 • IHA: 59.82%	MY 2023 •IHA: 57.26%	Mid-Year (Jan-Jun): 0%, (0/0) of activities were completed at mid-year. 2/2 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): (100%, 2/2)	N/A	Progress: On Track: Preliminary Q4 2023 rate at 58.81%.	Continue Initiative Unchanged

Program Details	Responsible Party	Objectives	MY 2022 Objectives Met (%, ratio):	MY 2023 Objectives Met (%, ratio):	2024 Mid-Year Activities Completed (%, ratio):	2024 Year-End Activities Completed (%, ratio):	Projected Mid-Year Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)2	Projected Year-End Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
5.A. Pediatric/Perinatal/Dental – Dental: TFL-CH Type of activity: • Ongoing activity - (monitoring of previously identified issue) Type of program: • Quality of Care • Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measure TFL-CH.	MY 2022 • TFL-CH: N/A – New Measure for MY 2023. But added due to DHCS MCAS priority measure.	MY 2023 • TFL-CH: (33%, 1/3) Fresno: 19.21% Kings: 9.63% Madera: 27.66%	Mid-Year (Jan-Jun): 0%, (0/0) of activities were completed at mid-year. 1/1 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 100% (1/1) of activities were completed at year-end.	Progress: Off Track: 0% (0/3) of measures projected to meet objectives. Measure is new for monitoring and further barrier analysis is needed. Planned activities will continue.	Progress: Off Track: 33.33% (1/3) of measures projected to meet objectives. Complete barrier analysis and modify activities as needed.	Continue with modifications. Complete barrier analysis and modify activities as needed.
5.B. Pediatric/Perinatal/Dental – Maternity/Perinatal Care: PPC-pre, PPC-pst Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain achievement of DHCS MPL, coordination of care priority) Type of program: •Quality of Care •Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measures: PPC-pre and PPC-pst.	MY 2022 • PPC-pre: (67%, 2/3) Fresno: 89.62% Kings: 87.76% Madera: 90.37% • PPC-pst: (100%, 3/3) Fresno: 84.23% Kings: 84.18% Madera: 87.04%	MY 2023 • PPC-pre: (100%, 3/3) Fresno: 90.39% Kings: 91.27% Madera: 90.82% • PPC-pst: (100%,3/3) Fresno: 82.1% Kings: 83.84% Madera: 80.1%	Mid-Year (Jan-Jun): 100%, (1/1) of activities were completed at mid-year. 3/5 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 83.33% (5/6) of activities were completed at year-end.	Progress: On Track: 100% (6/6) of measures projected to meet objectives at 50th percentile.	Progress: On Track: 100% (6/6) of measures projected to meet objectives at 50th percentile.	Continue Initiative Unchanged
5.C. Pediatric/Perinatal/Dental – Pediatric Measures for Children 3-21 of age: IMA-2, WCV Type of activity: •Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority area) Type of program: •Quality of Care •Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measures: IMA-2 and WCV.	MY 2022 • IMA-2: (67%, 2/3) Fresno: 39.17% Kings: 29.68% Madera: 53.86% • WCV: (33.33%, 1/3) Fresno: 48.14% Kings: 39.56% Madera: 57.71%	MY 2023 • IMA-2: (67%, 2/3) Fresno: 36.06% Kings: 31.39% Madera: 47.32% • WCV: (67%, 2/3) Fresno: 51.57% Kings: 41.79% Madera: 65.02%	Mid-Year (Jan-Jun): 100%, (1/1) of activities were completed at mid-year. 5/6 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 90% (9/10) of activities were completed at year-end.	Progress: Off Track: 50% (3/6) of measures projected to meet objectives. Barrier analysis is underway for these measures. The remaining activities will continue and contribute to improvements and will be modified as needed.	Progress: On Track: 83.33% (5/6) of measures projected to meet objectives.	Continue Initiative with Modifications
5.D. Pediatric/Perinatal/Dental – Pediatric Measures for Children under 3 years of age: CIS-10, LSC, DEV, W30-6+, W30-2+ Type of activity: •Ongoing activity – (monitoring of previously identified issue – under performing MCAS, DHCS priority) Type of program: •Quality of Care •Quality of Service	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet the 50th percentile benchmark for MCAS measures: CIS-10, LSC, CDEV, W30-6+, W30-2+.	MY 2022 • CIS-10: (33.33%, 1/3) Fresno: 27.49%, Kings: 23.84%, Madera: 48.42% • LSC: (33.33%, 1/3) Fresno: 49.88%, Kings: 53.77%, Madera: 66.42% • CDEV: N/A no benchmark this year • W30-6+: (33.33%, 1/3) Fresno: 50.01%, Kings: 53.48%, Madera: 56.71%, • W30-2+: (33.33%, 1/3) Fresno: 62.69%, Kings: 55.59%, Madera: 75.65%	MY 2023 • CIS-10: (33%, 1/3) Fresno: 27.74%, Kings: 19.83%, Madera: 47.45% • LSC: (33%, 1/3) Fresno: 56.69%, Kings: 58.64%, Madera: 78.1% • CDEV: (33%, 1/3) Fresno: 28.04%, Kings: 3.36%, Madera: 57.47% • W30-6+: (33%, 1/3) Fresno: 56.55%, Kings: 57.44%, Madera: 63.7% • W30-2+:(33%, 1/3) Fresno: 65.01%, Kings: 53.74% Madera: 79.19%	Mid-Year (Jan-Jun): 100%, (3/3) of activities were completed at mid-year. 10/15 ongoing or planned activities are on track to be completed by year-end.	Year-End (Jan-Dec): 91.30% (21/23) of activities were completed at year-end.	Progress: Off Track: 46.67% (7/15) of measures projected to meet objectives. Barrier analysis is under way. Initiatives will continue and be modified as needed.	Progress: Off Track: 66.67% (10/15) of measures projected to meet objectives. Use Power Automate to educate and engage providers in utilizing Cozeva to identify and prioritize non-compliant members to target quarterly for all early childhood measures.	Continue Initiative with Modifications
6. Pharmacy and Related Measures – AMR Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain or address under performing MCAS) Type of program: •Quality of Care •Quality of Service	Alicia Bednar, Program Manager III, QI Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: •AMR	MY 2022: •MCL: (66.67%, 2/3) Fresno: 62.15% Kings: 64.37% Madera: 72.93%	MY 2023: •MCL: (33.33%, 1/3) Fresno: 63.66% Kings: 59.29% Madera: 72.2%	Mid-Year (Jan-Jun): 100%, (1/1) activities were completed at mid-year. 1/4 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 87.5% (7/8) of activities were completed at year-end.	Progress: Off Track: 66.67%, (2/3) of measures projected to meet objectives. Barrier analysis is under way. Interventions to continue as planned and will be modified as needed.	Progress: Off Track: 66.67% (2/3) of measures projected to meet objectives. Member calls to highlight Cal Aim remediation services available to members will be done thru CHW partnerships. Targeted provider education to emphasize use of ICS combos to control exacerbation.	Continue Initiative with Modifications. Member calls to highlight Cal Aim remediation services available to members will be done thru CHW partnerships. Targeted provider education to emphasize use of ICS combos to control exacerbation.

Program Details	Responsible Party	Objectives	MY 2022 Objectives Met (%, ratio):	MY 2023 Objectives Met (%, ratio):	2024 Mid-Year Activities Completed (%, ratio):	2024 Year-End Activities Completed (%, ratio):	Projected Mid-Year Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)2	Projected Year-End Progress Towards MY 2024 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
7.A. Preventive Health – Cancer Screenings Type of activity: •Ongoing activity – (monitoring of previously identified issue – maintain or address under performing MCAS) Type of program: •Quality of Care •Quality of Service	Ravneet Gill, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measures: BCS, CCS, and CHL.	MY 2022: •BCS: 100%, 3/3 Fresno: 51.99% Kings: 58.44% Madera: 60.87% •CCS: 66.67%, 2/3 Fresno: 57.08% Kings: 58.95% Madera: 61.58% •CHL: 100%, 3/3 Fresno: 58.86% Kings: 62.15% Madera: 59.38%	MY 2023: •BCS: (100%, 3/3) Fresno: 57.87% Kings: 61.9% Madera: 63.18% •CCS: (100%, 3/3) Fresno: 60.55% Kings: 61.1% Madera: 68.37% •CHL: (100%, 3/3) Fresno: 61.35% Kings: 64.11% Madera: 62.08%	Mid-Year (Jan-Jun): 0%, (0/0) activities were completed at mid-year. 5/5 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 92.31% (12/13) of activities were completed at year-end.	Progress: On Track: 77.78%, (7/9) of measures projected to meet objectives.	Progress: On Track: 100%, (8/8) of measures projected to meet objectives.	Continue Initiative with Modifications
7.B. Preventive Health – Flu Campaign Type of activity: •New Activity – NCQA quality measure Type of program: •Quality of Care •Member Experience	Matt Anderson, Program Manager III, Quality Improvement CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year for the Flu Vaccine Adult Immunization Status.	MY 2022 AISE Flu: N/A	MY 2023 AISE Flu: 100% (3/3) Fresno: 21.45% Kings: 21.97% Madera: 23.92%	Mid-Year (Jan-Jun): 0%, (0/0) activities were completed at mid-year. 5/5 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 66.67% (2/3) of activities were completed at year-end.	N/A	N/A	Continue Initiative with Modifications
8.A Provider Communication/ Engagement – Improving Member Experience (CAHPS) – Provider Focus Type of activity: •New Activity – improve performance NCQA quality measure. Type of program: •Quality of Care •Quality of Service •Member Experience	Guille Toland, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year on CAHPS Access measures including: Getting Needed Care, Getting Care Quickly and Care Coordination	MY 2022 CAHPS: Regulatory CAHPS survey was conducted for MY2022. Regulatory CAHPS: Getting Needed Care, (NA) Getting Care Quickly, (NA) Care Coordination, (NA) *No HSAG or Regulatory CAHPS survey was conducted for MY2021. There was a CVH Member Access Survey conducted during this period. Results don't align to measure directional improvement for MY2022. MY2022 will be use as baseline for MY2023.	MY 2023 CAHPS: N/A since there was no Regulatory CAHPS survey done in MY2023 HSAG CAHPS: Getting Needed Care, (0/3, 0%) Getting Care Quickly, (NR) Care Coordination, (NR) Non-reportable due to small sample size (n<100). None of the above CAHPS measures met the directional improvement of 1-5% from previous years. Getting Needed Care had a 73.5% rate compared to prior year of 76.7% and not meeting directional improvement. The other measures had no reportable rate.	Mid-Year (Jan-Jun): 100% (3/3) activities were completed at mid-year. 6/6 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 71.43% (5/7) of activities were completed at year-end.	N/A	N/A	Continue Initiative with Modifications. Conduct quarterly root cause analysis that will drill down into the cause of these barriers. This will help identify any trends and points for improvement.
8.B Provider Communication/ Engagement - Improving Member Experience (CAHPS) – Plan Focus Type of activity: •Ongoing activity – (monitoring of previously identified issue – improve performance NCQA quality measure) Type of program: •Quality of Care •Quality of Service •Member Experience	Guille Toland, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	Meet directional improvement of 1-5% from prior year on the following CAHPS measures: Rating of Health Plan, Customer Service, Ease of Filling Out Forms	MY 2022 CAHPS: Regulatory CAHPS survey was conducted for MY2022. Regulatory CAHPS: Rating of Health Plan, (NA) Customer Service (NA) Ease of Filling out Forms (NA). *No HSAG or Regulatory CAHPS survey was conducted for MY2021. There was a CVH Member Access Survey conducted during this period. Results don't align to measure directional improvement for MY2022. MY2022 will be use as baseline for MY2023.	MY 2023 CAHPS: N/A since there was no Regulatory CAHPS survey done for MY2023 HSAG CAHPS: Rating of Health Plan (1/1, 100%) Customer Service, (NR) Ease of Filling out Forms (NR). Non-reportable due to small sample size (n<100). Rating of the Health Plan was the only measure that had a rate to compared from previous year. There was a 10.08% directional improvement.	MY 2023 CAHPS: N/A at mid-year (x/3, x%) HSAG CAHPS: Rating of Health Plan (1/1, 100%) Customer Service (N/A) Ease of Filling out Forms (N/A)	Year-End (Jan-Dec): 50% (2/4) of activities were completed at year-end.	N/A	N/A	Continue Initiative with Modifications
8.C Provider Communication/ Engagement - Improving Provider Survey Results Type of activity: •Ongoing activity – (monitoring of previously identified issue – compliance priority) Type of program: •Access and Availability	Paul Fuentes, Provider Relations Specialist II, Access and Availability Steven Si, Sr. Manager, Compliance and Privacy	To meet performance goal for Provider Appointment Access Survey (PAAS) at 70%. To meet performance goal for Provider After-Hours Access Survey (PAHAS) at 90%.	MY 2022 PAAS: 40% (2/5) •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% MY 2022 PAHAS: 100% (2/2) •Appropriate Emergency Instructions: 98.3% •Ability to Contact On-Call Physicians: 91.6%	MY 2023 PAAS: 60% (3/5) •PCP Urgent: 78.8% •PCP Non-Urgent: 85.3% •Specialists (All) Urgent: 56.8% •Specialists (All) Non- Urgent: 61.8% •Ancillary Non-Urgent: 89.4% MY 2023 PAHAS: 50% (1/2) •Appropriate Emergency Instructions: 98.4% •Ability to Contact On-Call Physicians: 85.9%	Mid-Year (Jan-Jun): 80% (4/5) activities were completed at mid-year. 2/2 ongoing or planned activities on track to be completed by year-end.	Year-End (Jan-Dec): 85.71% (6/7) of activities were completed at year-end.	N/A	N/A	Continue Initiative Unchanged

Section II: Ongoing Work Plan Activities

Section II includes ongoing monitoring of cross-functional activities across the organization.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	D. Saldarriaga; Manager, A&G S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical	12/31/24	Completed	12/31/2024	On track. Quarterly reports are provided to the CalViva Access workgroup where opportunities to improve member services and satisfaction are identified through the A&G system. We also provide monthly reports with the overall A+G universe including Access to care grievances, these reports are reviewed during the monthly MOM call and weekly QIUM workgroups.	Reports are provided to the CalViva Access workgroup which were reviewed during the monthly MOM calls. Feedback and education was done with multiple providers based on these reports around access issues, claims and balance billing related issues.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	5/1/24 - 12/31/24	Completed	12/18/2024	Training materials were produced are in review by the Marketing and Communications team. The first training will start 7/24/24 and continue through December 18th.	Access and Availability team conducted 10 timely Access provider training webinars with 744 attended and submitted webinar completion certificate.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q1-Q2 2024 validate and analyze survey results and identifies non-compliant PPGs and providers.	Completed	8/2/2024	Results for noncompliant PPGs and providers will be available in August 2024.	Survey completed. CAPs were sent out and closed 12/31/24.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q2 2024: Results for Q3-Q4 2023 PAAS PAHAS Telephone Access surveys conducted.	Completed	8/2/2024	Survey went out in July 2023. Results were expected in Q2 2024 but delayed to August 2024.	Telephone Access Survey Completed on 12/31/24.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	3/31/24	Completed	5/1/2024	DMHC extended due date to May 1, 2024. Submission was completed timely.	TAR filing submitted to the DMHC by filing due date.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Coordinate data and reporting for annual Provider Satisfaction Survey.	M. Miyashiro R. Davila S. Si, CVH Compliance	September 2024-November 2024	Completed	11/27/2024	Not started. On track.	Completed 11/27/24

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey.	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q1 2024	Off track/ Delayed	9/26/2024	Not started. Delayed to Q3 2024.	Provider outreached was completed on 9/26/24
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Engage with CalViva provider offices to complete MY 2024 MCAS training focused on best practices for closing care gaps.	A. Wittig, Director, Quality Improvement Erica Valdivia, Provider Engagement Amy Schneider RN, Sr. Director Medical Management	12/31/2024	Completed	12/31/2024	On track.	Our focus will be to engage and educate providers on MY2025 MCAS trainings. 2024 has been completed and closed out.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement. Analyze and inform Provider Network Management of areas needing increased contracting with a particular provider to improve availability.	D. Fang, Manager, Health Equity S. Si, CVH Compliance	Next report is due in Q3 2025.	Not started	Not started	Not started. Report will be complete in Q3 2025.	Not started. This report is not due until Q3 2025
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Health Equity Report: Analyze and report on Cultural and Linguistics.	D. Fang, Manager, Health Equity S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	Q2 and Q3	Completed	5/16/2024	2023 Health Equity Language Assistance Program End of Year report, 2024 Program Description, and 2024 Work Plan were completed and presented to CalViva Health QI/UM Committee on May 16, 2024. 2024 Work Plan and Language Assistance Program Mid-Year Evaluation reports will be completed in Q3.	2024 Work Plan and Language Assistance Program Mid-Year Evaluation reports were completed in Q3. 2024 Health Equity Language Assistance Program End of Year report, 2025 Program Description, and 2025 Work Plan will be completed in Q2 2025.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to complete interventions addressing systemic barriers to HEDIS performance.	A. Wittig, Director, Quality Improvement Erica Valvidia, Director, Provider Engagement	12/31/2024	Completed	12/31/2024	On track.	Approved 116 EDGE requests to primarily address pediatric barriers for $660K in funds that sponsored initiatives such as point-of-care member incentive gift cards, mobile mammography events, one-stop clinic events, and equipment/supplies (lead screening machines and fluoride kits).

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Maintain and manage the CAHPS Action Plan: Collaborate with CAHPS measure owners to identify areas of opportunity and activities to improve CAHPS, identifying process improvement activities. This also includes working with the Provider Engagement and Medical Affairs teams to review provider CAHPS improvement plans, identifying best practices, and recommending changes when plans are insufficient to improve the member experience in a measurable and meaningful way.	T. Jaghasspanian M. Anderson G. Toland S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/31/2024	On track.	Completed 12/31/24.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Maintain compliance with DHCS Initial Health Appointment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	A. Wittig, Director, Quality Improvement S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	11/21/24	Completed	11/21/2024	On track.	Completed 11/21/2024. MY 2024 final rates will be available in Q3 2025.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Monitor appropriate after-hours messaging and timely access to urgent/emergent care. Refer to Access and Availability Work Plan for additional details.	M. Miyashiro R. Davila S. Si, CVH Compliance	October 2024-January 2025	Completed	12/17/2024	Not started. On track.	Survey completed 12/17/24. Results are being analyzed.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Monitor Delegation Oversight activities through the PPG scorecards that captures PPGs' audit scores. The quarterly scorecard provides an opportunity to track/ trend low- high PPGs performers.	Manisha Makwana S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	Jan, May, Aug, and Dec 2024	PPG Scorecards were produced for 5 CalViva service area PPGs for Q1 and Q2 2024.	Q4 2023 report produced in January 2024; Q1 2024 produced in May 2024; Q2 2024 produced in August 2024; Q3 2024 produced in December 2024.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Write integrated member satisfaction reports, in partnership with the QIRA Team, to satisfy NCQA Accreditation ME.7 Standard. This report captures appeals, grievances, CAHPS results, and identifies barriers, areas of opportunity, and ongoing initiatives.	T. Jaghasspanian G. Toland S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	Q4 2024	Completed	11/6/2024	On track.	NCQA Accreditation ME.7 report was completed and sent to CVH Compliance team and QIUM workgroup on 11/06/24.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
BEHAVIORAL HEALTH	Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, etc.)	G. Gomez, Director, QI Amy Schneider RN, Sr. Director Medical Management	12/31/24	In progress	3/21/24 7/18/24 10/17/24	ECHO survey fielding starting in September with results report will be received in November. The CAHPS team to complete report. Remaining BH performance reports were delivered for Q1 (complete) and Q2 due in September. After that, fully transitioned to other units.	The ECHO Survey was fielded between July 21, 2024 and September 21, 2024. MHN reporting, Access 24/QIUM 40 Behavioral Health Performance Indicator Report for Q4 2023-Q3 2024 were reported by QI Team (Maya Cashman); MHN staff are fully transitioned to other units and under the responsibility of other departments. Due to MHN transition, Q3 2024 and current reports were reported by Behavioral Health Utilization Management, Clinical Ops (Jessie Blake's team). The completed Q3 2024 report will reviewed by QIUM Committee on 2/20/2025. The NCQA ME.7 QIUM 89 Behavioral Health report was reported in Q1 2024 and approved at 3/21 QIUM Committtee.
CONTINUITY AND COORDINATION OF CARE	Educate providers on importance of well-child visits. Well-child visits include developmental screenings.	J. Coulthurst, PMIII, QI Amy Schneider RN, Sr. Director Medical Management	12/31/2024	Completed	12/31/2024	Provider Facing Teams trained on all pediatric measures and importance of well-child visits and all services to be completed during well-child visits. All Provider Tip Sheets are up-to-date.	HEDIS team identified developmental screening coding issues. HEDIS team educated Provider facing teams and providers on correct coding and modifiers for developmental screenings. Provider facing teams continued provider education on importance of well-child visits.
CONTINUITY AND COORDINATION OF CARE	Monitor opportunities and interventions for NCQA Standards QI.3 & QI.4 Coordination of Care (COC) requirements (non-BH and BH reports).	K. Lesser/ M. Rosales Program Manager III, Quality Improvement	QI 3 & QI 4: 5/31/24 & 12/31/24	In progress	Q13: MY2022/ Year 1 was approved before 05/31/24. QI4: The 2024 QI4 Plan was reviewed/approved before 5/31/24	QI3- 1st year report (2023)was approved. QI4: Approved 2024 Plan identifies timeliness of exchange (measured by provider satisfaction) and often seen in PCP setting (measured by FUM and FUA) as selected opportunities (measurments) to improve COC between Medical and BH providers.	Approval of updated QIUM 65 and 67 reports by internal collaboration team members anticipated in January 2025. Once approved, Q1 & QI4 document will be presented for Plan approval at Q2 2025 Quarterly Quality Committee meeting.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CREDENTIALING / RECREDENTIALING	Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	M. Catello, Sr. Manager	12/31/24	Completed	12/19/2024	Not started. On track.	Completed.
CREDENTIALING / RECREDENTIALING	PPG Delegates Credentialing/Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	K. Bowling, Sr. Manager	12/31/24	Completed	11/1/2024	On track. Compliant.	Completed and compliant.
DISEASE/CHRONIC CONDITIONS MANAGEMENT	Monitor Chronic Conditions (Disease) Management Program for appropriate member outreach quarterly.	Denise Miller, Program Manager III Customer Experience	12/31/24	Completed	12/19/2024	Submitting new program updates for regulatory approval. On track.	Waiting for ETA on when CalViva will submit program revisions to DHCS.
QUALITY AND SAFETY OF CARE AND SERVICE	Complete all potential quality issues (PQIs) received within 90 day TAT to maintain internal compliance.	P. Carpenter, Director, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/31/2024	On track.	Completed and compliant.
QUALITY AND SAFETY OF CARE AND SERVICE	Delegation Oversight -- Monitor PPG-level delegated activities and issues, including CAPs, and report findings to CalViva Credentialling Sub Committee and QIUM Committee at least annually. Activities include Utilization Management, including CCM; credentialing; and claims payments.	K. Bowling A. Tonkogolosuk	12/31/24	Completed	12/17/24	On track.	All annual audits for delegates have been completed for 2024. Performance results including CAPs have been shared at least annually with the required committees and groups. Majority of the delegates were overall complaint. Needed CAPs were issued and addressed with delegates. On-going monitoring was conducted regularly and continues for 2025.
QUALITY AND SAFETY OF CARE AND SERVICE	Handling of Member Grievances and Appeals: Ongoing monitoring and assessment of compliance with the handling of member grievances and appeals; ensure compliance with regulatory requirements for TAT and process.	L. Carrera Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/31/2024	On track. Quality controls are in place to ensure every task with in the A+G process follows contractual and regulatory compliance standards.(FL, BKB, team and management Calibration calls, day 18 audits).	All TAT metrics met 95% or above across all categories.
QUALITY AND SAFETY OF CARE AND SERVICE	Integrated Care Management (ICM) • Implement PHM pyramid as the predictive modeling tool to identify high-risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	C. Patnaude, Director, Care Management	Ongoing by 12/31/24	Completed	12/31/24 - continue in 2025	On track.	Through Q2 outcomes readmision rate decreased by 4.3% (above 3% goal). ED claims down 21% (above 3% goal). CM had a significant reduction in IP and OP claims with slight increase in Rx claims. Member satisfaction is within 90% goal.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
QUALITY AND SAFETY OF CARE AND SERVICE	Monitor credentialing findings and report to CalViva Credentialing Sub Committee quarterly.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	4/9/2024, 7/11/2024, 10/07, 1/8/2025	On track.	Completed with no findings.
QUALITY AND SAFETY OF CARE AND SERVICE	Monitor peer review determinations and report to CalViva Credentialing Sub Committee quarterly.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	4/9/2024, 7/11/2024, 10/07, 1/8/2025	On track.	Completed with no findings.
QUALITY AND SAFETY OF CARE AND SERVICE	Monitor potential quality incidents and quality of care findings and report to CalViva quarterly.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	12/31/2024	On track.	Completed with no findings.
QUALITY AND SAFETY OF CARE AND SERVICE	Update Clinical A&G Quality of Care Concerns Policy & Procedure and Peer Review Committee Policy & Procedure.	P. Carpenter, Director, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	12/31/24	Completed	12/19/2024 Peer Review	On track.	Completed policy review.
QUALITY IMPROVEMENT AND COMPLIANCE	Evaluate written plan for safety and quality data collection: To improve patient safety by collecting and providing information on provider and practitioner safety and quality (at least annually).	L. Aaronson A. Wittig Pamela Carpenter Barbara Wentworth	February 2024	Completed	2/15/2024	2023 Evaluation was submitted to committee in February 2024 and presented to committee February 15, 2024. Refer to the 2023 Year End QI Executive Summary section on safety monitoring of potential quality issues.	Completed in Q1.
QUALITY IMPROVEMENT AND COMPLIANCE	Evaluation of the QIHEd program of the previous year (Q1). Complete QIHEd Work Plan evaluation semi-annually.	L. Aaronson M. Gumatay A. Wittig S. Luce T. Jaghasspanian L. Pak A. Schneider	February 2024 September 2024	Completed	3/18/2024 09/12/2024	Year end evaluation completed. Mid-year evaluation in progress.	Mid-year evaluation completed on 09/12/2024.
QUALITY IMPROVEMENT AND COMPLIANCE	Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure provider offices and medical records comply with DHCS contracted requirements per APL 22-107 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023. Report FSR/MRR data to DHCS twice per year (1/31 and 7/31), including all sites with failed scores.	P. Carpenter, Director, Quality Improvement	12/31/24	Completed	12/31/2024	On track. DHCS implementing a new portal called MSRP to upload bi-annual FSR/MRR data, however it is not in production yet. We have submitted data for 7/1/23-12/31/23 to DHCS on 4/26/24 using their existing process and 1/1/24-6-30/24 is due 8/16/24.	Completed and compliant.
QUALITY IMPROVEMENT INFASTRUCTURE	Care gap reports produced by the HEDIS Team monthly, by contract level and participating provider group (PPG) level to identify non-compliant members.	HEDIS D. Mehlhouse	Monthly by 12/31/24	Completed	Jan-December 2024	In progress and on track.	Completed monthly.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
QUALITY IMPROVEMENT INFASTRUCTURE	Encourage further Cozeva adoption/usage among PCPs and provider groups in program's 5th year; Expand Cozeva-EHR integrations and bidirectional data-sharing with priority PCP/clinics; Enhance Cozeva platform to support regulatory requirements and key opportunities / initiatives.	S. Pao S. Myers	12/31/2024	Completed	7/12/2024	Published first 2024 Cozeva adoption/engagement dashboard on 7/12/24; outreach to adopt new targeted providers and reengage existing users to begin in July 2024 and continue through December 2024; 4 of 20 Cozeva enhancement items completed, remaining 16 of 20 are in progress (ETC: 12/31/24).	Year-end 2024 Cozeva adoption for CalViva PCPs/clinics stands at 96% (equates to >99% of membership), and priority PCP/clinic platform “engagement” stands at 59% (vs. 30% annual goal).
QUALITY IMPROVEMENT INFASTRUCTURE	QI improves communication with stakeholder departments and identifies interventions to improve CAHPS through monthly Quality Focus Touchbase meetings and Quality Governance Committee meetings.	T. Jaghasspanian G. Toland M. Anderson	Monthly by 12/31/24	Completed	Q1 08/05/24 Q2 10/08/24 Q3 11/04/24 Q4 01/31/25	Off track for Q2 A&G Root Cause Analysis report. Q1 report was submitted on 09/05/2024.	Q3 A&G Root Cause Analysis report report was on track and submitted on 11/04/24. Q4 A&G Root Cause Analysis report will be submitted on 2/21/25.
QUALITY IMPROVEMENT INFASTRUCTURE	Quality Improvement team will work with Provider Engagement and Medical Affairs to review quality improvement action plans for best practices and recommend changes when existing action plans are ineffective in producing the needed change.	QI PMIII team members M. Najarro	12/31/2024	Completed	12/13/2024	As of June, 403 action plans have been submitted. Meetings are held monthly based on measure of focus calendar.	445 action plans were submitted in 2024. Fresno = 325 Kings = 40 Madera = 80
QUALITY IMPROVEMENT INFASTRUCTURE	Support development of HEDIS best practice tools.	S. Wright (lead)	12/31/2024	Completed	2/7/2024	Completed. QI Best Practices Slide deck given to the PE team 02/2024.	Completed activity on 02/2024.
WELLNESS/ PREVENTIVE HEALTH	Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	CalViva Health/HN K. Macsicza Director, Clinical Programs A. Schneider, RN, Sr. Director Med Management	May 2024	Completed	05/13/2024. 06/20/2024.	HN Medical Advisory Council approved the CPG on May 13, 2024. Provider communication distributed on June 20th.	HN Medical Advisory Council approved the CPG on May 13, 2024. Provider communication distributed on June 20th.
WELLNESS/ PREVENTIVE HEALTH	Collaborate with Marketing team to distribute member educational emails on various topics via internal and external resources: Topics TBD.	Health Ed	Q4: 12/31/2024	Cancelled	12/31/2024	On track.	Intervention was discontinued due to limited impact.
WELLNESS/ PREVENTIVE HEALTH	Distribute Preventive Screening Guidelines (PSG) to Members and Providers.	B. Head, Sr. Health Education Specialist A. Jayme A. Wittig S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer J. Felix	Sept/Oct 2024- via Member Newsletter	Completed	9/23/2024	Activity is on track. Article refers members on how to obtain access to PSGs in "Catch Problems Early with the Proper Health Screenings" article.	The Member Newsletter was distributted on 9/23/2024.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
WELLNESS/ PREVENTIVE HEALTH	Distribute the Health Education Programs and Services Flyer to members via the Medi-Cal member welcome packet.	M. Lin S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	12/31/24	Completed	12/31/2024	The Health Education Programs and Services flyer is being sent to members via the Medi-Cal member welcome packet. The 2025 version of the Health Education Programs and Services flyer is in the process of being updated.	The Health Ed Services flyer is being sent to members via the Welcome Packet monthly.
WELLNESS/ PREVENTIVE HEALTH	Health education material management	L. Aaronson, Director of Quality Improvement and Health Education A. Wittig, Director of Quality Improvement and Health Education A. Jayme, Program Manager II	12/31/24	Completed	12/31/2024	As of mid-year there have been nine calls to the CCC regarding health education and 6,620 pieces of printed health education material have been ordered.	At year end there were ten calls to the CCC regarding health education and 12,610 pieces of printed health education material were ordered.
WELLNESS/ PREVENTIVE HEALTH	Health Education System P&Ps, monitoring of initiatives, maintenance of printed materials, digital programs and requirements, health promotion to providers.	A. Wittig S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	12/31/24	Completed	12/31/2024	On track.	At year end all CVH P&Ps were renewed on their assigned renewal date.
WELLNESS/ PREVENTIVE HEALTH	Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016. Baseline: Quarterly monitoring of HEDIS Lead Screening for Children (LSC) RY 2020 administrative rate; Member education materials include lead screening flyer and preventive service guidelines (PSGs); Provider training and education include the Medi-Cal provider operations manual and HEDIS provider tools on Lead Screening for Children (LSC). Medical Record Reviews for lead screening conducted during Facility Site Reviews submitted to DHCS twice a year.	A. Wittig P. Carpenter S. Wright J. Coulthurst A. Schneider L.Armbruster	12/31/24	COMPLETED	12/31/2024	On track. Please see below for MY 2023 LSC Rates: MPL: 62.79% Fresno: 56.69% Kings: 58.64% Madera: 78.10%	Results are provided: MPL: 33.33% Fresno: 63.90% Kings: 52.94% Madera: 56.66%

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
WELLNESS/ PREVENTIVE HEALTH	Member newsletter	B. Head (Medi-Cal) S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	10/1/2024	Completed	10/1/2024	In February, the content development stage was completed with the weight management article added as a small blurb. CVH approved the content. In March, the project design phase was completed and moved into the regulatory review phase. In April, all internal reviews were completed, and the content was sent to CVH compliance for review, which would then send it to DHCS for approval. In May, the initial DHCS review was completed and sent back with minor edits. The edits were redlined and the updated version was sent to CVH for resubmission to DHCS. In June, the DHCS review was sent back with additional edits. The edits were redlined, and the updated final version was sent to CVH for the second AIR submission to DHCS.	English, Hmong & Spanish newsletter versions were posted to CVH website 9/9/24. Mailing distribution completed on 9/30 - reached 162,337 unique households.
WELLNESS/ PREVENTIVE HEALTH	Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	C. Patnaude, Director, Care Management S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	Ongoing by 12/31/24	Completed	12/31/24 - continue in 2025	On track.	Successful program with above 60% engagement rate with members. Program successful in increasing prenatal appointment attendance by 7%, postpartum appts by 9.1% (above 5% goals), and reduced preterm deliveries by 1.5% (just below 2% goal).
WELLNESS/ PREVENTIVE HEALTH	New vendor onboarding and ongoing management to provide Diabetes Prevention Program (DPP) services to our eligible Medi-Cal population.	A. Mojadedi S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	6/30/25	Off track/ Delayed	Continue in 2025	CVH on track to go to DHCS for review mid-September.	CVH was provided with all approved member materials and contracting documents on 11/1/24. CVH has submitted for DHCS approval.

Program Type	Activity Description	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
WELLNESS/ PREVENTIVE HEALTH	QR Code Material promotion	L. Aaronson, Director of Quality Improvement and Health Education A. Wittig, Director of Quality Improvement and Health Education A. Jayme, Program Manager II B. Head Sr. Health Education Specialist A. Schneider. Sr. Director, Medical Management	12/31/24	Completed	12/31/2024	Currently promoting digitial health education materials and resources. Working on a survey to assess the effectiveness of resources.	The survey, distributed to 1,134 providers, assessed relevance, clarity, usability, and satisfaction through closed- and open-ended questions. As of December 19, 28 providers responded. 3 of the 4 areas exceeded the 70% KPI benchmark for feedback scores. Key findings include: Relevance: 89% found the topics highly or moderately relevant. Usability: 97% reported navigating and sharing the presentation as easy. Satisfaction: 89% were satisfied with the quality and usefulness. Resource Sharing: 57% shared resources with patients via QR codes, printed materials, or direct discussions. This survey was also used to support the PEDS QMIP PDSA intervention.

Section III: Quality Improvement Tracking System Activities Log

Section III lists Quality Improvement Tracking System activities that support meeting program objectives for the year (listed in Section I).

Work Plan ID	Work Plan Section	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	End Date	Status	Department Owner	Mid-Year and Year-End Updates	Activity Barriers	Activity Changes
10072	N/A	IHQC - Project Management Training	QUALITY EDGE/TRAINING/PROVIDER COMMUNICATION - IHQC will host the Project Management (PM) training for a cohort of providers in April. The training includes content and incidental coaching to build skills to manage small scale projects and large initiatives. An additional PM training will be provided to internal staff (PE/QI) in May.	HPQI - Health Plan Quality Improvement	CVH-ALL	5/1/2024	5/31/2024	DELAYED	Gladys Lazaro, Lora Maloof-Miller	Lora Maloof-Miller - 7/1/2024: 7.1.24 No feedback from PE. We will hold this in 2025. -----Lora Maloof-Miller - 6/3/2024: Due to low enrollment, this training will be rescheduled. Potential dates: Late July/Aug. or November. Feedback from PE (Robin MacBride) is pending. Shekinah Wright is okay with offering it in 2025, if needed. -----Lora Maloof-Miller - 4/2/2024: 4.2.24 Dates selected: May 16th and 23rd. Flyer completed and sent to PE for distribution. -----Lora Maloof-Miller - 2/1/2024: Training in May 2024. Date: TBD.-----Lora Maloof-Miller - 11/13/2024: This training will be rescheduled to 2025. -----Gladys Lazaro - 1/18/2024:	None at this time.	Discontinue
10627	Section 1	HNBH/Participating Provider Group (PPG) Webinar	BEHAVIORAL HEALTH: Provider webinar-Topic TBD	FUA - F/U ED Substance Abuse - 30,FUA - F/U ED Substance Abuse - 7,FUM - F/U ED Mental Illness - 30,FUM - F/U ED Mental Illness - 7	CVH Fresno, CVH Madera, CVH Kings	1/1/2024	12/31/2024	DELAYED	Kelli Lesser	Kelli A. Lesser - 8/26/2024: 8/26/24-Deleted MCD LOB to allow for separate MCK entries-----Kelli A. Lesser - 4/11/2024: 2024 webinar topic still TBD; FUM/FUA measures are tentative-----Kelli A. Lesser - 12/20/2024: Intervention delayed until 2025 due to ongoing BH staffing changes	Ensuring provider attendance	Continue
9871	Section 2.A	Diabetes Prevention Program (DPP) Vendor Onboarding	CHRONIC CONDITIONAS - Diabetes Preventative Program for members with Pre-Diabetes.	CDC - Diabetes HbA1c poor control > 9	CVH-All	04/01/2024	12/31/2024	DELAYED	Arzoo Mojadedi	2.1.24 (AM)- SOW finalized and sent to procurement team. MSA signed. DHCS required member materials are ready. Once SOW is signed then all DHCS required documents will be sent to compliance. 10.14.24 (AM)- CVH on track to go to DHCS for review in early November. There has been a delay in timeline. 11.14.24 (AM)- Submitted branded materials and all DPP member materials to Hannah Kim for CVH compliance review on 11.1.24.	DPP contract will need approval from CA DHCS compliance.	Continue
10157	Section 2.A	Direct Mail Kits for Blood Glucose (HbAc/A1c) - CVH All	Chronic Conditions - A direct to member mail campaign to support members that may be due for an A1c (A1c kit). Quality Improvement (QI) is partnering with the vendor, to directly mail A1c Kits (to support an A1c home test).	CDC - Diabetes HbA1c < 8	CVH-All	1/1/2024	12/31/2024	DELAYED	Martha Zuniga	Martha A. Zuniga - 7/2/2024: Decision was made to contract with the Corporate vendor Everlywell for in-home kits. Everlywell contracting is in progress. -----Martha A. Zuniga - 12/20/2024: Did not have vendor stood up in 2024 for in-home A1c kit mailings to Medi-Cal members due to shifting contractual timelines and requirements. DHCS approval received in early December - moving forward with collateral submission and PPA execution.	Member may have moved; member does not return test kit.	Continue
10507	Section 2.A	In Home Test Kits -A1c	CHRONIC CONDITIONS - Non-compliant members receive in-home A1c kits from vendor; collaborate with PPGs/PCPs to encourage members to return completed kits	CDC - Diabetes HbA1c poor control > 9	CVH-ALL	01/01/2024	12/31/2024	DELAYED	Paul Nigels	Gigi A. Mathew - 6/15/2024: Everly Health member collateral undergoing approvals. C&L approved between 4/4/24 -4/11/24; submitted to Workfront. Privacy approved. SMS messaging privacy approval pending.-----Gigi A. Mathew - 12/20/2024: Did not have vendor stood up in 2024 for in-home A1c kit mailings to Medi-Cal members due to shifting contractual timelines and requirements. DHCS approval received early December - moving forward with collateral submission and PPA execution.	N/A	Continue
10400	Section 2.A	Sprinter Health Medi-Cal Member Outreach	Chronic Conditions: In-home Diabetic Retinal Exams (DRE) for eligible members. Results will be sent to member's PCP.	CDC - Diabetes HbA1c poor control > 9	CVH-ALL	08/01/2024	12/31/2024	DELAYED	Arzoo Mojadedi	Arzoo Mojadedi - 9/16/2024: 9.16.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval. -----Arzoo Mojadedi - 8/14/2024: 8.14.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval. -----Arzoo Mojadedi - 7/15/2024: 7.15.24 (AM)- For HN- received guidance from compliance to include NDN and NOLA links in the character count and to spell out the name of the Health Plan at least in the initial texting campaign. Abbreviations can be used for subsequent texting campaigns.Arzoo Mojadedi - 6/24/2024: 6.24.24 (AM)- For HN- All member materials approved by C&L and Privacy except the SMS campaign. Instructions sent to Sprinter via corporate liaison Eleni so Sprinter can update their SMS campaign with CA Privacy regulations. Arzoo Mojadedi - 5/14/2024: 5.14.24 (AM)- Meeting with corporate tomorrow to gain clarification on Sprinter's member incentive reward strategy. We will also be discussing the flexibility of modifying member materials if needed for HN internal processes and CA DHCS requirements. -----Arzoo Mojadedi - 11/14/2024: 11.14.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval. -----Arzoo Mojadedi - 10/14/2024: 10.14.24 (AM)- CVH to seek DHCS approval after HN submits and receives DHCS approval.	Ensuring that the Medi-Cal member documents meets the CA DHCS requirements.	Continue
10280	Section 2.A	Update Diabetes Resources Webpage	CHRONIC CONDITIONS: Project to update Diabetes Resources Webpage	CDC - Comprehensive Diabetes Care	CVH-All	02/01/2024	6/28/2024	DELAYED	Arzoo Mojadedi	Arzoo Mojadedi - 9/16/2024: 9.16.24 (AM)- CVH to receive mock-up of website once it's developed. Workfront request in progress. -----Arzoo Mojadedi - 8/14/2024: 8.14.24 (AM)- CVH to receive mock-up of website once it's developed. Workfront request will be submitted by Stacey this week. -----Arzoo Mojadedi - 7/15/2024: 7.15.24 (AM)- For HN-the document did not pass field testing layout review. Stacey will contact field testing team for suggestions on what to modify. -----Arzoo Mojadedi - 6/24/2024: 6.24.24 (AM)- The webpage prototype has been submitted for Health Educator review.-----Arzoo Mojadedi - 5/14/2024: 5.14.24 (AM)- This document has been sent to Traci in Legal for final approval. -----Arzoo Mojadedi - 4/15/2024: 4.15.24 (AM)- Readability is set at 6th grade level for this resource page so it can be utilized for all LOB's. Currently, it's being reviewed by Legal. -----Arzoo Mojadedi - 3/15/2024: 3.15.24 (AM)- Gigi, Stacey, and I are working on updating the Diabetes Resources webpage, to add more member focused content and resources. We're working on a similar Diabetes Resources Webpage across all LOB's. Currently, we have a layout complete and are verifying readability. -----Arzoo Mojadedi - 11/14/2024: 11.14.24 (AM)- Hannah Kim to connect with CVH to see if there is interest in posting the diabetes resources webpage to CVH's website. -----Arzoo Mojadedi - 10/14/2024: 10.14.24 (AM)- CVH to receive mock-up of website once it's developed. Workfront request in progress.	Some Krames materials does not meet readability per our Readability Studio.	Continue
10654	Section 2.B	BP Reach Initiative	CHRONIC CONDITIONS - Blood Pressure Disparities Reduction, Equity, and Access among safety net patients with Cardiovascular Health Risk is a NIH-fund initiative led by Dr. Amy Towfighi, Director of Neurology for LA County DHS and Associate Medical Director for Research at LA General Hospital, and Dr. Alejandra Casillas, Internal Medicine Faculty and RWJ Scholar from UCLA. The initaitive will focus on Medi-Cal members, starting with LA County and expanding to others, including CVH	CBP - Controlling Blood Pressure	CVH-ALL	04/01/2024	12/31/2024	CANCELLED	LA County DHS/UCLA - external study	Gigi A. Mathew - 9/9/2024: Met with BP researchers on 7/1 outlining next steps regarding plan's involvement. Identified potentially 850 members for study. Several requests made to researchers for BP flyer or any other detailed information to draft member letter. Researchers have been non-responsive. Tarjani sent email request on 9/6 asking for additional details.-----Gigi A. Mathew - 5/24/2024: The focus of the study is blood pressure (BP) control of patients with stroke or MI, who are enrolled into the randomized controlled trail for one year - currently recruiting members from health plans and FQHCs serving LA County. There is no cost for Health Net to participate --we need to provide a MOU and list of eligible participants meeting study criteria. Met with Legal on 5/6 and told member lists can not be shared directly with researchers, and suggested mailing a letter to eligible members informing of them of the study. On 5/24 reviewed the eligible member list -- identified missing systolic BP and PCP info; meeting with Dr. Towfighi team pending.-----Gigi A. Mathew - 12/20/2024: CANCELLED - Decision made not to proceed forward due to researchers' non-responsiveness to multiple outreaches by QI and Population Health team.12/31/24 This has been discontinued.	N/A	Discontinue
10126	Section 5.B, 5.C, 5.D	Peds+ POD Action Plan Reviews	PEDIATRIC/PERINATAL/DENTAL - Review all Pediatric/Perinatal/Dental Action Plans in the Provider Engagement Database and provide feedback to improve action plans	CIS - Childhood Immunization Combo 10,IMA - IMA - Adolescent Immunizations Combo 2,LSC - Lead Screening in Children,PPC - PPC - Postpartum Visit,PPC - PPC - Prenatal Visit (Timeliness),W30 - Well Child Visits in the First 30 Months of Life (previously W15),WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC)	CVH-ALL	01/08/2024	12/31/2024	DELAYED	Juli Coulthurst	Juli B. Coulthurst - 6/17/2024: Action Planning on Hold	N/A	Discontinue

10086	Section 5.D	Pfizer Missed Dose IVR	PEDIATRIC/PERINATAL/DENTAL - Missed Dose Program - sends IVR phone messages to parents of children at ages 6 months, 8 months, and 16 months to remind them they may have missed a vaccine shot.	CIS - Childhood Immunization Combo 10	CVH-All	02/01/2024	12/31/2024	DELAYED	Guille Toland	Guille V. Toland - 9/22/2024: Compliance Vendor intake pending approval.-----Guille V. Toland - 7/12/2024: Need HN approval before moving forwrd with CVH reviews. Vendor deploying campaigns contract ended 6/30. New contract has not been executed yet! All final approvals for HN are on hold due to this new encounter.-----Guille V. Toland - 6/10/2024: Waiting for Corporate to complete the new HN Compliance intake to be able to move the final review process forward.-----Guille V. Toland - 5/15/2024: Need HN approvals before moving forward with CVH.-----Meena Dhonchak - 2/21/2024: Will not be submitting Pfizer Missed Dose IVR Checklist for Missed Dose Program to corporate. -----Guille V. Toland - 12/19/2023: Working with Corporate to bring these programs to the CA Market-----Guille V. Toland - 12/12/2024: Corporate approved the new contract with Pfizer. DHCS already approved these campaigns for HNCS and CHPIV. Campaigns for COMM/MKT were also approved. Next steps are to get the Compliance Intake approved by Jamie Babby's team and check with Corp (Kelly Burton) that they can pull the CA data on their own.	Not getting the approvals needed to launch programs in a reasonable timeframe.	Continue
10174	Section 6	PPG/PCP Community Supports Asthma Remediation Campaign	PHARMACY & RELATED MEASURES - Increase awareness of the Asthma Remediation Services Program to Medi-Cal members with a focus on asthma denominator. Create email draft for PPG, PCP, and/or Community Supports Provider to use for outreach to members to inform them of the Asthma Remediation Project.	AMR - Asthma Med Ratio Total 5 to 64	CVH-All	1/1/2024	12/31/2024	DELAYED	Justina Felix, Alicia Bednar	Created email content to increase awareness of the Asthma Remediation Services Program to Medi-Cal members. The email content is intended for PPG, PCP, and/or Community Supports Provider to use for outreach to members to inform them of Asthma Remediation Services. Content was submitted for internal approval and received approval from C&L. We were informed by CalViva Health Compliance that the email address domain cannot have mention of clinic or PPG name and the goal of this activity was for the provider to send the email to the member. This activity is on pause until we explore other options/opportunities.	None at the moment.	Continue
9892	Section 7.B, 8.A, 8.B	CalViva Provider Communication CAHPS Article	CAHPS - CAHPS article and measure rates	CAHPS - Access to Care,CAHPS - Care Coordination,CAHPS - Annual Flu Vaccine,CAHPS - Rating of All Health Care,CAHPS - Rating of Health Plan,CAHPS - Rating of Specialist,CAHPS - Rating of Personal Doctor	CVH - ALL	1/1/2024	12/31/2024	DELAYED	Guille Toland	Guille Toland - 12/31/24: A new lead person was assigned to collect information for this provider communication. Work has not started yet.	Staffing change	Continue
9861	Section 8.A, 8.B	CAHPS Playbook (One Time)	CAHPS - best practices captured in one resource (internal use)	CAHPS - Access to Care,CAHPS - Rating of Personal Doctor,RHP - Rating of Health Plan,RDP - Rating of Drug Plan,CS - Customer Service,CAHPS - Care Coordination	CVH-All	1/15/2024	12/31/2024	DELAYED	Taline Jaghasspanian	CAHPS Best Practices captured in this provider CAHPS playbook resource. The CAHPS provider playbook hasn't been updated since 2023 so it's delayed to 2025 and the CAHPS team will work on refreshing it in Q1 2025.	None	Continue

3

Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

Item #12
Attachment 12.A-B

2024 Annual Utilization Management Case Management Work Plan Evaluation

12.A Executive Summary
12.B Year End Evaluation

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Patrick Marabella, MD, Chief Medical Officer, Amy Schneider, RN, Senior Director Medical Management
COMMITTEE DATE:	February 20, 2025
SUBJECT:	2024 CalViva Utilization Management/Care Management Work Plan End of Year Evaluation Executive Summary

Summary:

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

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

- 1.3 Separation of Medical Decisions from Fiscal Considerations
- 1.4 Periodic Audits for Compliance with Regulatory Standards
- 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance
- 3.3 PPG Profile

Purpose of Activity:

CalViva Health (CalViva) has delegated responsibilities for utilization management and care management (UM/CM) activities to Health Net Community Solutions, Inc. (Health Net), but CalViva oversees the UM/CM Programs. CalViva's UM/CM activities are handled by qualified staff in Health Net.

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

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

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

Analysis/Findings/Outcomes:

I. UMCM Committee Oversight and Structure

In 2024, CalViva's UMCM Program was successfully supported by the CalViva QI/UM Committee which met seven times. The committee supervised the UMCM Program, provided feedback, decision support, and recommendations for the UMCM program throughout the year. The QI/UM Committee reported to the CalViva RHA Commission six times in 2024. CalViva's QIUM Committee structure is supported by the HNCS Committee structure as noted in the Annual Program Description.

The QI/UM Workgroup supports the efforts of the QI/UM Committee by scheduling, receiving, reviewing, editing, and approving reports for presentation at the QI/UM Committee. QI Workgroup aids in the identification and pursuit of opportunities to improve health outcomes, safety, access and member and provider satisfaction. Significant findings and follow-up were reported to the QIUM Committee and RHA Commission.

The QI/UM Workgroup met thirty (30) times in 2024 and was chaired by CalViva's Chief Medical Officer. Members of the Workgroup consisted of CalViva staff including Senior Director of Medical Management (who is a Registered Nurse) and a Manager of Medical Management Services (also a registered nurse); and Health Net staff from Utilization and Care Management, Quality Improvement, Appeals and Grievances, Health Equity, Pharmacy, Credentialing, Customer Contact Center, Population Health Management, Provider Network Management, and Provider Relations. The Workgroup conducted review of UMCM routine and special reports and discussions of monitoring UMCM activities, findings, barriers, and interventions to develop and implement actions.

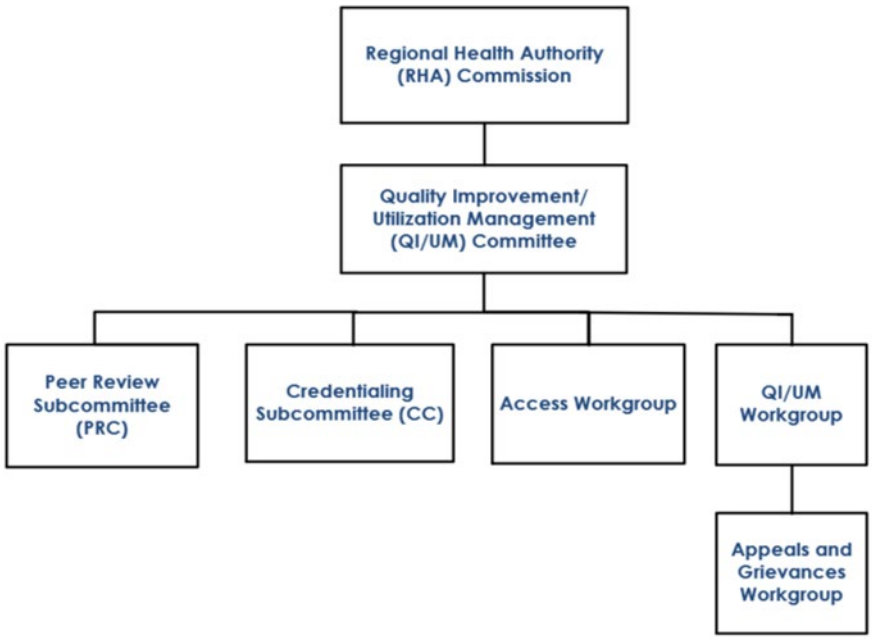
The Appeal and Grievance Workgroup reports to the QI/UM Workgroup and supports the UMCM program through the review and analysis of appeal and grievance data. The Workgroup processed, tracked and trended member grievances and appeals for 2024 at the provider and plan level evaluating for type, severity, volumes, rates, and the identification of opportunities for improvement. The Workgroup submitted reports to the QI/UM Workgroup and Peer Review Subcommittee to review, act, and follow-up on identified significant events or trends. The Appeals and Grievances Workgroup met seven times in 2024.

The CalViva Health Access Workgroup reports directly to the QI/UM Committee through quarterly reports and committee minutes. This access focused Workgroup included representatives from CalViva Health and Health Net departments with access and network adequacy related functions. The Workgroup reviewed findings from ongoing monitoring of access to plan services, identified gaps, and developed and evaluated activities that addressed those gaps in access to care. The Workgroup submitted issues that required escalation to the Management Oversight Meeting ("MOM"), QI/UM Committee and/or RHA Commission for final decision and approval of recommended actions. CalViva's Access Workgroup met seven times in 2024.

CalViva's Credentialing and Peer-Review Subcommittees also successfully supported CalViva's UMCM Program, as demonstrated in the organizational chart below. The subcommittees met 4 times each in 2024.

Please refer to the 2024 Utilization Management and Care Management Program Descriptions for more information on the committees and sub-committees.

CalViva's Quality Improvement Utilization Management Committee Organizational Chart



II. Compliance with Regulatory & Accreditation Requirements

All Compliance activities met objectives for this end of year evaluation with no barriers identified with the exception of work plan activities 1.3 Separation of Medical Decisions from Fiscal Considerations and 1.4 Periodic Audits for Compliance with Regulatory Standards.

a. Separation of Medical Decisions from Fiscal Considerations (work plan activity 1.3)

CalViva conducted an audit in Q1-2024 of 2023 evidence of attestations to the Affirmative Statement about Incentives which reflected 73% compliance. CAP was issued in Q1 and resolved in Q2.

Barriers included:

Yearly assignment of 'Affirmative Statement about Incentives' is not automated.

Actions taken:

Centene University Report job aid was updated to address the Affirmative Statement training yearly assignment. Effective July 2024 Clinical Managers will assign the training in January and July.

New finding was identified in CalViva's Q1-2025 audit of 2024 evidence of attestations. Health Net UM teams will re-evaluate the root cause and establish appropriate actions to resolve in 2025.

b. Periodic Audits for Compliance with Regulatory Standards (work plan activity 1.4)

A corrective action plan (CAP) was issued in Q1 and Q2 2024 regarding post stabilization practices.

Barriers included:

Requirements related to post stabilization were not met due to inaccurate interpretation and execution of APL 23-009 requirements.

Actions taken:

Evaluation was completed regarding Post Stabilization CAP to ensure all points of APL 23-009 are accurately followed. P&Ps were updated and retraining provided to staff as of December 2024. Provider notification was distributed December 2024 to ensure compliance with the APL.

III. Monitoring the Utilization Management Process

UM Process Monitoring activities met objectives for this end of year evaluation.

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

The Plan monitored TAT as planned throughout 2025 and met all goals of 95% or better.

Authorization TAT	Q1	Q2	Q3	Q4
Pre-Service Routine	100%	95.60%	100%	100%
Pre-Service Routine with Extension/Deferral	100%	99.09%	99.09%	100%
Pre-Service Expedited	98.18%	97.00%	99.09%	100%
Pre-Service Expedited with Extension/Deferral	100%	100%	100%	100%
Post Service	100%	100%	100%	100%
Concurrent	100%	100%	100%	100%

Barriers identified:

PA Deferral Turn Around times was impacted in January by the following:

1. In Q1 two Preservice expedited cases missed TAT. One was due to weekend processes. The second, a staff member did not follow protocol as case was misclassified as urgent.
2. In Q2 and Q3, Preservice Expedited TAT and Q3 Pre-Service Expedited, work process was not followed which resulted in missed TAT.
3. In Q2 June Preservice Routine there was misalignment with the Juneteenth holiday

Action taken:

1. As a result of the preservice expedited TAT failures in Q1 corrective action was implemented to establish weekend cutoff time to align process and time for cases to be handled within TAT on weekends.

2. Retraining was provided to staff members that did not follow protocols/work processes.

3. Training documents regarding holidays were revised and re-education was provided to teams regarding compliance.

4. Identified opportunities for improvement within UM TAT reporting in 2024 which will lead to a deep dive assessment in 2025.

b. Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making (workplan element 2.3)

World Professional Association for Transgender Health (WPATH) training was put on hold in late Q3-2024 which impacted 15 staff. Staff not yet trained do not perform utilization reviews for gender affirming care therefore, there was no negative impact to compliance.

Barriers identified:

A need to better fulfill DMHC requirements necessitated a hold on training.

Actions taken:

The 15 staff will be trained in Q1-2025 and will be retested/retrained based on directive from the health plan/DHMC.

IV. Monitoring Utilization Metrics

Monitoring Utilization Metrics activities did not meet objectives for this end of year for work plan elements 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance and 3.3 PPG Profile.

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

Based on data through December 2024, results of our goal to reduce ALOS by 2% was met. Although 30 day readmission utilization was reduced >2% the Plan is not on track to reduce readmissions 8-30 days based on claim data.

Key Indicator Report thru December 2024:

Metric	2023	2024	% Change
Bed Days Acute PTMPY	207	197	-4.83%
Admits PTMPY	38.2	39	2.09%
ALOS Acute	5.4	5.0	-7.41%
Readmit 30 Day	11.3%	11.0%	-2.65%
Readmit 8-30 Day*	7.76%	7.65%	-1.41%

*8-30 day readmission per claim data through 12/2024. Other KIR metrics are authorization based.

Barriers identified:

Consistency in transitional care (TCS) and care management (CM) services.

Actions taken:

Opportunities were identified to improve tight management of inpatient stays with successful handoffs to TCS and CM which were implemented in August 2024. Changes implemented increased collaboration with TCS and CM at discharge.

b. PPG Profile (work plan activity 3.3)

Activities related to PPG Profile performance did not meet objectives. Annual audit reviews resulted in corrective action plans (CAPs) for PPGs due to falling below turn around time targets, denials, access to staff, appropriate professionals and delegation. CAPs identified during the annual audits were monitored and followed-up by HN Delegation Oversight and reported to CalViva.

Barriers identified:

- Specialty access continues to be a challenge for PPGs.

- PPG A/B: CAPs remain open. Increase in authorization requests led to delays. Staffing ratios were reassessed which resulted in hiring additional coordinators, onboarded by 1/1/2025.
- PPG D: CAP Closed 9/2024:
    - The extension pend letter template instructions/layout not followed.
    - Incorrect Your Rights template being used.
    - Incorrect non-discrimination notice (NDN) inserts being used.
    - Incorrect language inserts being used.
- PPG F: CAP Closed 8/2024: Decision TAT was non-compliant due to workflow management, high volume of requests and inadequate staffing.
- PPG C: CAPs
    - Timeliness closed 9/2024: Staff error. The staff were re-trained by UM Manager. Daily huddles were initiated and daily report is run multiple times per day to catch auths near out of compliance
    - Denial closed 12/2024 related to inadequate letter templates and denial process. Monthly oversight monitoring continues

Actions taken:

- Continued monitoring and engagement to address CAPs.

V. Monitoring Coordination with Other Programs

All activities related to monitoring coordination with other programs and vendor oversight met objectives for this end of year evaluation.

VI. Monitoring Activities for Special Populations

All monitoring activities for special populations met objectives for this end of year evaluation and no barriers were identified.

VII. Adequacy of UMCM Program Resources

Based upon the results of the 2024 monitoring activities noted above and within the attached full Work Plan, CalViva has determined that program resources met the needs of CalViva membership and providers.

VIII. Program Scope, Processes, Information Sources

The scope of services offered to CalViva members meets the state of California requirements for Medi-Cal Managed Care Plans. Evidence of this is provided by CalViva's most recent annual DHCS survey (2024) which had only two deficiencies identified. Ongoing out-reach efforts to CalViva membership demonstrates a commitment to informing and engaging members in the programs and services available to them. From prenatal services to Behavioral Health Case Management, to Enhanced Care Management and Community Supports services and many more, appropriate benefits and services are available for all members. Identification of opportunities to improve processes, care, and service is something that CalViva and HNCS continually work on together. Ongoing monitoring of interventions is essential for all areas to ensure appropriate actions are being taken to meet goals.

IX. Practitioner Participation and Leadership Involvement in the UM Program

The CalViva committee structure ensured that external and internal physicians with various specialties participated in the oversight, monitoring, evaluation, and improvement of the UMCM Program. Six external providers were participants in the QI/UM Committee and both the Credentialing and Peer Review

Sub-Committees with specialties in Pediatrics, Family Medicine, behavioral health, Internal Medicine, Obstetrics and Gynecology, and general surgery. CalViva's Chief Medical Officer chaired the committees and invited external practitioners to participate. The behavioral health provider (psychologist) has attended all meetings since her appointment to the QI/UM Committee in June 2023. She actively participates in the review, discussion, and decision making for reports, data, and performance improvement activities related to behavioral health.

Practitioner involvement in 2024 included: reviewing and approving the 2023 UMCM Work Plan Annual Evaluation, and the 2024 UMCM Work Plan and 2024 Program Descriptions for both Utilization Management and Case Management and the 2024 UMCM Work Plan Mid Year Evaluation. Practitioners discussed monitoring results of performance. Practitioners were also involved in discussions regarding opportunities for improvement based upon findings and experience.

CalViva's Chief Medical Officer and Senior Director of Medical Management RN participate in weekly Multi-disciplinary Care Rounds with the Health Net Concurrent Review team to assess adequacy of care and address barriers to discharge for high-risk members.

Health Net ensures senior physician involvement in the planning, design, implementation, and review of the UMCM program. This includes the behavioral health aspects of the UM Program. See attached full Work Plan Annual Evaluation for more information.

Next Steps:

Teams are continuing monitoring of 2024 activities. Ongoing monitoring of interventions is essential for all areas to ensure appropriate actions are being taken to meet goals.

CalViva Health
2024
Utilization Management (UM)/ Care Management (CM)
Work Plan End of Year Evaluation

Last updated: February 14, 2025

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide clinical continuing education opportunities to staff. Conduct Population Health and Clinical Operations (PHCO) Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Ongoing As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Courses offering clinical continuing education units (CEUs) are available to team members through the Plan's online learning management system. Clinical courses that include CEUs are also offered to the external Provider community and internal staff are able to attend. New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered and completion was monitored through our online learning management system. Training materials were reviewed and revised as needed. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform). IRR training and testing is on target for completion in Q3-Q4-2024	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Courses offering clinical continuing education units (CEUs) are available to team members through the Plan's online learning management system. Clinical courses that include CEUs are also offered to the external Provider community and internal staff are able to attend. New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered and completion was monitored through our online learning management system. Training materials were reviewed and revised as needed. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform). IRR training and testing was completed in Q3-Q4-2024	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to PHCO processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, received from the Compliance Department and/or the Regulatory and Legislative Implementation committee. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in compliance committees to review and monitor compliance to standards.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and reminded annually thereafter. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire. Annual reminders will be distributed in Q3-2024. CalViva conducted audit in Q1-2024 of 2023 evidence of attestations to the Affirmative Statement about Incentives which reflected 73% compliance. CAP was issued in Q1 and resolved in Q2. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	Yearly assignment of 'Affirmative Statement about Incentives' is not automated.	Centene University Report job aid was updated to address the Affirmative Statement training yearly assignment Effective July 2024 Clinical Managers will assign the training in January and July.	Q3-2024
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	In 2024, all staff making UM decisions were required to sign an 'Affirmative Statement about Incentives' upon hire and reminders were submitted via a training alert in August 2024, acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in under-utilization or which adversely affect subsequent claim activity. CalViva conducted audit in Q1-2024 of 2023 evidence of attestations to the Affirmative Statement about Incentives which reflected 73% compliance. CAP was issued in Q1 and resolved in Q2. No Management Incentive Plan (MIP) Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	Yearly assignment of 'Affirmative Statement about Incentives' is not automated.	Centene University Report job aid was updated to address the Affirmative Statement training yearly assignment. Effective July 2024 Clinical Managers will assign the training in January and July. New finding was identified in CalViva's Q1-2025 audit of 2024 evidence of attestations. Health Net UM teams will re-evaluate the root cause and establish appropriate actions to resolve in 2025.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing January 2024, April 2024, July 2024, October 2024

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues of 30 sample size per metric. When a variance from compliance standards is identified, sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented Program Metrics Reporting (PMR) meeting.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards is identified sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results are presented to the Health Net Program Metrics Reporting (PMR) meeting and results shared with the CalViva Health QIUM Committee within the Key Indicator Report (KIR).	A corrective action plan was issued in Q1 and Q2 2024 regarding Post stabilization due to inaccurate interpretation and execution of APL 23-009 requirements.	Evaluation was completed regarding Post Stabilization CAP to ensure all points of APL 23-009 are accurately followed. P&Ps were updated and retraining provided to staff as of December 2024. Provider notification was distributed December 2024 to ensure compliance with the APL.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2024. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Scheduled reports to CVH and HN Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CVH Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for the first two quarters in the year.	None identified	Health Net Medical Directors participated in DHCS-MCP Health Equity & Quality Think Tank in June 2024.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for all quarters in the year.	None identified	Health Net Medical Directors participated in the quarterly DHCS-MCP Quality and Health Equity Think Tank that started in June 2024.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures as needed and at least annually.	☒ Medi-Cal	Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements. Senior Physician involvement is ensured, including behavioral health aspects of the UM Program.	Core group comprised of State Health Programs Chief Medical Officer (CMO), Regional Medical Directors, Director of PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2024 UM and CM Program Descriptions. Write and receive CalViva approval of 2023 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2024 UMCM Work Plan. Write and receive CalViva approval of 2024 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2024 Q 1 2024 Q 1 2024 Q 3 2024 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2023 Year End UM/CM Work Plan Evaluation, 2024 UM/CM Work Plan, 2024 UM Program Description and the 2024 CM Program Description were submitted and approved in Q1 2024. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	The 2023 Year End UM/CM Work Plan Evaluation, 2024 UMCM Work Plan, 2024 UM Program Description and the 2024 CM Program Description were submitted and approved in Q1-2024. The 2024 UMCM Work Plan Mid-Year Evaluation was submitted and approved in Q3-2024. CalViva continues to monitor and revise policies and procedures based on DHCS, DMHC and other regulatory requirements.	None	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.7 Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making	☒ Medi-Cal	All new and current UM clinical criteria and practice guidelines related to UM decision making are reviewed and approved annually by the Medical Advisory Council (MAC), which includes input from local Medical Directors. The Plan makes UM criteria and clinical practice guidelines available to practitioners via the provider portal.	Centene's Corporate Clinical Policy Committee and HN California's Medical Advisory Council (MAC) reviews and approves policies on clinical criteria annually. Clinical practice guidelines are reviewed and approved at least every two years. Medical policies and clinical practice guidelines are available to providers upon request; Change Healthcare, Inc.'s InterQual criteria are available to providers upon request. CalViva QIUM Committee reviews and approves policies for clinical criteria for UM decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Confirm annually: • Health Net of California's Medical Advisory Council (MAC) in conjunction with Centene's Corporate Clinical Policy Committee reviews, updates as necessary, and approves policies for clinical criteria for UM decision making. • Ensure UM clinical criteria and UM clinical practice guidelines are made available to practitioners via provider portal (or website) and practitioners are notified of new policies and changes via the Quarterly Medical Policy provider fax.	Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	All clinical policies were reviewed and updated on an annual schedule. Policies are posted on the provider website and providers are notified of changes monthly via a provider update.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	All clinical policies were reviewed and updated on an annual schedule. Policies are posted on the healthnet.com site and providers are notified of changes monthly via a provider update. No barriers were identified. A summary of the annual review and edits of the UMCM Policies and Procedures was presented to HNCS QIHEC Q4-2024. The CalViva Health QIUM Committee received any monthly updates and affirmed annual review and adoption of clinical practice guidelines in July 2024 and clinical criteria for UM decision making via UM-113 in November 2024.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.8 Evaluate inclusion of new technologies and new application of existing technologies in applicable benefit packages including: medical, behavioral procedures, pharmaceuticals, devices, and new application of existing technologies	☒ Medi-Cal	Standardized process is used for review of new technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages	New technologies are reviewed and approved by Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Decisions are based on nationally recognized primary sources including: Hayes® Medical Technology Directory and Hayes® Alert technology-based evaluations, InterQual® and information from evidence-based medical journals, colleges and academies. CalViva QIUM Committee reviews and approves policies for clinical criteria for UM decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Evaluate new technologies and ensure inclusion in member benefits as applicable throughout 2024.	Ongoing monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Clinical policies are developed for new technology and new uses of established technology as needed and brought to the monthly Medical Advisory Council for review and approval. Presented at the CalViva QI/UM Committee via quarterly provider updates.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Clinical policies are developed for new technology and new uses of established technology as needed and brought to the monthly Health Net Medical Advisory Council for review and approval. The CalViva Health QIUM Committee received any monthly updates and affirmed annual review and adoption of clinical criteria for UM decision making relating to new technologies in July 2024.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Turnaround times (TAT) • Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. Continue support for long-term care benefit carve in and ensure continuity of care.	Ongoing

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

☒ ACTIVITY ON TARGET

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

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

LTC Specialist attends clinical rounds, engages with SNFs and supports acute hospitals with challenging discharges.

<table>
<tr><th></th><th colspan="3">Authorization Volume</th></tr>
<tr><th>Months</th><th>Approved</th><th>Denied</th><th>Modified</th></tr>
<tr><td>January</td><td>6968</td><td>1248</td><td>168</td></tr>
<tr><td>February</td><td>8314</td><td>1186</td><td>103</td></tr>
<tr><td>March</td><td>7094</td><td>1075</td><td>90</td></tr>
<tr><td>April</td><td>9633</td><td>1335</td><td>119</td></tr>
<tr><td>May</td><td>10075</td><td>1223</td><td>111</td></tr>
<tr><td>June</td><td>10026</td><td>1194</td><td>105</td></tr>
<tr><td>Totals</td><td>52110</td><td>7261</td><td>696</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

Annual Evaluation

☒ **MET OBJECTIVES**

☒ **CONTINUE ACTIVITY IN 2025**

The Health Net leadership team meets daily to review reports to track turn-around times (TAT), current inventory and staffing resources. Daily goals, action plans, barriers are discussed and staffing adjustments are made in order to meet TAT goals.

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

LTC Specialist attends clinical rounds, engages with SNFs and supports acute hospitals with challenging discharges.

	Authorization Volume		
Months	**Approved**	**Denied**	**Modified**
January	6968	1248	168
February	8314	1186	103
March	7094	1075	90
April	9633	1335	119
May	10075	1223	111
June	10026	1194	105
July	10620	1158	150
August	10198	1227	113
September	9571	1316	120
October	11473	1758	164
November	9209	1340	166
December	7871	878	247
2024 Totals	111052	14938	1656

Prior year for comparison:

2023 Totals	**78205**	**15587**	**744**
2022 Totals	**67869**	**12443**	**681**
2021 Totals	**76,001**	**12,236**	**463**

None identified

None

Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>The plan met all TAT goals of 95% or better in the first half of the year.

<table><tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th></tr><tr><td>Pre-Service Routine</td><td>100%</td><td>95%</td></tr><tr><td>Pre-Service Routine with Extension/Deferral</td><td>100%</td><td>99%</td></tr><tr><td>Pre-Service Expedited</td><td>98%</td><td>97%</td></tr><tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td></tr><tr><td>Post Service</td><td>100%</td><td>100%</td></tr><tr><td>Concurrent</td><td>100%</td><td>100%</td></tr></table></td><td>In Q1 two Preservice expedited cases missed TAT. One was due to weekend processes. The second, a staff member did not follow protocol as case was misclassified as urgent.

In Q2, April Preservice Expedited TAT, work process was not followed which resulted in missed TAT.

In Q2 June Preservice Routine there was misalignment with the Juneteenth holiday.</td><td>As a result of the preservice expedited TAT failures in Q1 corrective action was implemented to establish weekend cutoff time to align process and time for cases to be handled within TAT on weekends.

Retraining was provided to staff members that did not follow protocols/work processes.

Training documents regarding holidays were revised and re-education was provided to teams regarding compliance.</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2025</td><td>The Plan monitored TAT as planned throughout 2024 and met all goals of 95% or better.

<table><tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>Pre-Service Routine</td><td>100%</td><td>95.60%</td><td>100%</td><td>100%</td></tr><tr><td>Pre-Service Routine with Extension/Deferral</td><td>100%</td><td>99.09%</td><td>99.09%</td><td>100%</td></tr><tr><td>Pre-Service Expedited</td><td>98.18%</td><td>97.00%</td><td>99.09%</td><td>100%</td></tr><tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Post Service</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr><tr><td>Concurrent</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr></table></td><td>In Q1 two Preservice expedited cases missed TAT. One was due to weekend processes. The second, a staff member did not follow protocol as case was misclassified as urgent.

In Q2 and Q3, Preservice Expedited TAT and Q3 Pre-Service Expedited, work process was not followed which resulted in missed TAT.

In Q2 June Preservice Routine there was misalignment with the Juneteenth holiday.</td><td>As a result of the preservice expedited TAT failures in Q1 corrective action was implemented to establish weekend cutoff time to align process and time for cases to be handled within TAT on weekends.

Retraining was provided to staff members that did not follow protocols/work processes.

Training documents regarding holidays were revised and re-education was provided to teams regarding compliance.

Identified opportunities for improvement within UM TAT reporting in 2024 which will lead to a deep dive assessment in 2025.</td><td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td></tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	PHCO Learning and Development administers new hire and annual IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews All new hire and annually staff must achieve a minimum passing score of 90% on each IRR test	Administer the Change HealthCare InterQual IRR test in Q3-Q4 2024 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. Documented coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented coaching may include but is not limited to the following: precepting of staff, retraining of the staff by reviewing the Initial/Retake IRR test(s) or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the new hire and annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and documented coaching is initiated by the People Leader.	Q3-4 2024 Q4-2024

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	IRR testing and training will be held Q3-4 2024 for medical and behavioral health (BH) teams. The Change HealthCare/Optum InterQual IRR testing and training is held for medical teams. BH teams administer IRR testing for ABA and Psychological and Neuropsychological testing services.	None identified	None	12/31/2024
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	2024 InterQual Annual Summary of Changes and Road to Successful IRR training was provided. Annual InterQual IRR testing followed and was completed in Q3-Q4 2024. The Change HealthCare/Optum InterQual IRR testing was administered to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews requiring a minimum score of 90% to pass. Final Pass Rate for InterQual IRR 2024 was 98% WPATH SOC8 training was completed for new hires through Q3-2024, followed by administration and completion of WPATH IRR testing. Final Pass Rate for WPATH IRR 2024 was 100%. ABA IRR testing was completed for BH teams in June-July 2024 with pass rate at 100% and average score 95.31%.	WPATH training was put on hold in late Q3-2024 to better fulfill DMHC requirements which impacted 15 staff. The 15 staff will be trained in Q1-2025 and will be retested/retrained based on the revised directive.	The WPATH delay was a one time occurrence. Going forward staff will be tested in accordance with the new WPATH process. Staff not yet trained do not perform utilization reviews for gender affirming care.	12/31/2024 This is a consistent component of QI/UM and is tracked on an annual basis. Activity is repeated annually to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. On a monthly basis appeal trends are reported via a monthly dashboard. Additionally, appeals will be analyzed for trends. This analysis and recommendations will be reported to CalViva Health QI/UM Committee. Ensure appeals are processed by specialty matched physicians, when appropriate which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21. The data from appeals and grievances is shared with the Provider Network Management, Adverse Action Team, and Utilization Management/ Quality Improvement (UMQI) committees and is aggregated and reviewed for additional actions and recommendations. This data is shared with the CalViva QI/UM Committee for review and identification of opportunities for improvement.	Ongoing

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

☒ ACTIVITY ON TARGET

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

The top trends were Diagnostic – MRI (34) and Diagnostic – Cat Scan (24)

A&G team has been engaging with our delegated radiology vendor to identify root cause of overturn to decrease the overall overturn rates.

All 176 cases, standard and expedited, the compliance rate was 100%.
<table>
<tr><th colspan="3">2024 Semi-Annual Count of Appeal Type</th></tr>
<tr><th>Appeal Type</th><th>Case Count</th><th>Percentage</th></tr>
<tr><td>Overturn</td><td>98</td><td>55.60%</td></tr>
<tr><td>Uphold</td><td>71</td><td>40%</td></tr>
<tr><td>Partial Uphold</td><td>7</td><td>3.97%</td></tr>
<tr><td>Withdrawal</td><td>0</td><td>0.00%</td></tr>
<tr><td>Case Total</td><td>176</td><td></td></tr>
</table>
Aggregated grievances outcomes were shared with the CVH QI/UM Committee, HN Grievance Reduction Workgroup including Provider Network Management as well as the Adverse Action Team, and HNCS QIHEC committees. Actions taken related to identified opportunities are discussed in the CVH Peer review committee, Access to care Committee, UMQI and Vendor oversight Committees amongst others.</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2025</td>
<td>Turnaround Time Compliance for resolved standard and expedite appeals =100%. Time frame January – December 2024.

Not medically necessary (421) and Community Supports related (23) remain as the two top classifications for appeals during the review period.</td>
<td>None identified</td>
<td>None</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality</td>
</tr>
</table>

The two top sub classifications for Not Medically Necessary were Diagnostic-MRI (73) and Diagnostic – CAT Scan (53) during this review period.

The two top sub classifications for ILOS related were Meals/Medically tailored meals (21) and Housing deposits (2).

2024 Annual Count of Appeal Type		
Appeal Type	**Case Count**	**Percentage**
Overturn	258	56.70%
Uphold	171	37.58%
Partial Uphold	19	4.18%
Withdrawal	7	1.54%
Case Total	**455**	

outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.5 Review annual member and practitioner surveys to assess satisfaction with UM process and to address areas of dissatisfaction	☒ Medi-Cal	Continually assess customers' satisfaction with the UM process to identify areas that can be improved. Interventions are made to improve satisfaction levels where dissatisfaction is identified	The Plan strives to improve Satisfaction with UM Process. Annually satisfaction surveys are conducted and followed by: • Review of satisfaction survey data and trends. • Comparison of survey results with other source data. • Prioritization and implementation of interventions to improve member and practitioner satisfaction with UM processes. • Re-measurement of satisfaction periodically to ensure interventions is effective. • Improved member and practitioner satisfaction results based on surveys and other satisfaction data, including but not limited to: <u>Member</u> Consumer assessment of healthcare providers and systems (CAHPS) survey Member Grievances <u>Practitioner Survey</u> Provider Satisfaction Survey	Complete annual Member and Practitioner Satisfaction survey to assess satisfaction with UM Process. Establish process to assess annual satisfaction survey outcomes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CalViva Health utilizes Health Net's provider network who participate in an annual provider survey. The 2024 surveys are scheduled Q3-2024. Results will be assessed and presented in Q1 2025. 2023 Regulatory CAHPS satisfaction survey results were reported to CalViva in Q1-2024. 2024 HSAG CAHPS member satisfaction surveys were collected in Q1 and Q2-2024. Results will be reviewed and analyzed with trends and highlights presented at the HN CAHPS work group in Q4-2024. Results will be provided to CalViva in Q1 2025. Member grievances are tracked and monitored on a monthly and quarterly basis. Opportunities related to member and practitioner satisfaction with UM processes were reviewed with the Grievance Reduction Workgroup, PNM, Provider relations and vendor management teams with the goal of identifying drivers and improve processes.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	CalViva Health utilizes Health Net's provider network who participate in an annual provider survey. The 2024 surveys were completed Q3-2024. Results will be assessed and presented in Q1 2025. 2023 Regulatory CAHPS satisfaction survey results were reported to CalViva in Q1-2024. 2024 HSAG CAHPS member satisfaction surveys were collected in Q1 and Q2-2024. Results were reviewed and analyzed with trends and highlights presented at the HN/CVH CAHPS work group in Q4-2024. Results of CAHPS survey and root cause analysis are reviewed in CalViva Health's quarterly A&G Work Group. Final results will be provided to CalViva in Q1 2025.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

	Member grievances are tracked and monitored on a monthly and quarterly basis. Opportunities related to member and practitioner satisfaction with UM processes were reviewed with the Grievance Reduction Workgroup, PNM, Provider relations and vendor management teams with the goal of identifying drivers and improve processes.			

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and PHCO manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2024 Goals: • 2% reduction in readmissions between 8-30 days over 2023 • 2% reduction in ALOS over 2023	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. Leverage Member Connections to support on-site bed side enrollment of members into programs such as MedZed, CalAim, Complex Care Management and Community Supports. Explore areas for on-site support (clinical or non).	Ongoing

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout 2024 including daily UM huddles and weekly huddles with key hospitals.

On-site resource established at CRMC supporting transitional care services, including transitions to ECM, internal CM and CalAIM Community Supports.

Key Indicator Report thru June 2024:
<table>
<tr><th>Metric</th><th>2023</th><th>2024 Q1-Q2</th><th>% Change</th></tr>
<tr><td>Bed Days Acute PTMPY</td><td>207</td><td>198.7</td><td>-4%</td></tr>
<tr><td>Admits PTMPY</td><td>38.1</td><td>38.2</td><td>0.3%</td></tr>
<tr><td>ALOS Acute</td><td>5.4</td><td>5.2</td><td>-3.7%</td></tr>
<tr><td>Readmit 30 Day</td><td>11.3%</td><td>10.3%</td><td>-8.8%</td></tr>
<tr><td>Readmit 8-30 Day</td><td>8.15%</td><td>7.37%</td><td>-9.54%</td></tr>
</table>
</td>
<td>None identified</td>
<td>Partnered with CRMC beginning in March in an ongoing effort to decompress hospital and support transition to lower level of care, including diversion to assisted living.

In June, CVH supported grant funding for a provider to open 100 recuperative care beds in Fresno, and 24 recuperative care beds in Madera to go live late in 2024, or early 2025.</td>
<td>Ongoing</td>
</tr>
</table>

<table>
<tr>
<td>Annual Evaluation

☐ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2025</td>
<td>The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout 2024 including daily UM huddles and weekly huddles with key hospitals.

On-site resource established at CRMC supporting transitional care services, including transitions to ECM, internal CM and CalAIM Community Supports.

Based on data through December 2024, results of our goal to reduce ALOS by 2% was met. Although 30 day readmission utilization was reduced >2% the Plan is not on track to reduce readmissions 8-30 days based on claim data.

Key Indicator Report thru December 2024:
<table>
<tr><th>Metric</th><th>2023</th><th>2024</th><th>% Change</th></tr>
<tr><td>Bed Days Acute PTMPY</td><td>207</td><td>197</td><td>-4.83%</td></tr>
<tr><td>Admits PTMPY</td><td>38.2</td><td>39</td><td>2.09%</td></tr>
<tr><td>ALOS Acute</td><td>5.4</td><td>5.0</td><td>-7.41%</td></tr>
<tr><td>Readmit 30 Day</td><td>11.3%</td><td>11.0%</td><td>-2.65%</td></tr>
<tr><td>Readmit 8-30 Day*</td><td>7.76%</td><td>7.65%</td><td>-1.41%</td></tr>
</table>
*8-30 day readmission per claim data through 12/2024. Other KIR metrics are authorization based.</td>
<td>Barriers to reduce readmission rate: Consistency in transitional care (TCS) and care management (CM) services.</td>
<td>Partnered with CRMC beginning in March in an ongoing effort to decompress hospital and support transition to lower level of care, including diversion to assisted living.

In June, CVH supported grant funding for a provider to open 100 recuperative care beds in Fresno, and 24 recuperative care beds in Madera to go live late in 2024, or early 2025.

Opportunities were identified to improve tight management of inpatient stays with successful handoffs to TCS and CM which were implemented in August 2024. Changes implemented increased collaboration with TCS and CM at discharge.</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. Specialty referrals for target specialties PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. Additionally PHM KPI monitoring includes: • Percentage of members who had more ED visits	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 2024 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPGs with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Reevaluate appropriate metrics to be included in the PPG dashboard. Specialties and PPGs identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional joint operations meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard. New quarterly over-under report being generated will include direct network and PPG membership. Report will include ambulatory care measures (OP visits PTMPY, ED visits PTMPY) and selected surgical procedures PTMPY as markers of over-underutilization.	Ongoing

			than primary care visits within a 12-month period; • Percentage of members who had a primary care visit within a 12-month period; • Percentage of members with no ambulatory or preventive visit within a 12-month period.		

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>PPG UM data is shared at CalViva Management Oversight Meetings, every quarter.

Shifts in utilization were reviewed in quarterly JOMs with PPGs.

Q4 2023 – Q1-2024 Utilization PPG F not yet available)
<table>
<tr><th>Metric</th><th>Q</th><th>Admits/ K</th><th>Bed Days/K</th><th>ALOS</th><th>% 30-Day Readmit</th><th>ER/K</th></tr>
<tr><td rowspan="2">B</td><td>Q4</td><td>93.5</td><td>467.9</td><td>5.00</td><td>16.8%</td><td>562.7</td></tr>
<tr><td>Q1</td><td>97.9</td><td>498.0</td><td>5.09</td><td>12.5%</td><td>519.8</td></tr>
<tr><td rowspan="2">G</td><td>Q4</td><td>64.2</td><td>359.5</td><td>5.60</td><td>14.6%</td><td>395.8</td></tr>
<tr><td>Q1</td><td>67.3</td><td>351.7</td><td>5.22</td><td>12.2%</td><td>406.1</td></tr>
<tr><td rowspan="2">C</td><td>Q4</td><td>14.9</td><td>32.4</td><td>2.17</td><td>27.3%</td><td>376.1</td></tr>
<tr><td>Q1</td><td>25.1</td><td>112.0</td><td>4.46</td><td>6.3%</td><td>440.9</td></tr>
<tr><td rowspan="2">D</td><td>Q4</td><td>56.2</td><td>266.2</td><td>4.74</td><td>11.5%</td><td>403.1</td></tr>
<tr><td>Q1</td><td>53.6</td><td>286.6</td><td>5.34</td><td>9.2%</td><td>423.3</td></tr>
<tr><td rowspan="2">E</td><td>Q4</td><td>93.9</td><td>550.3</td><td>5.86</td><td>19.6%</td><td>488.9</td></tr>
<tr><td>Q1</td><td>92.1</td><td>536.4</td><td>5.83</td><td>18.3%</td><td>493.7</td></tr>
</table>
Specialty referral performance with utilization of top specialty by PPG is compared to regional standards in the quarterly delegation oversight dashboard.</td>
<td>• Due to data lag, utilization for new PPG F, may not be available for several quarters of 2024.
• Utilization for PPG that ceased PPG G will run off in the first few quarters.
• Madera Community Hospital closed in December 2022. Impact on overall utilization is unclear.</td>
<td>• HN promotes eConsult adoption with partner FQHCs and PPGs, as a means of timely access to specialty care.
• Preparation for new telehealth vendor (TelaDoc) to be available beginning Q3 to ease provider access for common ambulatory conditions.
• HN advocates for value in acute care delivery by participating in Interdisciplinary Care Team (ICT) meetings and convening discussions with clinical leaders at acute care facilities in the region.
• Transitional Care Services (TCS) and Enhanced Care Management (ECM) have been socialized in area facilities to improve care transitions and address SDoH among vulnerable populations.
• Over/Under reporting continues. ER/k, OP/k, C-Section Count/k, Bariatric Surgery Count/k and Appendectomy Count/k all show declines in MY 2023 compared to MY 2022, for all Counties. Compared to the previous year, IP/k is up in MY 2023 for Kings and Madera. IP/k is trending lower for Fresno in MY 2023.
• Utilization data and strategies to address high inpatient utilization shared with PPGs (PPG B/E).</td>
<td>Ongoing</td>
</tr>
</table>

Annual Evaluation

☒ **MET OBJECTIVES**

☒ **CONTINUE ACTIVITY IN 2025**

Quarterly PPG UM data presented at CalViva Management Oversight Meetings.
Quarterly JOMs with PPGs review utilization patterns quarterly and are compared with the region.

Q4 2023-Q3 2024 Utilization:

PPG	Q	Admits/ K	Bed Days/K	ALOS	% 30-Day Readmit	ER/K
B	Q4	93.5	467.9	5.00	16.8%	562.7
	Q1	97.9	498.0	5.09	12.5%	519.8
	Q2	90.6	1084.8	11.97	14.5%	470.4
	Q3	92.5	554.3	5.99	20.0%	512.9
G	Q4	64.2	359.5	5.60	14.6%	395.8
	Q1	67.3	351.7	5.22	12.2%	406.1
C	Q4	14.9	32.4	2.17	27.3%	376.1
	Q1	25.1	112.0	4.46	6.3%	440.9
	Q2	16.7	59.9	3.59	0.0%	412.3
	Q3	13.9	37.5	2.7	0.0%	431.3
D	Q4	56.2	266.2	4.74	11.5%	403.1
	Q1	53.6	286.6	5.34	9.2%	423.3
	Q2	57.4	351.8	6.13	13.2%	393.2
	Q3	54	349.6	6.47	11.1%	424.6
E	Q4	93.9	550.3	5.86	19.6%	488.9
	Q1	92.1	536.4	5.83	18.3%	493.7
	Q2	100.3	640.1	6.38	18.6%	509.4
	Q3	96.4	588.3	6.1	18.0%	537.8

- Due to at risk status, we do not track PPG A utilization.
- PPG G: utilization monitoring discontinued Q2-2024.
- PPG F 2024 utilization not yet available.

- New over-under report was presented in 05/2024 and 11/2024. This report will be presented semi-annually to the CalViva MOM.
- Health Net monitored PHM KPI quarterly in 2024.

PPG B has high utilization at hospital outpatient facility (HOPF) and cites lack of specialist privileges at Ambulatory Surgery Centers (ASCs).

- HN promotes eConsult adoption with partner FQHCs and PPGs, as a means of timely access to specialty care. Onsite and virtual 3-way meeting with PPG B and Omni with presentation by ConferMED CEO. EConsult utilization is monitored and data shared with PPG and FQHC.
- Telehealth vendor (TelaDoc) became available beginning Q4 to ease provider access for common ambulatory conditions.
- HN advocates for value in acute care delivery by participating in Interdisciplinary Care Team (ICT) meetings and convening discussions with clinical leaders at acute care facilities in the region.
- Transitional Care Services (TCS) and Enhanced Care Management (ECM) have been socialized in area facilities to improve care transitions and address SDoH among vulnerable populations.
- Health Net consistently shares utilization data and best practices with PPG E to address high inpatient utilization.

This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The PPG Profile Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Q1 2024 PPG Profile and Narrative was provided 05/20/24 PPG's profile reports are made available quarterly. Q2 - 8/23/24 Q3 - 11/24/24, Q4 - TBD Q1 & Q2 Annual Reviews - PPG D had 1 Corrective Action Plan (CAP) for Extension letter Accuracy issues issued in May 2024. - PPG F had 1 CAP for TAT failure for the lookback period of Jan to March 24. Consistent TAT compliance was established as of May 2024. Pending Annual Reviews for Q3 & Q4 - PPG A - PPG B - PPG C - PPG E Delegation oversight monitors CAPs to ensure actions are implemented, documented and followed to completion. Both PPGs have implemented an action plan to ensure compliance with denial letters/template. Q4 2023-Q1 2024 Prior Authorizations:	• Specialty access continues to be a challenge for PPGs. • PPG D CAP remains open due to: o The extension pend letter template instructions/layout not followed. o Incorrect Your Rights template being used. o Incorrect NDN inserts being used. o Incorrect language inserts being used. • PPG F Decision TAT was non-compliant due to workflow management, high volume of requests and inadequate staffing and remained open at the end of Q2.	• Started three-way conversations between PPG E, Family Health Care Network and Health Net to address barriers to HEDIS performance and better integration of PHM platform with EHR. • The Plan is continues monitoring of open CAPs to PPG D and PPG F. • PPG F increased staffing and automated workflows to accommodate volume and address TAT.	Ongoing

	Q4-2023 PTMPY **PPG** A B C D E F **Total Auths** 844 1,150 495 1,002 203 812 I-Net 771 1,114 485 981 121 783 OON 73 36 10 21 82 29 **TAT % Compliance** **Urgent** 99.86% 99.46% 97.87% 99.95% 97.19% 80.41% **Routine** 99.94% 99.92% 100% 99.89% 99.90% 85.10% Q1-2024 PTMPY **PPG** A B C D E F **Total Auths** 889 1,258 401 969 240 2732 I-Net 832 1,208 391 941 136 2633 OON 57 50 10 28 104 99 **TAT % Compliance** **Urgent** 99.59% 100% 97.22% 99.93% 98.91% 91.62% **Routine** 99.93% 100% 100% 99.99% 100% 95.29%			
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	PPG Profile and Narrative were provided on: 2024 Q1, Q2 & Q3: 5/20/24, 8/16/24 & 11/25/2024. Q4-2024 is due February 2025. Annual audit reviews - PPG A had 1 CAP for TAT failure (Aug to Oct 2024), issued in Nov 2024, with TAT compliant in Nov 2024. - PPG B had 1 CAP for TAT failure (Aug to Oct 2024), issued in Nov 2024, with TAT compliant in Nov 2024. - PPG C had no new CAPs issued in 2024. They had 2 CAPs for timeliness and denial issues in Sept 2023 that were closed in 2024. - PPG D had 1 CAP for accuracy, closed in Sept 2024. - PPG E had no CAP issued. - PPG F had 1 CAP for timeliness, closed in Aug 2024.	• Specialty access continues to be a challenge for PPGs. • PPG A/B CAPs remain open. Increase in authorization requests led to delays. Staffing ratios were reassessed which resulted in hiring additional coordinators, onboarded by 1/1/2025. • PPG C 2023 CAPs o Timeliness closed 9/2024: Staff error. The staff were re-trained by UM Manager. Daily huddles were initiated and daily report is run multiple times per day to catch auths near out of compliance. o Denial closed 12/2024 related to inadequate letter templates and denial process. Monthly oversight monitoring continues. • PPG D CAP Closed 9/2024: o The extension pend letter template instructions/layout not followed. o Incorrect Your Rights template being used. o Incorrect NDN inserts being used. o Incorrect language inserts being used.	Continued monitoring and engagement to address open CAPs	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Prior Authorizations Q4-2023-Q3-2024:

Q4-2023 PTMPY

PPG	A	B	C	D	E	F
Total Auths	**844**	**1,150**	**495**	**1,002**	**203**	**812**
I-Net	771	1,114	485	981	121	783
OON	73	36	10	21	82	29
TAT % Compliance						
Urgent	**99.86%**	**99.46%**	**97.87%**	**99.95%**	**97.19%**	**80.41%**
Routine	**99.94%**	**99.92%**	**100%**	**99.89%**	**99.90%**	**85.10%**

Q1-2024 PTMPY

PPG	A	B	C	D	E	F
Total Auths	**889**	**1,258**	**401**	**969**	**240**	**2732**
I-Net	832	1,208	391	941	136	2633
OON	57	50	10	28	104	99
TAT % Compliance						
Urgent	**99.59%**	**100%**	**97.22%**	**99.93%**	**98.91%**	**91.62%**
Routine	**99.93%**	**100%**	**100%**	**99.99%**	**100%**	**95.29%**

Q2-2024 PTMPY

PPG	A	B	C	D	E	F
Total Auths	**896**	**1,390**	**456**	**999**	**279**	**3152**
I-Net	838	1,331	447	967	169	3067
OON	58	59	9	32	110	85
TAT % Compliance						
Urgent	**100%**	**99.43%**	**100%**	**99.69%**	**100%**	**96.31%**
Routine	**99.91%**	**99.86%**	**100%**	**99.95%**	**100%**	**98.30%**

Q3-2024 PTMPY

PPG	A	B	C	D	E	F
Total Auths	**862**	**1,343**	**469**	**898**	**299**	**3057**
I-Net	811	1,294	458	856	185	3003
OON	51	49	11	42	114	54
TAT % Compliance						
Urgent	**99.67%**	**98.00%**	**94.00%**	**99.92%**	**98.89%**	**95.77%**
Routine	**99.89%**	**99.79%**	**99.68%**	**99.96%**	**98.89%**	**98.61%**

- PPG F CAP Closed 8/2024: Decision TAT was non-compliant due to workflow management, high volume of requests and inadequate staffing.

4. Monitoring Coordination with Other Programs

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.1 Care Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. Reviewing Member self-referrals to ECM and Community supports and referring members to ECM providers as appropriate. Members not meeting criteria will be referred to care management.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report including PHM Key Indicators to track and trend Care Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in care management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction o Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and o Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge. o ECM Enrollment and Graduation Rates	Dedicated staff of RNs, LCSWs, Program Specialists, Program Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly. Member connections team to collaborate with care management by providing in home visits to support appropriate interventions and improve member outcomes. ECM program and provider performance by county are reported quarterly CVH UM/QI Committee	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Number of Health Information Forms (HIFs) completed in January-June by member and returned or Envolve People Care outreach was 6,880 and 662 members subsequently referred to Care Management through June. Total members managed through Q2 across physical, behavioral health, and Transitional Care Services programs was 2,159. Outcome measures include: readmission rates, Emergency Department (ED) utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Physical Health, Behavioral Health, & Transitional Care Services & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2024 & 3/31/2024 & remained eligible 90 days after case open date. 452 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 6.2% difference • Volume of ED claims/1000/year decreased by 504 • Total health care costs reduction primarily related to reduction in inpatient costs and outpatient services, and some increase in pharmacy costs • Member Satisfaction Survey: 22 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the Case Management and reported the goals they worked on improved understanding of their health.	Fewer than expected number of satisfaction surveys completed.	CM's to encourage members to take survey, gain preferred contact method by member for survey.	Ongoing

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Number of HIFs completed in January – December 2024 by member and returned or EPC outreach was 13,169; 1,458 members subsequently referred to CM. Total members managed through Q4 2024 across physical, behavioral health, and OB programs was 4,539. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Results reported through Q2 include members with active or closed case on or between 1/1/2024 & 6/30/2024 & remained eligible 90 days after case open date. 859 members met criteria. Data through Q3/Q4 is not yet available. Results of members managed: • Number of admissions and readmissions was lower; 4.3% decrease in readmission rate. • Volume of ED claims/1000/year decreased by 480 • Total health care costs reduction primarily related to reduction in inpatient costs, some increase in outpatient services and pharmacy costs • Member Satisfaction Survey comprised of ten questions; 45 members were successfully contacted Q1 through Q3 • Care Team Satisfaction - overall members were satisfied with the Care Management program and the help they received from their Care Manager and reported the tools they received from their Care Manager helped them reach the goals they worked on	Decreased referrals from Concurrent Review to some programs due to restructure of Transitional Care Services program.	Utilized additional reports for outreach.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Care Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPGs of patients identified for program. Measure program effectiveness based on the following measures: ○ Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high-risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

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

Mid-Year Report
 	
☒ **ACTIVITY ON TARGET**
 	
☐ **TOO SOON TO TELL**
	Through Q2 1,277 members managed in PCM program. Engagement rate for this program remains high at 67% through Q2.
	
	Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. In addition the rate of pre-term delivery of high risk members managed is compared to high risk members not managed. Results reported in Q1 for 2024 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed.
	
	• 247 members met the outcome inclusion criteria for visits; 34 members met preterm delivery criteria
	• Members enrolled in the High Risk Pregnancy Program demonstrated:
	  ○ 7.6% greater compliance in completing the first prenatal visit within their first trimester,
	  ○ 7.4% greater compliance in completing their post-partum visit
	  ○ 1.5% less pre-term deliveries in high risk members
		None identified	None	Ongoing

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Referrals – 2,046 Q1-Q4 2024 with average engagement rate 63.8%. Through Q4 1,779 members managed in PCM program; higher than number managed in 2023 (1,276). Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 7 & 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition, the rate of pre-term delivery of high-risk members managed is compared to high risk members not managed. Results reported through Q2 2024 demonstrated greater compliance in managed	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

	members for both visit measures and lower pre-term deliveries of high risk members managed. Data through Q3/Q4 is not yet available.
	• 476 members met the outcome inclusion criteria for visits; 70 members met preterm delivery criteria
	• Members enrolled in the Pregnancy Program demonstrated:
	  o 7% greater compliance in completing the first prenatal visit within their first trimester
	  o 1.4% greater compliance in completing their post-partum visit
	  o 9.1% less pre-term deliveries in high-risk members
	Pregnancy Program mailings: January through December
	• NOP mailings 7,988
	• Pregnancy mailings 1,141
	• Post-delivery packets 3,547			

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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Data reported is a subset of information provided in 4.1. Total members managed through Q2 is 311. Calendar Year engagement rate 62.7%. Total Referrals to CM are monitored in the KIR which includes referrals from Impact Pro. Outcome measures include: readmission rates, Emergency Department utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Behavioral Health Care Management & 90 days after enrollment. Results reported for Q1 include members with active or closed case on or between 1/1/2024 & 3/31/2024 and remained eligible. Outcome results are consolidated across Physical Health, Behavioral Health, & Transitional Care Services programs and are reported in 4.1.	Reduced referrals from internal teams as some referrals now going to Transitional Care Services team.	The Plan increased referrals based on data from ADT reports	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Data reported is a subset of information provided in 4.1. Referrals to behavioral health program Q1-Q4 2024 1,075. Total members managed increased in 2024 to 801 compared to 572 in 2023. Overall engagement rate 67.4%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Results reported through Q2 include members with active or closed case on or between 1/1/2024 & 6/30/2024 & remained eligible. Data through Q3/Q4 is not yet available. Outcome results are consolidated across PH, BH CM programs and are reported in 4.1.	Reduced referrals from internal teams as some referrals now going to Transitional Care Services team.	The Plan increased referrals based on data from ADT reports	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Chronic Condition Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy, medical claims, and referrals. Plan Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Review prevalence data to affirm selection of Chronic Condition Management program offerings. Submit Disease/Chronic Condition Management redesign proposal for approval.	Ongoing 12/31/2024 12/31/2024

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment YTD = 158.

Ongoing program monitoring is conducted to assure that member needs are met. Program elements include:

• educational materials and information about the program are sent to enrolled CVH members.
• outbound telephonic interventions are conducted
• referrals to case management and other programs as needed.

Major conditions reviewed by prevalence and utilization across 12 months of claims. Asthma, diabetes and heart failure continue to be represented, per the below rankings. These 3 conditions continue to be among those identified within the PHM Pyramid Prevalence Conditions.

<table>
<tr><th>Condition</th><th>Rank</th></tr>
<tr><td>Obesity</td><td>1</td></tr>
<tr><td>Hypertension</td><td>2</td></tr>
<tr><td>Severe and Persistent Mental Illness</td><td>3</td></tr>
<tr><td>Diabetes</td><td>4</td></tr>
<tr><td>Other Social Needs</td><td>5</td></tr>
<tr><td>Serious Emotional Disorder</td><td>6</td></tr>
<tr><td>CKD</td><td>7</td></tr>
<tr><td>SUD</td><td>8</td></tr>
<tr><td>Asthma</td><td>9</td></tr>
<tr><td>Cardiac Bundle</td><td>10</td></tr>
<tr><td>Major Depressive Disorder</td><td>11</td></tr>
<tr><td>Heart Failure</td><td>12</td></tr>
<tr><td>CAD</td><td>13</td></tr>
<tr><td>COPD</td><td>14</td></tr>
<tr><td>Alcohol Use</td><td>15</td></tr>
</table>
</td>
<td>None identified</td>
<td>The current Disease/Chronic Health Coaching program is on target to phase out in Q4 and be replaced with a revised program.

The revised Disease/Chronic Condition Management focus areas are intended to include additional programs such as COPD and Behavioral Health screening and is being submitted for regulatory approval in Q3.</td>
<td>Implementation of Program revision: Q4-2024</td>
</tr>
</table>

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<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2025</td>
<td>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment at year end = 290.

Ongoing program monitoring is conducted to assure that member needs are met. Program elements include:

• educational materials and information about the program are sent to enrolled CVH members.
• outbound telephonic interventions are conducted
• referrals to case management and other programs as needed.

Major conditions reviewed by prevalence and utilization across 12 months of claims. Asthma, diabetes and heart failure continue to be represented, per the below rankings. These 3 conditions continue to be among those identified within the PHM Pyramid Prevalence Conditions.

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<tr><td>COPD</td><td>14</td></tr>
<tr><td>Alcohol Use</td><td>15</td></tr>
</table>
</td>
<td>None identified</td>
<td>Disease/Chronic Condition Management redesign strategy was established in 2024. Focus areas are intended to expand programs that address Lifestyle Management, Respiratory, Cardiac and Diabetes conditions, including a Behavioral Health screening. The program was submitted for DHCS approval in Q4-2024.</td>
<td>Program monitoring is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Implementation of Program revision: 12/31/2024 Submitted for DHCS approval in Q4.</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2024 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	State Health Program (SHP) MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the injectable guidelines for medical benefit drugs to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data.	Monthly report of PA requests.	Continued active engagement with pharmacy. Revised CVH UM/QI reporting based on Medical Benefit drug review. Revised DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	CVH UM/QI quarterly reporting continues in 2024 based on the 2021 Medi-Cal RX changes and shift to medical benefit drug tracking. SHP Quarterly meeting topics for 2024: • Continued review of Medi-Cal Rx program updates and status post implementation. DHCS audits completed • DSNP expansion in CalViva counties • Annual CMS DUR survey completed and submitted to DHCS with no errors reported. A&G trends and concerns reviewed for medical benefit drugs. • QI reporting pre-review moved to this meeting to ensure readiness in weekly QI meeting • Regulatory and operational (i.e. policy changes) issues discussed as needed • Trending in PA volume and drugs QA/IRR results for medical benefit drug reviews in Q1 2024 completed and Q2 results are pending final review at the Q3 QI meeting.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	• No significant Medi-Cal Rx issues addressed or reported in 2024 • A&G cases for medical benefit pharmacy drugs tracked in 2024. For Q1-Q4 2024, 38 total appeals were reviewed in the Quarterly SHP meetings. No significant findings or trending identified in the reviews, and total cases for the year were slightly lower compared to 2023. • IRR process reviewed for Q4 2023 through Q3 2024. Results were at threshold for all quarters reported. 90% threshold met in Q1, Q2, and Q4. 95% goal met in Q2 2024. Q4 2024 results are currently pending review.	None identified.	• Medi-Cal RX issues will continue be tracked 2025 to assess impact on patient care. • DUR programs will continue in 2025 based on data from Medi-Cal RX. For 2025, the Antipsychotic/ Antidepressant/Mood stabilizer program has been enhanced to capture more data in a single program compared to 2024 where it was reported in multiple reports. • QIUM reporting for medical benefit pharmacy drugs will continue in 2025 the same as 2024 with no changes planned. • A&G data will continue to be tracked in 2025 based on medical drugs.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.6 Behavioral Health (BH) Care Coordination	☒ Medi-Cal	CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals.	Review data that indicates when a member was referred to the County for services to ensure that the behavioral health team staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that the behavioral health team provides. Prepare for expansion of closed loop referrals in 2026 per DHCS required changes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Q1-Q2-2024 BH Clinicians continue regular rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care Q1: Medi-Cal CalViva **Count of Action Grouping / Medi-Cal County** **Action Category / Action Grouping / FRESNO / KINGS / MADERA / Grand Total** Received / TOC Add-On (R11) / 6 / 1 / / 7 Screening MH (R09, R21) / 80 / 1 / 41 / 122 TOC Stepdown (R10, R22) / 89 / 11 / 3 / 103 **Received Total** / **175** / **13** / **44** / **232** Sent / Screening MH (R12, R20) / 8 / 1 / / 9 TOC Add-On (SUD) (R15, R23) / 2 / / / 2 Screening SUD (R13) / 2 / / 2 / 4 TOC StepUp (MH) (R14) / 3 / / / 3 TOC Add-On (MH) (R16) / 1 / / / 1 **Sent Total** / **16** / **1** / **2** / **19** **VID Requests** / VID Benefit Explanation (R30) / / / 1 / 1 **VID Requests Total** / / / / **1** / **1** **Other** / Met SMHS - Member Declined (R: / 7 / / 2 / 9 Care Coordination (BHC) / 623 / 51 / 149 / 823 **Other Total** / **630** / **51** / **151** / **832** **Grand Total** / **821** / **65** / **198** / **1084** Q2: Medi-Cal CalViva **Count of Action Grouping / Medi-Cal County** **Action Category / Action Grouping / FRESNO / KINGS / MADERA / Grand Total** Received / TOC Add-On (R11) / 5 / 0 / 0 / 5 Screening MH (R09, R21) / 85 / 0 / 14 / 99 TOC Stepdown (R10, R22) / 116 / 13 / 3 / 132 **Received Total** / **206** / **13** / **17** / **236** Sent / Screening MH (R12, R20) / 5 / 0 / 0 / 5 Screening SUD (R13) / 4 / 0 / 1 / 5 TOC StepUp (MH) (R14) / 0 / 0 / 1 / 1 **Sent Total** / **9** / **0** / **2** / **11** **VID Requests** / VID Benefit Explanation (R30) / 3 / 1 / 1 / 5 **VID Requests Total** / / **3** / **1** / **1** / **5** **Other** / Met SMHS - Member Declined (R: / 6 / 0 / 0 / 6 Care Coordination (BHC) / 747 / 59 / 66 / 872 **Other Total** / **753** / **59** / **66** / **878** **Grand Total** / **971** / **73** / **86** / **1130**	None Identified	None	Ongoing

<table>
<tr><th>Report Timeframe</th><th>Status Report/Results</th><th>Barriers</th><th>Revised/New Interventions</th><th>Target Completion Date</th></tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2025</td>
<td>BH Clinicians continue regular rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care

Based on DHCS audit findings, a distinct policy and procedures, focused on assessment, referral and follow up procedures, was drafted and implemented along with a revised desk reference providing clinicians additional guidance and detailing requirements related to referral, care coordination and ensuring members are linked to referred services (closed loop).

Summary Data for 2024
<table>
<tr><th>Action Category</th><th>Action Grouping</th><th>Totals</th></tr>
<tr><td>Received</td><td>TOC Add On</td><td>64</td></tr>
<tr><td></td><td>Screening MH</td><td>307</td></tr>
<tr><td></td><td>TOC Step down</td><td>431</td></tr>
<tr><td>Received Total</td><td></td><td>802</td></tr>
<tr><td>Sent</td><td>Screening MH</td><td>37</td></tr>
<tr><td></td><td>Screening SUD</td><td>25</td></tr>
<tr><td></td><td>TOC Add-On (MH)</td><td>4</td></tr>
<tr><td></td><td>TOC Step-Up (MH)</td><td>7</td></tr>
<tr><td></td><td>TOC Add-On (SUD)</td><td>5</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Sent Total</td><td></td><td>78</td></tr>
<tr><td>Other</td><td>VID Benefit Explanation</td><td>17</td></tr>
<tr><td></td><td>Met SMHS-Member Declined</td><td>22</td></tr>
<tr><td></td><td>Care Coordination (BHC)</td><td>3162</td></tr>
<tr><td>Other Total</td><td></td><td>3201</td></tr>
<tr><td>Referred to CM</td><td>Member referred to case management</td><td>58</td></tr>
<tr><td>Referred to CM Total</td><td></td><td>58</td></tr>
<tr><td></td><td>Grand Total</td><td>4139</td></tr>
</table>
</td>
<td>None Identified</td>
<td>None</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Appointment Accessibility by Risk Rating: 0 Cases for Q1 and Q2. Authorization Decision Timelines: Percentage of Authorization decision in compliance Q1-2024-99.6%; Q2-2024-99.9% Potential Quality Issues: There were 0 PQI cases, Untoward Events or PQIs related to accessing Autism Services in Q1- Q2 of 2024 Provider Disputes: 100% Resolved within 45 working days in Q1 &Q2 2024 Q1-2024: Health Net Medi-Cal PDR Quarterly Report RBO/Capitated Provider Name: CALVIVA Q1 for MHN — RBO Reporting No.: Q1 - CALVIVA Reporting Period: 01/01/2024 - 03/31/2024 		Total Submitted During Reporting Period	Total Resolved in Quarter in Favor of Provider	Total Resolved in Quarter in Favor of Payer	Total Number with Pending Resolution	Subtotal Resolved in Quarter (B + C)	No. Resolved Within 45 Working Days	% Resolved Within 45 Working Days (F / E)*	Total Resulting in Written Determination
---	---	---	---	---	---	---	---	---
Claims/Billing	A	B	C	D	E	F	G	H
Contracted**		71	112	58				
Non-contracted**		16	19	10				
Professional**	269							
Institutional**	16							
Other Providers**	1							
Non-Claims								
UM/Med. Necessity**								
Contract/Other Reasons'		-	-	-				
GRAND TOTAL	286	87	131	68	218	218	100.00%	218 | Provide an informative summary on any emerging or established patterns of provider disputes and demonstrate how that information has been used to improve the payor's administrative capacity, payor-provider relations, claim payment procedures, quality of care assurance system (process) and quality of patient care (results): **"Observations/Insights"** - No major variance noted in the data". Will continue to observe and report any significant fluctuations and reasons behind them. I certify (or declare) that I have read and reviewed the above report and all attachments thereto and know the contents thereof, and that the statements therein are true and correct to the best of my knowledge and belief. *(Signature of Designated Principal Officer Above)* Date: *April 18, 2024* **"If the average (Grand Total) percentage in the "% Resolved Within 45 W-Days" column (G) is less than 95%, attach a corrective action plan".** Printed Name: *Lisa Howerton* Primary Title: *Claims Manager* Phone Number: E-Mail Address: Lisa.M.Howerton@CENTENE.COM	None Identified	None	Ongoing

Q2 2024:

Network Availability- CVH exceeds network availability standards in Q1-2024. Q2 data is not yet available.

Network Adequacy - Member Ratios:

MHN PDR Quarterly Report

RBO/Capitated Provider Name	CALVIVA Q2 for MHN	RBO Reporting No.	Q2 - CALVIVA
Reporting Period	04/01/2024 - 06/30/2024		

	Total Submitted During Reporting Period	Total Resolved in Quarter in Favor of Provider	Total Resolved in Quarter in Favor of Payer	Total Number with Pending Resolution	Subtotal Resolved in Quarter (B + C)	No. Resolved Within 45 Working Days	% Resolved Within 45 Working Days (F / E)*	Total Resulting in Written Determination
Claims/Billing	A	B	C	D	E	F	G	H
Contracted**		78	152	1				
Non-contracted**		8	44	-				
Professional**	255							
Institutional**	32	-	-	-				
Other Providers**								
Non-Claims								
UM/Med. Necessity**		2	1	1				
Contract/Other Reasons**		-	-	-				
GRAND TOTAL	287	88	197	2	285	285	100.00%	285

Provide an informative summary on any emerging or established patterns of provider disputes and demonstrate how that information has been used to improve the payor's administrative capacity, payor-provider relations, claim payment procedures, quality of care assurance system (process) and quality of patient care (results):

"Observations/Insights" - No major variance noted in the data". Will continue to observe and report any significant fluctuations and reasons behind them.

I certify (or declare) that I have read and reviewed the above report and all attachments thereto and know the contents thereof, and that the statements therein are true and correct to the best of my knowledge and belief.

(Signature of Designated Principal Officer Above)

Date *July 19, 2024*

Printed Name	*Lisa Howerton*
Primary Title	*Claims Manager*
Phone Number	
E-Mail Address	Lisa.M.Howerton@CENTENE.COM

"If the average (Grand Total) percentage in the "% Resolved Within 45 W-Days" column (G) is less than 95%, attach a corrective action plan*.

CVH exceeds network adequacy standards in Q1-2024. Q2 data is not yet available.

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	**Appointment Accessibility by Risk Rating:** There were 0 cases during 2024 that were risk rated. **Authorization Decision Timelines**: Percentage of Authorization decision in compliance Q1-2024-Q3-2024: 90% Q4-2024 data not yet available **PQI Issues:** There were 0 PQI cases in Q1- Q4 of 2024 There were 0 Untoward Events in Q1- Q4 of 2024 There were 0 PQIs related to accessing Autism Services in Q1- Q4 of 2024 **Provider Disputes:** 100% resolved within 45 working days in 2024. **Network Availability/Network Adequacy**: CalViva Health exceeds BHP and QAS network adequacy, availability, and open practice standards Quarter over Quarter. The Plan continues to monitor the network and look for opportunities of improvement when the need arises. **Year end summary of planned interventions involving member phone outreach (BH follow up team):** In the first quarter of 2024, the Follow up Outreach Behavioral Health Team initiated an expansion of their services to CalViva Health members in Fresno and Madera as part of their FUA (Follow-Up After Hospitalization for Mental Illness) and FUM (Follow-Up After Emergency Department Visit for Mental Illness) outreach programs. This strategic move aimed to enhance the accessibility and quality of behavioral health care for these communities. The outreach efforts in Madera were met with promising results. Of the 142 FUA/FUM members contacted, 40 individuals engaged with the services offered, translating to a notable engagement rate of 28%. The successful engagements culminated in the completion of the Behavioral Health HEDIS (Healthcare Effectiveness Data and Information Set) Assessment, a tool used to measure the performance of health plans in key areas, including behavioral health. Similarly, in Fresno, the outreach team reached out to approximately 1,689 FUA/FUM members. From this effort, 344 members—equating to an engagement rate of 20%—completed the Behavioral Health HEDIS Assessment. While the engagement rate in Fresno was slightly lower than that in Madera, the sheer volume of members reached and engaged is indicative of the program's impact. A noteworthy outcome from these engagements was the high number of outpatient referrals for behavioral health care. These referrals are crucial as they connect individuals with the necessary support and treatment, fostering better mental health outcomes and overall well-being.	None identified	Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder data not collected by BH.	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

	Looking ahead to 2025, the Follow up Outreach Behavioral Health Team is set to broaden its horizon even further. The team plans to extend the FUA/FUM outreach to Kings County, building upon the successes achieved in Fresno and Madera. This expansion signifies a commitment to bridging gaps in behavioral health services and ensuring that more individuals have access to the care they need.			

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
5.1 Monitor California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Identify 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, care management, pharmacy, claims review, member appeals and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Collaborate with Public Programs and Coordination of Care Team to facilitate transition of Independent Care Facility CCS membership (begins July 1st 2024). Continue to monitor Aging-out membership, identified 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Teams continued efforts to identify and refer cases to CCS in collaboration with supporting departments such as UM and Pharmacy.

The CCS identification rates for the CVH under 21 population continue to trend above 6% in all counties.

2024 Monthly CCS Identification Rates
<table>
<tr><th>Month</th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>7.71%</td><td>6.87%</td><td>7.01%</td><td>7.56%</td></tr>
<tr><td>Feb</td><td>7.76%</td><td>6.78%</td><td>7.07%</td><td>7.59%</td></tr>
<tr><td>Mar</td><td>7.79%</td><td>6.86%</td><td>7.10%</td><td>7.63%</td></tr>
<tr><td>Apr</td><td>8.74%</td><td>7.36%</td><td>8.31%</td><td>8.57%</td></tr>
<tr><td>May</td><td>8.65%</td><td>7.82%</td><td>8.24%</td><td>8.53%</td></tr>
<tr><td>Jun</td><td>8.60%</td><td>7.72%</td><td>8.16%</td><td>8.47%</td></tr>
</table></td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2025</td>
<td>Staff continued efforts to identify and refer cases to CCS in collaboration with supporting departments such as UM and Pharmacy. The team exceeded goal of minimum 5% identification rate for the year.

2024 CCS Identification Rates
<table>
<tr><th>Qtr Avg</th><th>CCS Elig (CA + CC)</th><th>Total SHP Membership</th><th>Membership < 21 years old</th><th>% of CCS Eligibles</th></tr>
<tr><td>Q1</td><td>15,147</td><td>429,964</td><td>199,517</td><td>7.59%</td></tr>
<tr><td>Q2</td><td>16,907</td><td>434,731</td><td>198,351</td><td>8.52%</td></tr>
<tr><td>Q3</td><td>16,844</td><td>435,197</td><td>198,003</td><td>8.51%</td></tr>
<tr><td>Q4</td><td>16,694</td><td>430,168</td><td>196,057</td><td>8.51%</td></tr>
</table>
Prior Year CCS Identification Rates
<table>
<tr><th>Period</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>2022</td><td>8.69%</td><td>8.72%</td><td>8.31%</td><td>8.44%</td></tr>
<tr><td>2023</td><td>8.17%</td><td>7.91%</td><td>7.87%</td><td>7.73%</td></tr>
</table></td>
<td>None identified</td>
<td>None</td>
<td>This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2024 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Care Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for Integrated Case Management (ICM) as noted under 4.1. 697 Seniors and Persons with Disabilities (SPD) members (Supplemental Security Income Dual and Non-Dual) have been managed through Q2. This includes Physical Health Care Management, Behavioral Health Care Management, Transitional Care Services & Obstetrics Care Management, as well as both complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members for Q1 and Q2 (100% on time). 12,338 members were outreached from January through June 2024.	None identified.	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2025**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 1,482 SPD members (SSI Dual and Non Dual) have been managed Q1-Q4 2024. This includes PH CM, BH CM, TCS & OB CM, as well as both providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members YTD 2024 was 100%. A total of 26,430 members were outreached in 2024.	None identified	None	This is a consistent component of QI/UM and is tracked on a routine and ongoing basis. Activity is ongoing to ensure quality outcomes are met.

Item #12
Attachment 12.C

2025 Utilization Management
Program Description & Change Summary

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Marianne Armstrong, Utilization Management

COMMITTEE DATE: February 20, 2025

SUBJECT: Utilization Management Program Description Change Summary

UM Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Updated year from 2024 to 2025
Throughout	Multiple	Grammatical and formatting edits for readability
ii-iii	Table of Contents	Page numbering and section headers updated to align with content
2	Provider Network	Removed Medical records
5	Health Net Community Solutions Purpose	Distinguished behavioral health
6	Goals and Objectives	Mental health parity added
8	Scope of Utilization Management	• Updated CCR Title reference • Moved auth exclusion references to Preauthorization / Prior Authorization
9	Direct Referrals/Self Referrals	Moved auth exclusion references to Preauthorization / Prior Authorization
9-10	Preauthorization / Prior Authorization	Expanded list of services requiring authorization and excluded from authorization requirements
11-12	Inpatient Facility Concurrent Review	• Removed reference to clinical staff onsite • Removed Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) as not applicable to Medi-Cal
16	Behavioral Health Care Services	• Included Non-specialty Mental Health Services • Added APL references • Edited criteria used to include non profit association criteria and guidelines and removed LDC/NCDs
17-18	Pharmacy	Description of Pharmacy advisory committee role added
19-21	Health Promotion Programs	• Weight Management Programs updated • CalViva Pregnancy Program updated • Diabetes Prevention Program updated • Healthy Hearths Healthy Lives Program removed • Health Promotion Incentive Programs updated • Community Health Education classes updated
22	Over and Under Utilization	Updated types of methods
23	Utilization Decision Criteria	Added SB855
25	Consistency of Application of Utilization Decision Criteria	Revised section to better describe how consistency of utilization criteria is achieved

32-35	Organizational Structure and Resources	Updated titles
36	The Behavioral Health Team Medical Director and Medical Staff	Removed reference to separate BH committees
39-40	Delegation	Section revised to better describe activities

2025

Health Net Community Solutions, Inc. CalViva Health

Utilization Management (UM) Program Description

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TABLE OF CONTENTS

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Section 1

Introduction and Background

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Introduction and Background

Introduction

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

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

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

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

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

Background

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

Provider Network

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

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

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

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

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Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

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

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

Information Systems and Analysis

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

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- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

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Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, Medical Advisory Council, Customer Service and Claims. Additional sources of information include member and provider feedback.

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Section 2

Purpose

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About Health Net

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

Mission

Transforming the health of the communities we serve, one person at a time.

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Values

Accountability • Courage • Curiosity • Trust • Service

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Health Net Community Solutions UM Purpose

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

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

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary medical and behavioral health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address issues related to access and timeliness of care
- Initiate documentation to support investigation of potential quality of care concerns
- Identify and resolve issues leading to excessive resource utilization and inefficient delivery of health care services
- Identify and resolve issues that result in either underutilization or overutilization of services
- Assess the impact cost containment activities on the quality of care provided
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of members through integration and coordination within PHCO and external Public Health Programs
- Optimize the members' health benefits by linking and coordinating services with appropriate county and state sponsored programs

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Goals and Objectives

The Program has the following specific objectives:

- Ensure consistent application of all UM functions for members
- Review and assess health care services for quality, medical necessity and appropriate levels of care
- Identify and evaluate actual and potential quality issues during the review process and refer to the appropriate quality management personnel
- Evaluate the need for care management and discharge planning in coordination with the hospital and primary care providers (PCPs)
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation Oversight to determine delegation status for UM activities
- Evaluate the UM Program regularly to adapt to changes in the health care environment
- Collaborate with county Public Health-Linked Programs to ensure effective care delivery.
- Provide equitable access to care by addressing health disparities, such as structural racism, social risks, social determinants of health (SDoH), and specific community needs
- Recommend and implement strategies to eliminate health disparities and improve individual and community health outcomes
- Ensure full compliance with mental health parity requirements, applicable laws, regulations, and accreditation standards, fostering equitable access to mental health services.

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Section 3

Description of Program

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Description of Program

Utilization and Care Management

The Health Net Utilization Management Program is designed to ensure all members receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization Management Program operates under the clinical supervision of the Chief Medical Officer of Health Net, LLC who plays a key role in the development and implementation of the program.

Scope of Utilization Management

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

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

Health Net has developed, implemented, and continually enhances its UM Program to ensure effective processes are in place to review and approve the provision of medically necessary covered services. The plan is staffed with qualified professionals who are dedicated to its implementation and oversight.

The plan ensures the separation of medical decision making from fiscal and administrative management, safeguarding against undue influence on medical decisions. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 28 section 1300.67.3 (a) (1) and California Health and Safety code section 1367 (g), except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) All Plan Letters.

Additionally, Health Net's Utilization Management Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and Managed Risk Medical Insurance Board (MRMIB) for Utilization Management and Care Coordination activities.

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

Health Net ensures that Utilization Management (UM) policies and procedures are accessible to members and providers upon request.

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fFamily planning services, ¶
pPreventive services, ¶
bBasic prenatal care, ¶
sServices related to the treatment of sexually transmitted infections, ¶
HIV counseling and testing, ¶
tTherapeutic and elective pregnancy termination, ¶
bBiomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer and ¶
iImmunizations at the Local Health Department (LHD). ¶
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Health Net Utilization Management nurses play a vital role by providing:

- Decision support and member advocacy,
- Identification and recommendation of alternative plans of care,
- Identification and use of alternative funding and
- Coordination with community resources to support members' plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director.

These services are outlined under the Scope of Utilization Management section of the UM Program Description. Direct referrals are designed to enhance the member's ability to access specialists quickly and efficiently.

Preauthorization / Prior Authorization

Health Net requires delegated PPGs to develop and maintain programs, policies and procedures that meet Health Net's established standards. Health Net Utilization Management staff is responsible for making pre-service decisions for request types that are not delegated.

Pre-service decisions include both the initial determination of requests for both urgent and non-urgent services, as well as requests for continuity of care services. Pre-service decisions are required for:

- Elective inpatient admissions
- Services out of the CalViva Health service area, if not an emergency or urgent care
- Selected ambulatory surgery
- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- Select durable medical equipment
- Select specialized treatments such as home IV infusion
- Selected diagnostic and radiology procedures
- Medical transportation services when it is not an emergency

The purpose of obtaining a pre-service decision is to evaluate proposed services to ensure they are:

- Medically necessary
- Covered by the member's benefit plan

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- The most current and appropriate medical and behavioral health interventions, based on clinical evidence
- Provided by a contracted practitioner or provider, when appropriate
- Delivered in the most appropriate setting.

Health Net, along with its delegated PPGs, does not require prior authorization for the following services or others as required:

- emergency services,
- minor consent services
- adult sensitive care services
  - family planning and birth control including sterilization for adults 21 and older,
  - pregnancy testing and counseling and other pregnancy related services
  - HIV/AIDS prevention and testing
  - sexually transmitted infections prevention testing
  - sexual assault care
  - outpatient abortion services
- preventive services from a participating provider
- basic prenatal care with a participating network obstetrician
- specialist referral (initial referral to participating specialist)
- urgently needed services when the member is outside their county
- certified nurse midwife and obstetrical/gynecological (OB/GYN) services from a participating provider
- MOA 638 Indian Health Service facilities
- biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer (FDA approved)
- COVID-19 diagnostic and screening testing
- services that are rendered under the Children and Youth Behavioral Health Initiative fee schedule
- initial mental health and substance use disorder assessments
- adult preventive immunizations from a participating physician or other provider
- second opinion from a participating physician or other provider
- Comprehensive Perinatal Services Program (CPSP) services

Health Net has established a tracking system to monitor referrals requiring prior authorization. Health Net's authorization tracking system includes authorized, denied, deferred and/or modified authorizations. Additionally, the authorization tracking process ensures the monitoring of timeliness on these decisions.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an ongoing assessment process that determines medical necessity or appropriateness of services as they are provided. It focuses on evaluating the need for continued inpatient care and the continued provision of an approved course of treatment over a period of time or a specific number of treatments. Concurrent review is a member-centric process that involves medical necessity review, discharge and transitional care planning, and coordination of care.

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A goal of CCR is to support the member and their healthcare team in optimizing health outcomes, particularly when there is a change in the member's health status. This process is carried out in collaboration with the PPG, the member and the Interdisciplinary Care Team to:

1) Ensure timely access to services,
2) Educate the member's healthcare team about the member's benefit structure and resources,
3) Facilitate the expedited authorization of services when appropriate,
4) Provide referrals to relevant member resources, such as the behavioral health team, care management, and community resources.

The CCR nurse plays a key role in ensuring a smooth transition from the acute care setting or Skilled Nursing Facility (SNF) to the next level of care or community services. This is achieved by bridging the inpatient to outpatient process, facilitating healthcare services and supporting member care management programs.
Health Net nurses and Medical Directors along with delegated partners, conduct telephonic concurrent review of patients admitted to hospitals, rehabilitation units, custodial care/long term care, intermediate care facility, or skilled nursing facilities. Health Net may also monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status.

The inpatient review process occurs within one business day from the day of hospital admission or notification of admission and continues throughout the patient's hospital stay. This review process includes:

- The application of standardized nationally recognized criteria for medical appropriateness
- Evaluation of levels of care,
- Discharge planning and transitional care management
- Assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses utilize nationally recognized criteria, including InterQual® criteria, Hayes, and Health Net's Medical Hierarchy Policy, to assess the appropriateness of the admission, level of care, and length of stay.

The determination of medical appropriateness takes into account both the individual patient's specific needs and the capacity of the local delivery system, which is particularly important in remote or underserved areas of the state. When necessary, board-certified physician specialists are involved in making medical determinations to ensure accuracy and clinical appropriateness.

Health Net's non-clinical staff plays a supportive role in pre-service and concurrent reviews by handling data entry, receipt and documentation of notifications, and attaching clinical content as needed.

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When requests do not meet guidelines or criteria for approval, they are referred to a Health Net Medical Director for a second level case review. During the concurrent review process, nurses assess the member's specific care management needs, disease or chronic condition management. Cases requiring further evaluation are referred to Care Management for a comprehensive review and evaluation. Concurrent Review Nurses also collaborate with Care Managers on all members identified as part of active care management.

The primary goals of CCR include:

1. Supporting the member and their healthcare team to optimize health outcomes, especially when there is a change in member's health status.
2. Advocating on behalf of the member through collaboration with the PPG, member and the interdisciplinary care team to
   a. Ensure timely access to services,
   b. Educate the member's healthcare team about the member's benefit structure and available resources,
   c. Facilitate expedited authorization of services when appropriate,
   d. Facilitate referrals to relevant member resources, such as the behavioral health team, care management, and community resources.

The CCRN further supports a smooth transition from the acute care setting or SNF to the next level of care or community. This is achieved by bridging the inpatient to outpatient process through facilitation of healthcare services and member care management support programs.

Discharge Planning

Health Net and/or its delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care, in collaboration with the practitioner, the member, and the member's family, ensuring a safe and timely discharge. Discharge planning begins pre-service or on the first day of the member's admission. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to:

- Home health care,
- Durable medical equipment
- Transfers to a lower level of care (e.g., skilled nursing facility, custodial care/long term care, intermediate care facility or acute rehabilitation).

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HN Concurrent Review nurses also identify potential care management cases and refer them to Care Management and other outpatient programs for post discharge evaluation and/or services.

The criteria used for guiding timely discharge planning include nationally recognized criteria, such as InterQual®, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) and Health Net's Medical Hierarchy policy. Discharge planning is an integral part of the Utilization/Care Management Program and includes the following elements:

- Assessment of continuity of care, including the identification of Community Supports and Complex Care Management needs.
- Assessment of member's support system to determine necessary services and support needs.
- Development of a discharge plan of care based on short-term medical and psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

Post Service/Retrospective Review

Delegated PPGs conduct post service or retrospective review activities in alignment with Health Net standards. For non-delegated providers, Health Net carries out these activities directly.

Health Net and its delegated partners perform post-service or retrospective review of medical records when services rendered have not been pre-authorized. If services do not meet established criteria, they are forwarded to Health Net and delegated partners' Medical Directors for final determination and recommendations regarding payment adjudication. The purpose of the post-service review is to assess whether the requested services, as for documented in the member's medical records, meet the criteria for medical necessity. Review determinations are made once all required information has been obtained.

Second Opinion

A member, the member's authorized representative, or a provider may request a second opinion for medical, surgical or behavioral health conditions. Typically, PCPs will refer their assigned members to a participating physician within the same medical group for a second opinion. If a member requests a second opinion about specialty care from a participating specialist outside the member's PCP's medical group, the request will be forwarded to Health Net Utilization Management team for review.

Health Net does not routinely require prior authorization for second opinion services, whether the opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, if the member's plan

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requires prior authorization for these services, the determination will be made promptly, in line with state specific mandates.

The organization ensures the member can obtain a second opinion from an in-network provider or, if necessary, arranges for the member to receive a second opinion from an out of network provider at no cost to the member.

Members may obtain a second opinion from a qualified healthcare professional. If a qualified healthcare professional is not available within the Health Net Network, Health Net will coordinate arrangements for the member to access the second opinion from an out-of-network provider at no cost to the member.

Management of Information Systems

Health Net utilizes automated documentation systems to efficiently enter, view, and audit medical management information, ensuring accurate and streamlined data management.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals, and ancillary service providers to deliver high-quality, cost-effective medical services to members and their dependents. The foundation for accessing appropriate healthcare services is the selection of a Primary Care Provider (PCP) and establishment of a strong relationship with that provider, is the

PCPs include:

- Internists
- Family Practitioners
- General Practitioners
- Pediatricians
- Nurse Practitioners
- Women's Health Care Providers (WHCP)

Access / Availability to Health Care Services

Health Net conducts ongoing review of its network to ensure the availability of and access to all required levels of care. The review includes an analysis of the network's scope, including Primary Care Physicians, specialists, facilities and ancillary services in relation to members' healthcare needs.

Key components of the review process include:

- Analyzing the alignment of network resources with members' requirements
- Conducting site reviews and medical record audits to verify compliance with standards for access to care and services, and the confidentiality of member records.

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When gaps or unmet needs are identified, targeted recruitment efforts are initiated to enhance the network and ensure comprehensive coverage for all members.

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Coordination with Quality Improvement Programs

The Health Net Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve member care and service.

Coordination with Internal Programs

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

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- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate members for Public Health, Long Term Services and Supports (LTSS), waiver programs and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers.
- Identifies and refers appropriate members for Health Education Services, including tobacco cessation and obesity prevention programs.
- Identifies and refers appropriate members for Cultural and Linguistic Services, including members needing translation of documents or interpreter service for office visits.
- Offers disease/chronic condition management Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

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Behavioral Health Care Services

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The behavioral health team administers the Medi-Cal Non-specialty Mental Health Services (NSMHS) carved into the Managed Care Plans.

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The behavioral health team provides early and periodic screening, diagnosis and treatment services for members ages 0 to 20. These services include medically necessary Behavioral Health Treatment (BHT) such as Applied Behavioral Analysis

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(ABA) and other evidence-based behavioral intervention regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

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

The behavioral health team's utilization management decisions are based on the behavioral health team's evidence-based nonprofit professional association criteria and guidelines such as Council of Autism Service Provider (CASP) and American Psychological Association. The behavioral health team's evidence-based internal criteria guidelines are based on a variety of clinical sources such as the evidence-based American Psychiatric Association Practice Guidelines.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). The behavioral health team and Health Net do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. CalViva will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

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

Further, the underlying processes, strategies, and evidentiary standards, considered by the behavioral health team and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental

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health and substance use disorder benefits. Factors considered in the determination process are supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

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

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

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Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Medical Benefit Drug Prior Authorization, Education programs for physicians and members, and Pharmaceutical Safety.

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A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

The Health Net Pharmacy Advisory Committee (PAC) is responsible for oversight and communication about Health Net's pharmaceutical program. The quarterly Committee advises on medical and pharmacy drug benefit services to ensure they are being managed effectively and efficiently, while ensuring quality care is provided to the health plan membership. Membership includes CalViva Health Chief Medical Officer, Health Net's Medical Directors or his/her designees, Centene Pharmacy Services California Pharmacy team, physicians and pharmacists, and other areas that may be impacted by pharmacy operations.

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Continuity and Coordination of Care

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

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating members and their families to implement a smooth and coordinated plan of care.
- Implementation of specific population-based, chronic condition management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal care management, asthma or diabetes.
- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan members with pre-existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.
- Members/Providers who make a continuity of care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.
- The continuity of care process is facilitated by licensed nurses based on member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.
- Care Managers are patient advocates and assist members to ensure that they receive timely and uninterrupted medical care during the transition process.

Primary Care Physician responsibility:

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

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

As an additional aid to the primary care provider, Health Net provides a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and

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availability standards through our network relationships, member and provider education and triage services.

Health Promotion Programs

CalViva Health provides health education programs, services and resources to Medi-Cal members to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

The goal is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to have member engagement and to have preventive wellness, and chronic condition management in accordance with national peer-reviewed published guidelines. Preventive medicine services, achieved through proactive education and active engagement of the members, promotes optimal health.

Programs include:

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

Nurse Advice Line

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

Chronic Condition Management

The Chronic Condition Management Program increases awareness of self-care strategies and empowers participants to better manage their disease. The program targets members with high-risk chronic conditions including, but not limited to: chronic asthma, diabetes and heart failure conditions. It encourages them to participate in the program. This program includes a population-based identification process, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of

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these efforts. Referrals to chronic condition management are multichannel and come through provider, Care Management and member self-referrals.

Weight Management Programs

Members have access to weight management resources through our Krames and Staywell Libraries.

Health Education Programs, Services and Resources

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

- CalViva Pregnancy Program - The pregnancy program incorporates the concepts of care management, care coordination, chronic condition management, and health promotion, teaching members how to have a healthy pregnancy through 60 days postpartum. In addition, the program supports the following:
  - Information about pregnancy and newborn care.
  - Community resources to assist parents in getting the things they need during pregnancy and after the baby's birth. These services include food, cribs, housing, and clothing.
  - Breastfeeding support and resources.
  - Professional medical staff who work with doctors and nurses to support members with a more difficult pregnancy.
  - Resources for members who feel down during or after their pregnancy.
  - Methods to help pregnant members quit smoking, alcohol, or drug use.

  The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- Smoking cessation
  - Kick It California – Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Telephonic coaching is available Monday-Friday, 7am-9pm, and Saturday from 9am-5pm (excluding holidays) by calling 1-

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800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.

- CalViva offers members a 90-day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts.
- CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.

- Diabetes Prevention Program – The Diabetes Prevention Program (DPP) is a 12-month long program focused on helping Medi-Cal members lower their risk for diabetes through healthy lifestyle choices and weight loss. Eligible members include any member 18 years of age and older at risk for developing type 2 diabetes.
- Digital Health Education - Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and encourage members in accessing timely preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with depression, anxiety, stress, substance use, pain management, and insomnia.
- Health Promotion Incentive Programs - The Health Education Department (HED) partners with Quality Improvement Department to develop, implement and evaluate incentive programs to encourage members to access HEDIS related preventive health care services. CalViva Health follows MMCD Policy Letter 16-005 to develop, implement and evaluate appropriate incentive programs to promote positive health behaviors among members.
- Community and Telephonic Health Education Classes – No-cost health education classes and webinars are available to members and the community. Classes are available in various languages. Topics vary and are determined by the community's needs and topic availability.
- Community Health Fairs – CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide screenings, presentations, and/or health education materials at these events.

The following educational resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, dental health, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Member Request Form – Members complete an order form to request free health education materials available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line or view some materials online at www.CalVivaHealth.org. They can also get CalViva Health's print resources at contracted providers and health education classes.

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Healthy Hearts Healthy Lives Program - Members have access to a health heart prevention toolkit (educational booklet, tracking journal, an exercise band, and online fitness videos) and access to community classes to learn how to maintain a healthy heart.
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- Health Education Programs and Services Flyer – This flyer contains information on all health education programs and services offered to members and information on how to access services.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in English, Spanish and Hmong.
- Member Newsletter – Newsletter is mailed to members on an annual basis and covers various health topics and the most up-to-date information on health education programs and services.

Over and Under Utilization

Health Net requires all providers to submit claims and encounter data for all services rendered. A variety of methodologies are utilized to monitor key aspects of utilization management, including under, over utilization, referral timeliness, provider appeals, denials and member appeals and grievances.

The types of methods include:

- Annual On-Site Evaluation: Comprehensive reviews of network-wide PPGs Medi-Cal Utilization Management Programs to ensure compliance and effectiveness. Member Complaint Tracking: Identification of over or Under utilization patterns based on trends in member complaints.
- Focused Audits: Targeted reviews of specific providers or services to address potential concerns.
- Data Analysis: Examination of medical group-specific metrics, including inpatient utilization, ER usage, and pharmacology data, to identify trends and outliers.
- Evaluation of Practice Patterns: Assessment of individual direct contract physicians to ensure alignment with best practices and quality standards.

These methodologies enable Health Net to maintain high standards of care, address potential issues proactively, and ensure optimal resource utilization.

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

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

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- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

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

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

Health Net completes the Quality Management education process with its contracted providers through local interaction with the Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

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

1. State law/guidelines:
    a. Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters
    b. California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals
    c. State definition of medical necessity: (Title 22 CCR Section 51303(a))
    d. Expanded guidelines for members under the age of 21 (W & I Code Section 14132 (v))
    e. Per Regulation SB855 for mental health and substance abuse (MH/SA) the most recent versions of treatment criteria developed by nonprofit professional agencies.
2. Plan-specific clinical policy
    a. Includes custom content within InterQual® and other vendor specific criteria
3. Centene clinical policy
    a. Includes Centene customized clinical policies within InterQual®
4. Nationally Recognized Decision Support Tools:
    a. When no specific Plan, or Centene clinical policy exists, tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are applied
5. Additional considerations (if no guidance from 1-4), when available:

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a. Peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations
b. Recognized US professional standards of safety and effectiveness for diagnosis, care, or treatment
c. Nationally recognized drug compendia (e.g., Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines)
d. Medical association publications (e.g., American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.);
e. Government-funded or independent entities that assess and report on clinical care decisions and technology (e.g., Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.);
f. Published expert opinions (e.g., Up-To-Date);
g. Opinion from health professionals in the area of specialty involved;
h. Opinion of attending provider in case at hand.

Benefit Determinations Criteria:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
D. Preferred Drug List (PDL)

Conflict Resolution:
- When Medi-Cal (state Medicaid) coverage provisions conflict with the Plan or Centene specific clinical policies, Medi-Cal provisions take precedence.
- Refer to the Medi-Cal manual for applicable coverage provisions.

Transparency and Accessibility:
- Clinical policies, benefit provision, guideline, protocol or criteria are available upon request, in compliance with Federal and State regulations.

Separation of Medical Decisions from Fiscal and Administrative Management

Health Net's UM Program is structured to ensure that medical decisions made by the Plan or PPG medical directors are not unduly influenced by fiscal or administrative considerations. To achieve this, Health Net affirms that it adheres to the following principles:

Medical Necessity and Appropriateness:
- All utilization management decisions are based solely on medical necessity and medical appropriateness

No Compensation or Incentives for Denial:
- Health Net does not provide compensation to physicians or nurse reviewers for denials of service requests
- No incentives are offered to encourage denials of coverage or service
- Special attention is given to mitigate the risk of under-utilization

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- Health Net and its delegates distributes a statement outlining its policies and restrictions on financial incentives to all practitioners, providers, and employees.

Decision Making integrity:

- Utilization management decisions are based solely on the appropriateness of care, service and existence of coverage
- Delegated entities are also prohibited from rewarding practitioners or others involved in utilization review for denying coverage or service

Independent Oversight:

- Health Net Medi-Cal Medical Directors and the Health Net Community Solutions CMO/VP Medical Director do not report to:
  - Health Net's Chief Financial Officer,
  - Health Net's Marketing Director

Consistency of Application of Utilization Decision Criteria

Health Net ensures the consistent application of utilization decision criteria through structured processes and evaluations involving both Health Net staff and delegated PPG's such as:

- **Weekly Regional Utilization Management (UM) Rounds** – Use of Rounds facilitates interdisciplinary collaboration to enhance consistent decision-making, optimize patient outcomes, and improve resource management.
- **PPG Collaboration –** PPG management issues are referred to the Provider Oversight Department for resolution.
- **Real-Time Feedback from Leadership** – Continuous guidance and support from medical leadership are provided to reinforce standardized decision-making practices.
- **Ongoing UM Training** – Mandatory training sessions led by the Learning and Development team for all clinical review staff, both new and existing including training that focuses on:
  - Clinical Criteria Hierarchy and its application
  - Identification and utilization of available criteria sources
- **Inter-Rater Reliability (IRR) Testing**

Inter-Rater Reliability (IRR) Review Process:

New hire and annually, IRR testing are conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. New UM staff are required to successfully complete IRR testing prior to being released from training oversight.

Staff are required to test on the Medical Necessity Criteria products applicable to their role. All staff must score 90% or greater for any new hire and annual IRR test. If a staff scores < 90% for any subset the staff must complete remediation and successfully retest within 30 days of completing remediation. Documented Coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented Coaching may include but is not limited to the following: precepting of staff, retraining of the staff, or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the New Hire and Annual IRR test(s) are not completed within the

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Reviews include a selection At these meetings, a selection of appropriate inpatient admissions and outpatient services, summarized to ensure appropriate utilization are reviewed and summarized. ¶
Problematic cases are discussed for staff in detail to promote staff education and appropriate utilization improvement. ¶
Potential PPG management issues are identified and referred to the Provider Oversight Department for resolution.¶

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designated testing period, a failure of all applicable IRR tests is applied, and Documented Coaching is initiated by the People Leader.

IRR results are reported annually at the CalViva Health Quality Improvement/Utilization Management (QI/UM) Committee Meeting.

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

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

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Standards of Timeliness of UM Decision Making

Health Net maintains strict adherence to established time frames for UM decision making to ensure that members receive timely care. These time frames are designed to minimize disruptions in the provision of healthcare services and are based on the urgency of the clinical situation.

Key Points on Timeliness of Decision Making:

- Turnaround Time (TAT) Standards
  - The TAT standards for decisions making regarding medical necessity and authorization requests are guided by current DHCS, DMHC, and State regulatory guidelines.
  - The most stringent of these guidelines are applied to ensure compliance and consistency.
- Timeliness Communication
  - All decisions regarding authorization or medical necessity are communicated to both the member and the provider within the required regulatory timeframes.
  - The communication method and timeframe are determined by DHCS, DMHC, and State regulations, whichever set of guidelines has the most stringent requirement
- Delegated Provider's Compliance
  - Health Net's delegated providers are informed of the decision timeliness standards as outlined in the Provider Operations Manual.

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By maintaining these standards and monitoring compliance, Health Net ensures that healthcare decisions are made promptly and in accordance with regulatory requirements, ensuring members receive timely care and services.

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Denials

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

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

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

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

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the contact telephone number to schedule a conversation with the Medical Director or Pharmacist who issued the denial and Medical Director contact information is available on the provider portal website.

Appeals

A licensed physician reviews all member medical necessity appeals.

CalViva Health has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

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

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

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

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

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

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

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

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Evaluation of Medical Technology and Procedures

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Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

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

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

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

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Satisfaction with the Utilization Management Process

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

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Communication Services

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

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

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

Emergency Services

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

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

After Health Net completes its internal review and approval process, the CalViva Health UM Program Description is forwarded to CalViva Health for review and approval. This ensures that all relevant policies, procedures, and protocols are aligned and in accordance with CalViva Health's standards before they are finalized and implemented. The review and approval process is a key step in ensuring the consistency, compliance, and quality of the UM program.

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Section 4

Organizational Structure and Resources

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Organizational Structure and Resources

CalViva Health Staff Resources and Accountability

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CalViva Chief Medical Officer

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

Department Resources

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

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Medical Management Team

The Medical Management team will include a Chief Medical Officer, Senior Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Senior Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CalViva and HNCS will ensure that staff involved with the Utilization Management program are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.

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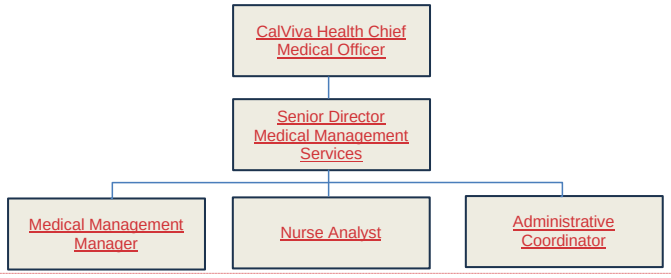

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CalViva Health Quality Improvement/Utilization Management Committee

The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, and

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

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

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

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

Health Net Organizational Structure and Resources

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

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

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The Health Net, LLC CMO's responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations.

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

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

Health Net Community Solutions (HNCS) CMO / Vice President (VP) Medical Director

The HNCS CMO/VP Medical Director, is responsible for Utilization Management and Care Management activities for Medi-Cal. In addition, the HNCS CMO/VP Medical Director is responsible for QI activities for these programs. The HNCS CMO/VP Medical Director is the chair of the Health Net Community Solutions Committee and is actively involved in implementing the UM Program. The HNCS CMO/VP Medical Director reports to HN LLC's CMO.

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

Medical Directors

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

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

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

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as

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consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement and Health Equity Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

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

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

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

Utilization Management (UM) Resources

Director/Senior Director, PHCO

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

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

Health Net UM Clinical Staff

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

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Care/Chronic Condition Management when appropriate,
- Management of out-of-area cases, and

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- All UM LVN, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of members to County CCS offices when eligible
- Referral of members to LTSS and Waiver Programs
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health
- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health Team Medical Director and Medical Staff

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

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

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

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Health Net Community Solutions (HNCS) Quality Improvement/Health Equity Committee (QIHEC)

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The HNCS QIHEC reports directly to the HNCS Board of Directors. The committee is charged with the monitoring of the PHCO and quality of care and services rendered to members within HNCS including identification and selection of opportunities for improvements, monitoring interventions and addressing UM,QI, PMH and Health Equity activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the HNCS QIHEC quarterly reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI. The Committee membership also includes practicing network physician representatives. The HNCS QIHEC is chaired by the HNCS CMO/VP Medical Director for HNCS and meets quarterly.

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs), contracted vendors and strategic partners (delegated partners). Health Net has established processes in place to assess and determine the appropriateness delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment.

Health Net has an experienced team of Compliance Auditors to oversight of delegated entities. At least annually, Delegation Oversight audits delegated partners which include file and policy and procedure reviews. Delegates are required to provide monthly turn around time reporting This reporting is reviewed for completeness and required performance standards. The Delegation Oversight team also routinely conducts system validation checks to evaluate the delegates' data quality. If an auditor discovers a below standard performance during an auditing or monitoring activity, a Corrective Action Plan (CAP) is requested from the delegate. All CAP remediations are evaluated, tracked and validated prior to closure. These oversight processes are established to ensure compliance with Federal, State, contractual and Health Net's criteria for delegated activities.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC). Summary reports are provided to CalViva Health's monthly Management Oversight Meeting.

Delegation Oversight Committee

The purpose of the Delegation Oversight Committee (DOC) is to provide a forum for discussion of the delegates' performance and to address significant risks with health plan leadership. During this meeting d oversight activities, recommendations of the subcommittee Delegation Oversight Workgroup (DOW), audit results, and corrective actions are discussed. As needed, the DOC will discuss remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing oversight
- Financial sanctions through a capitation deduction
- Membership Freeze; and/or
- Required change in Management Services Organization
- Denial of business expansion or changes
- De-delegation, and/or contract termination
- Terminating the organization's contract with Health Net

Sub-delegation

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

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

A review of the contracted delegates shall be conducted annually, or more frequently as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net's review upon request.

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Section 6

Utilization and Care Management (UM/CM) Program Evaluation

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UM/CM Program Evaluation

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

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

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

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

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

UM/CM Program Work Plan

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

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Section 7

Approvals

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Fresno-Kings-Madera Regional Health Authority Commission Approval

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

_____ _____

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

Date

_____ _____

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

Date

Health Net Medi-Cal Utilization Management Program Approval

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

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Brenda Belmudez
Vice President of Population Health and Clinical Operations

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Item #12
Attachment 12.D

2025 Utilization Management
Case Management Work Plan

CalViva Health 2025 Utilization Management (UM)/ Care Management (CM) Work Plan

Last updated: February 11, 2025

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide clinical continuing education opportunities to staff. Conduct Population Health and Clinical Operations (PHCO) Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Ongoing As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to PHCO processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and reminded annually thereafter. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing January 2025, April 2025, July 2025, October 2025

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors CMO Meetings ▪ MMCD workgroups ▪ DHCS-MCP Quality and Health Equity Think Tank There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2025. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures as needed and at least annually.	☒ Medi-Cal	Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements. Senior Physician involvement is ensured, including behavioral health aspects of the UM Program.	Core group comprised of State Health Programs Chief Medical Officer (CMO), Regional Medical Directors, VP and Directors of PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2025 UM and CM Program Descriptions. Write and receive CalViva approval of 2024 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2025 UMCM Work Plan. Write and receive CalViva approval of 2025 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2025 Q 1 2025 Q 1 2025 Q 3 2025 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.7 Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making	☒ Medi-Cal	All new and current UM clinical criteria and practice guidelines related to UM decision making are reviewed and approved annually by the Medical Advisory Council (MAC), which includes input from local Medical Directors. The Plan makes UM criteria and clinical practice guidelines available to practitioners via the provider portal.	Centene's Corporate Clinical Policy Committee and HN California's Medical Advisory Council (MAC) reviews and approves policies on clinical criteria annually. Clinical practice guidelines are reviewed and approved at least every two years. Medical policies and clinical practice guidelines are available to providers upon request; Change Healthcare, Inc.'s InterQual criteria are available to providers upon request. CalViva QIUM Committee reviews and adopts policies for clinical criteria for UM decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Confirm annually: • Health Net of California's Medical Advisory Council (MAC) in conjunction with Centene's Corporate Clinical Policy Committee reviews, updates as necessary, and approves policies for clinical criteria for UM decision making. • Ensure UM clinical criteria and UM clinical practice guidelines are made available to practitioners via provider portal (or website) and practitioners are notified of new policies and changes via the monthly Provider Update.	Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
1.8 Evaluate inclusion of new technologies and new application of existing technologies in applicable benefit packages including: medical, behavioral procedures, pharmaceuticals, devices, and new application of existing technologies	☒ Medi-Cal	Standardized process is used for review of new technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages	New technologies are reviewed and approved by Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Decisions are based on nationally recognized primary sources including: Hayes® Medical Technology Directory and Hayes® Alert technology-based evaluations, InterQual® and information from evidence-based medical journals, colleges and academies. CalViva QIUM Committee reviews and adopts policies for clinical criteria for UM decision making annually, providing mid-year updates and monthly Medical Policy provider updates.	Evaluate new technologies and ensure inclusion in member benefits as applicable throughout 2025.	Ongoing monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Turnaround times (TAT) • Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. Continue support for long-term care benefit carve in and ensure continuity of care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining. Initiate end to end assessment of UM TAT monitoring processes.	Ongoing UM TAT summaries due monthly 12/31/2025

	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	PHCO Learning and Development administers new hire and annual IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews All new hire and annually staff must achieve a minimum passing score of 90% on each IRR test	Administer the Change HealthCare/Optum InterQual and relevant non profit criteria IRR tests in Q3-Q4 2025 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. Documented coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented coaching may include but is not limited to the following: precepting of staff, retraining of the staff or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the new hire and annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and documented coaching is initiated by the People Leader.	Q3-4 2025 Q4-2025

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. On a monthly basis appeal trends are reported via a monthly dashboard. Additionally, appeals will be analyzed for trends. This analysis and recommendations will be reported to CalViva Health QI/UM Committee. Ensure appeals are processed by specialty matched physicians, when appropriate which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals. The data from appeals and grievances is shared with the Provider Network Management, Adverse Action Team, and Quality Improvement / Utilization Management (QI/UM) committees and is aggregated and reviewed for additional actions and recommendations. This data is shared with the CalViva QI/UM Committee for review and identification of opportunities for improvement.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
2.5 Review annual member and practitioner surveys to assess satisfaction with UM process and to address areas of dissatisfaction	☒ Medi-Cal	Continually assess customers' satisfaction with the UM process to identify areas that can be improved. Interventions are made to improve satisfaction levels where dissatisfaction is identified	The Plan strives to improve Satisfaction with UM Process. Annually satisfaction surveys are conducted and followed by: • Review of satisfaction survey data and trends. • Comparison of survey results with other source data. • Prioritization and implementation of interventions to improve member and practitioner satisfaction with UM processes. • Re-measurement of satisfaction periodically to ensure interventions is effective. Improved member and practitioner satisfaction results based on surveys and other satisfaction data, including but not limited to: <u>Member</u> Consumer assessment of healthcare providers and systems (CAHPS) survey and Member Grievances <u>Practitioner Survey</u> Provider Satisfaction Survey	Complete annual Member and Practitioner Satisfaction surveys to assess satisfaction with UM Process. Assess annual satisfaction survey outcomes. Monitor Member Grievances to assess satisfaction with UM process. Results are reviewed through Access and Appeals and Grievances work groups and reported to CalViva QIUM Committee	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and PHCO manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2025 Goals: • 2% reduction in Acute Bed days over prior year • Achieve ALOS <5 • Maintain 11% or below 30 day readmission rate	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data and predictive modeling to identify high cost/high utilizing members to target for care management. The UM team will continue transitional care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. Support on-site and telephonic enrollment of members into programs such as CalAim, Complex Care Management and Community Supports. Explore areas for additional on-site support (non clinical).	Ongoing

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics are reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and Plan include SPD, MCE and TANF populations: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. Specialty referrals for target specialties PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. Health Net tracks PHM KPI quarterly including: • Percentage of members who had more ED visits than primary care visits within a 12-month period; • Percentage of members who had a primary care	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net (Central Valley) and Health Net Medi-Cal State wide. PPGs with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Reevaluate appropriate metrics to be included in the PPG dashboard. Specialties and PPGs identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional joint operations meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard. Direct network and PPG membership over/under utilization report includes ambulatory care measures (OP visits PTMPY, ED visits PTMPY) and selected surgical procedures PTMPY as markers of over-under utilization and is reported to CalViva MOM semi-annually in the MOM 18 PPG Dashboard. Adjust PHM KPI reporting per DHCS guidance as needed.	Ongoing

			visit within a 12-month period; • Percentage of members with no ambulatory or preventive visit within a 12-month period.		

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Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
3.3 PPG Profile and Vendor List	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM. The MOM 20 vendor list provides audit dates and findings for each vendor. For completed audits an audit summary is shared with the monthly report, detailing audit results. Issues identified during audits or via ongoing performance monitoring are included in the monthly MOM 20 update.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The PPG Profile Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN. The Health Net vendor audit and monitoring process includes annual auditing of delegates' policies and files and ongoing review of delegates' adherence to service level performance.	Ongoing

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

4. Monitoring Coordination with Other Programs

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
4.1 Care Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. Reviewing Member self-referrals to ECM and Community supports and referring members to ECM providers as appropriate. Members not meeting criteria will be referred to care management.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report including PHM Key Indicators to track and trend Care Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in care management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction o Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and o Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge. o ECM Enrollment and Graduation Rates	Dedicated staff of RNs, LCSWs, Care Navigators, Care Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Work group. Transitional Care Services staff to do onsite bedside enrollment of members into TCS program at Hospital/Facilities. TCS to transition members to Physical Health (PH) or Behavioral Health (BH) CM teams after immediate discharge needs have been met. Collaboration with PPGs, Providers, Facilities on members who would benefit from Care Management to support appropriate interventions and improve member outcomes. ECM program and provider performance by county are reported quarterly CVH UM/QI Committee	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Care Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPGs of patients identified for program. Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high-risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Care Navigators, and Care Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Provide members with education about and referrals to Doulas throughout their pregnancy. Help members schedule prenatal and postpartum appts. Help members schedule their newborn child first well child exam visit, and refer into our First Year of Life Program. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Work group.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFTs, and Care Navigators to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Partner with Health Net Behavioral Health Teams to increase referrals to BH CM team to support outreach to follow up with Members who were provided resources. Help members schedule appointments with BH CM providers and connect with resources in the community to meet Member's SDOH needs. Collaborate with ECM and CS providers to ensure warm hand off of members care plan needs. Provide guidance to ECM CM taking over members care related to benefits as appropriate. Outcome measures are included in the CCM Quarterly reports and reviewed in the QI UM Committee.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a Chronic Condition Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes.	Eligibility data from sources such as: pharmacy, medical claims, and referrals. Plan Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Annual review of prevalence data to monitor Chronic Condition Management program offerings. Obtain DHCS approval and implement redesigned Disease/Chronic Condition Management program offerings..	Ongoing 12/31/2025 12/31/2025

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2025 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	State Health Program (SHP) MDs, the Health Net Pharmacy Advisory Committee (PAC) and the CalViva Health Chief Medical Officer work with Pharmacy Department to refine the injectable guidelines for medical benefit drugs to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy Department to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy Department to improve CCS ID using pharmacy data.	Monthly report of PA requests.	Continued active engagement with pharmacy. CVH UM/QI reporting based on Medical Benefit drug review. DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
4.6 Behavioral Health (BH) Care Coordination	☒ Medi-Cal	CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals.	Review data that indicates when a member was referred to the County for services to ensure that the behavioral health team staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that the behavioral health team provides.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios --- Authorization Decision Timeliness: goal 100% with corrective action initiated at <95%	Participate in cross functional team to improve quality of behavioral health care. Consistent monitoring of performance measures to ensure continued compliance.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2025 Planned Interventions	Target Completion Date
5.1 Monitor California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Identify 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, care management, pharmacy, claims review, member appeals and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Collaborate with Public Programs and Coordination of Care Team to facilitate transition of Independent Care Facility CCS membership (begins July 1st 2025). Continue to monitor Aging-out membership, identified 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

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Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2025 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Care Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2026**				

Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

Item #13
Attachment 13.A

Case Management

2025 Program Description
& Change Summary

Health Net Community Solutions and CalViva Health Care Management Program Description 2025

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Table of Contents

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PURPOSE

The purpose of the Care Management Program Description is to define care management, identify care management functions, describe methods and processes for Member identification, assessment, components of managing Member care, and measuring outcomes.

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

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

In both delegated and non-delegated situations, the Care Management program provides individualized assistance to Members experiencing complex, acute, or catastrophic illnesses, and to Members who are out-of-area. The focus is on early identification of high-risk Members, applying a systematic approach to coordinating care and developing treatment plans that will increase satisfaction with their providers, and improve health and functional status. In addition, certain Care Management responsibilities are an integral part of Carve-Out and Public Health programs (e.g., California Children's Services, Regional Centers).

The Plan provides a comprehensive, high-risk perinatal program to Members regardless of delegation status. Care Managers work with PCPs and other providers to develop individualized plans for appropriate Members.

SCOPE

Definition of Care Management

Care Management is a key component for managing the health of the population. The Plan adheres to the Case Management Society of America's (CMSA) definition of case management; "A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and quality cost effective outcomes".
The Plan also abides by the principles of case management practice, as described in CMSA's most recent version of the Standards of Practice for Case Management, revised in 2022.

The Care Management program and the tools utilized to manage care were developed from evidence-based clinical practice guidelines and preventive health guidelines adopted by Centene and the Plan. The assessments utilize the CMSA Standards of Practice for Case Management and other evidence-based tools including the Patient Health Questionnaire-2/9 (PHQ2/9). Disease-specific assessments include research of latest scientific sources, along with articles and publications from national organizations such as the American Diabetes Association. The Program also adheres to Healthcare Effectiveness Data and Information Set (HEDIS),

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effectiveness of care measures and the associated technical specifications to promote Member adherence.

Care Management associates are trained in and utilize motivational interviewing techniques to guide Member goal identification and associated actions.

Levels of Care Management Include:

1. **Basic Population Health Management (BPHM)**
   A. **Care Coordination** – Appropriate for Members with primarily social determinants of health (SDOH) such as housing, financial, etc. with the need for referrals to community resources for assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services at this level of coordination include outreach to Member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure follow-through. In addition, this level of care management is used for continuity of care transitions and supplemental support for Members managed by the county.
   B. **Care Management** – Appropriate for Members needing a higher level of service, with clinical needs. Members in Care Management may have a complex condition or multiple co-morbidities that are generally well-managed. Members in Care Management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services at this level include those provided at the level of Care Coordination along with identification of Member agreed-upon goals, identification of interventions needed to meet the goals, and necessary support to meet those goals.
2. **Complex Care Management (CCM)**
   CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. CCM is for Members with complex needs, including Members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. CCM is provided by Health Net for Members who need additional support to avoid adverse outcomes, and/or those who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the Member receives appropriate services and care. Services at this level include all Care Coordination and Care Management services described above, along with more frequent Member contact to assess continued appropriateness and adherence with their treatment plan, and progress towards meeting goals. Care Managers monitor Members' key indicators of disease progress, e.g., hemoglobin A1c levels and medication adherence. Care Managers also evaluate Members for referral to Enhanced Care Management (ECM) services as appropriate.

Goals and Objectives

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

- Assist Members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.

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

The Goals of the Care Management Program are:

Measure	Goal	Frequency
Member experience survey – each question and overall	> 90%	Annual
Member complaints/grievances	< 1/10,000	Annual
Reduce Non-Emergent ER Visits	> 10%	Annual
Reduce Readmissions	> 5%	Annual
Members managed in high-risk OB program have greater % of Members completing the 1st pre-natal visit within the 1st trimester or 42 days of enrollment than pregnant Members not managed.	> 8% difference	Pregnancy
Members managed in high-risk OB program have greater % of Members completing the post-natal visit between 7-84 days post-delivery than pregnant Members not managed.	> 10% difference	Pregnancy
Members managed in high-risk OB program have a lower rate of pre-term delivery than high risk Members not managed.	>2% lower rate	Pregnancy

Care Management Functions:

Care Management Functions Include:

- Early identification of Members who have special needs.
- Assessment of Member's risk factors.
- Development of an individualized plan of care in concert with the Member and/or Member's family, PCP, and managing providers.
- Identification of barriers to meeting goals included in the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Referrals and assistance to ensure timely access to providers.
- Active coordination of care linking Members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the Member's changing condition.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/care management activities.
- Addressing the Member's right to decline participation in the Care Management program or disenroll at any time.

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- Accommodating the specific cultural and linguistic needs of all Members.
- Conducting all care management procedures in compliance with HIPAA and state law.

Program Segments

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

Complex Care Management Criteria

The Plan uses the Population Health Management (PHM) report to identify Members for Complex Care Management. The PHM report combines data from multiple sources to use in its population and program eligibility process. Data elements from multiple sources are stored in data warehouses. Data from the warehouse is extracted into a predictive modeling tool, Impact Pro. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from Plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information. Members are stratified into one of ten Population Health Categories in Impact Pro: Level 01: Healthy to Level 10: End of Life. In addition to Impact Pro, a web-based customizable report generating system, MicroStrategy®, is used to produce adjunctive analytical reports for related PHM programs including Complex Care Management.

Members stratified as described below are identified as complex and are referred to care management.

Members stratified into one of the PHM report categories below:

- 08b High Priority Homeless/SUD
- 07b High Priority PH CM
- 07a high Priority BH CM
- 05d Chronic Highly Complex
- 05c Chronic High Risk - With Care Gap (under Clinical Analytics Population Grouping)
- 05b Chronic Moderate Risk

AND have:

- ER likelihood: highly or most likely

Members referred from other sources may also be managed as a complex care based on the Member's need.

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

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INFRASTRUCTURE AND TOOLS

Organizational Structure

CalViva Health Quality Improvement/Utilization Management Committee

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

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

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

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

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CalViva Health Staff Resources and Accountability

CalViva Chief Medical Officer

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

Department Resources

CalViva staff, with assistance from HNCS interdisciplinary staff, contribute to the success of the CalViva Utilization Management & Case Management (UMCM) Program. These administrative and clinical staff work with CalViva's Chief Medical Officer and Director of Medical Management to oversee UMCM activities for CalViva's Medi-Cal Members and provider network. The resources and responsibilities of departments most involved in the UMCM process are described below.

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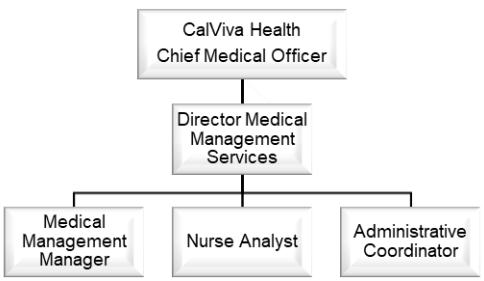
Medical Management Team

The Medical Management team will include a Chief Medical Officer, Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Nurse Analyst, and an Administrative Coordinator to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis. CalViva and HNCS will ensure that staff involved with the Utilization & Care Management programs are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.



Health Net Organizational Structure

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO responsibilities include assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network; overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/Utilization Management operations.

The Health Net, LLC CMO has decision-making responsibilities for medical matters across the California market of affiliated health plans. The CMO oversees, directs and coordinates all health services functions in partnership with the Health Net Community Solutions' CMO/Vice President Medical Director, Health Net's Vice President Medical Director, Vice President of Medical Affairs, Medical Directors, Quality Improvement, and Appeals and Grievances associated with Quality of Care and Program Accreditation.

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

Health Net Community Solutions Inc., (HNCS) CMO/ Vice President (VP) Medical Director

The HNCS CMO/VP Medical Director, is responsible for Utilization Management and Care Management activities for Medi-Cal including resolving Grievances related to quality of care. In addition, the CMO/VP Medical Director is responsible for QI activities for these programs. The CMO/VP Medical Director is the chair of the HNCS QIHEC and is actively involved in implementing the HNCS UM Program. The HNCS CMO/VP Medical Director reports to the Health Net, LLC CMO with direct access to the Health Net President.

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

Behavioral Health Practitioner

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

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

The VP PHCO is a registered nurse with experience in utilization management and care management activities. The VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management programs. The VP PHCO reports to the Plan

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The Health Net Community Solutions (HNCS) Chief Medical Officer (CMO) has operational responsibility for and provides support to the Plan's Care Management program. The Plan CMO, Sr. Vice President of Population Health & Clinical Operations (SVP PHCO), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the Care Management program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to care management. A behavioral health practitioner participates in the implementation, monitoring, and directing of behavioral health aspects of the Care Management program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the CMO, the Plan may have one or more Medical Director and/or Associate Medical Directors.¶
The HNCS CMO's responsibilities include, but are not limited to, coordination and oversight of the following activities:¶
Assist in the development and revision of care management policies and procedures as necessary to meet state statutes and regulations.¶
Monitor compliance with the Care Management program.¶
Provide clinical support to the care management staff in the performance of their care management responsibilities.¶
Provide a point of contact for practitioners with questions about the care management process.¶
Communicate with practitioners as necessary to discuss care management issues.¶
Assure there is appropriate integration of physical and behavioral health services for all members in care management as needed.¶
Educate practitioners regarding care management issues, activities, reports, requirements, etc.¶
Report care management activities to the Quality Improvement Health Equity Committee and other relevant committees.¶

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Chief Operating Officer. The VP PHCO, in collaboration with the CMO, assists with the development of the Care Management program strategic vision in alignment with the Corporate and Plan objectives, policies, and procedures.

Care Management Director

The Care Management Director is a registered nurse or other appropriately licensed healthcare professional with experience in care management activities. The VP PHCO is responsible for overseeing the operational activities of the Plan's Care Management program. The Care Management Director reports to the Vice President of Population Health & Clinical Operations and assists with the development and oversight of the strategy, policy, and operational planning and execution of work processes for the Care Management program. The Care Management Director works in conjunction with the Utilization Management Director to execute the strategic vision of Plan objectives and attendant policies and procedures and state contractual responsibilities.

Care Management Manager

The Manager of Care Management is a registered nurse or other appropriately licensed healthcare professional with care management experience. The Manager assists with the planning and execution of work processes for the Care Management program. The Manager partners with other departments and providers to assist in reaching dept goals and execute plan projects. The Care Management Manager directs and coordinates the activities of the department including supervision of Supervisors and Lead Care Managers. The Care Management Manager reports to the Director of Care Management.

Supervisor, Care Management

The Supervisor of Care Management is a registered nurse or other appropriately licensed healthcare professional with care management experience. The Care Management Manager directs and coordinates the activities of the department including supervision of Care Managers, Care Navigators, Resource Specialist and Care Coordinators. The Supervisor Care Manager reports to the Manager of Care Management.

Supervisor, Care Coordinator (CC)

The Supervisor CC is highly skilled high school graduate or equivalent with 5 or more years of prior authorization, physician's office, customer service, claims processing or provider relations experience, preferably in a managed care setting. The Supervisor CC oversees day to day operations and supervision of the Care Coordinators in CM and performs collaborative duties related to coordinated care programs. The Supervisor CC provides support to the Care Coordinators to promote quality and continuity of services delivered to Members and providers. The Supervisor CC reports to the Manager of CM.

Care Team (CT) Staffing Model

Care Coordination/Care Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-licensed personnel to perform non-clinical based health service coordination and clerical functions and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Management staff work closely with the concurrent review staff to coordinate care when Members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health

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The Manager of Care Management is a registered nurse or other appropriately licensed healthcare professional with care management experience. The Care Management Manager directs and coordinates the activities of the department including supervision of Care Managers, Program Specialists and Program Coordinators. The Care Management Manager reports to the Director of Care Management. ¶
Supervisor, Program Coordinator (PC)¶
The Supervisor PC is highly skilled high school graduates or equivalent with 5 or more years of prior authorization, physician's office, customer service, claims processing or provider relations experience preferably in a managed care setting. The Supervisor PC oversees day to day operations and supervision of the Program Coordinators in CM and performs collaborative duties related to coordinated care programs. The Supervisor PC provides support to the Program Coordinators to promote quality and continuity of services delivered to members and providers. The Supervisor PC reports to the Director of CM.¶

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information for each Member that includes medical, behavioral health, and all other services the Member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the Member needs, a Care Manager's average active case load may be up to 75 cases. The high-risk pregnancy program Care Managers may hold 150 caseload as they also carry first year of life cases that have less frequent outreach. The Integrated Care Team roles and responsibilities include care managers, other licensed clinical staff, non-licensed social workers, and care coordinators.

Medical Director

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

Care Manager (CM)

- Registered Nurse (RN), Licensed Marriage and Family Therapist (LMFT), or Licensed Clinical Social Worker (LCSW)
- CM certification preferred.
- Responsible for collaborating with the Member and their physician to identify needs and create a care plan to help the Members achieve their goals.
- Participates in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the Member's treating providers.
- Communicates and coordinates with the Member and their caregivers, physicians, behavioral health providers, Disease Management staff, and other Members of the care team to ensure that Member's needs are addressed.

Care Navigator/Resource Specialists/Transition Specialist (CN/RS/TS)

- Non-licensed Social Worker or licensed vocational nurse.
- May be assigned lower acuity caseload and responsible for following all standards of care management practice.
- Provides support for moderate or low risk Members.
- Collects data for Health Risk Screening.
- Provides information to CM for care plan.
- Provides telephonic or in-person outreach to Members as appropriate
- Provides educational promotion, Member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager/Program Specialist.

Care Coordinator (CC)

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

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- Provides telephonic outreach to Members to enroll in CM programs.

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

Information System

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

The clinical documentation system contains additional clinical information, e.g., inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the Member. It also houses documentation of other activities regarding the Member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Management staff to add all providers and facilities associated with the Member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a Member's case in one central location.

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

MEMBER IDENTIFICATION AND ACCESS TO CARE MANAGEMENT

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

Data Sources

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

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data

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

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

Referral Sources

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

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Care Management program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.
- Nurse Advice Line has policies and procedures in place for referring Members to the Health Plan for care management screening. This may be accomplished via a "Triage summary report" that is sent to the Plan electronically on the next business day after Member contact has occurred, or by direct communication with the designated contact person at the Plan.
- Disease Management (DM) program staff work closely with the Care Management staff to refer Members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as care management rounds, are held between the care team and DM staff.
- Hospital staff (e.g., hospital discharge planning and emergency department staff) are educated about the Plan's Care Management program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff are encouraged to inform Plan UM staff if they feel a Member may benefit from care management services; UM staff then facilitate the referral.
- Health Plan staff, including Utilization Management, work closely with Care Management staff on a daily basis and can initiate a referral for care management services verbally or through a referral task in the clinical documentation system when a Member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - Health Plan Member Services - Member Services staff is also trained in all departments within the Plan and have a full understanding of all staff functions, including the role and function of the care team.
    - Other intradepartmental referrals e.g., Provider Specialists, Plan Advocates, and QI Department.

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- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - Members are educated about care management services in the Member Handbook, received upon enrollment and available on the Plan website, Member newsletters, and through contact with Member Services and/or other Plan staff.
- Community/social service agency staff are informed of the Care Management program during interactions with Plan staff in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential care management needs to Plan staff (California Children's Services (CCS), Local Health Department (LHD), Local Mental Health Plan (MHP) etc.).
- State agency/state enrollment center.

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

SCREENING AND ASSESSMENT

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within seven (7) calendar days of identification as a potential candidate for care management. Care Team staff complete the care management screening and/or initial assessment once Member contact is made. Care Team staff also explain the Care Manager role and function, and benefits of the Care Management program to the Member and/or their authorized representative or guardian. Members can opt out of Care Management at any time.

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

Members and/or their authorized representative or guardian are enrolled in the Care Management program and are informed they may opt out or decline participation/disenroll from care management at any time.

The Member/guardian is notified of the potential need for the Care Team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information, and is informed that Member consent is always obtained prior to any contact. If a Member declines participation, it is documented.

Members unable to be contacted via telephone, following multiple attempts, are mailed a letter requesting that the Member call the Care Team.

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Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly stable, and the Member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are assigned to a care manager who confirms the findings of the screening assessment and may complete a more thorough assessment with the Member. Outpatient outreach to Members is initiated within seven (7) calendar days and completed within 21 calendar days of identification/referral. Inpatient outreach to Members is initiated within one (1) business day, and a minimum of three (3) outreaches in three (3) business days are made. A Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data, if available, that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the Member based on their diagnosis/es and/or medical treatment history. Stratification as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Care Management, or Complex Care Management may be revised at this time or following further assessment.

The Care Manager then begins outreach to the Member and/or authorized representative or guardian telephonically within one (1) day for inpatient Members, and within one week for outpatient Members identified as high priority and appropriate for Complex Care Management to perform an in-depth assessment to identify and prioritize the Member's individual needs. An additional, condition-specific assessment may also be completed to obtain more detailed information about a Member's condition(s). These condition-specific assessments, such as the Diabetes and Asthma assessment, are derived from evidence-based clinical guidelines. During the in-depth care management assessment, the Care Manager evaluates the full scope of the Member's situation and documents their conclusions about the data collected, including:

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

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- Evaluation of need for, and availability of, community resources.
- Assessment of educational and vocational factors.

Care Managers also frequently reach out to the referral source, the Member's PCP, other providers, hospital care managers, and any others involved in the Member's care, to gather additional information that can assist in building a complete picture of the Member's abilities and needs. The role and function of the Care Manager is also explained to the Member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The Care Manager reviews the gathered information and begins to build a plan of care. The initial assessment and plan of care are started within 30 days of enrollment in Care Management. The assessment is completed in 30 days for non-complex cases. For complex cases the assessment is completed no later than 60 days after the identification/referral of the Member to Care Management (per National Committee for Quality Assurance [NCQA] standards), but in most cases is completed earlier. A Member is considered eligible for care management services upon their consent to participate unless otherwise defined by individual state laws. Members case and care may be managed by one Care Manager or a Care Team. Care teams may include Care Managers: RN and LCSW/LMFT Care Navigators, Care Coordinators, and/or Transition Specialist. Each contributes different skills and functions to the management of the Member's case. Other key participants in the development of the care plan may include:

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

Behavioral Health Services

The Plan is responsible to provide mild to moderate mental health services to all Members, including Applied Behavioral Analysis (ABA) when medically necessary. The Plan strongly supports the integration of both physical and behavioral health services through screening, prevention, and early intervention. Specialty mental health services are not covered under the Plan and are paid under Medi-Cal FFS. The Plan ensures that Members who need Specialty Mental Health Services are referred to and are provided these services by an appropriate Medi-Cal FFS mental health provider or the local mental health plan in accordance with contract requirements. The Plan will assist Members with scheduling referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care. The Plan also assists individuals

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requesting Voluntary Inpatient Detoxification (VID) services and provide care coordination to assist the Member in locating a general acute care hospital (may not be a chemical dependency treatment facility or institution for mental disease).

Continuity and Coordination of Care between Medical and Behavioral Health Care

When staff identifies a Member with coexisting medical and behavioral health disorders, the identifying staff will notify the Plan Care Manager. Whether the Member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health Care Manager will serve as the Primary Care Manager. The medical and behavioral health Care Managers confer with each other to confirm which Care Manager will serve as the primary or secondary Care Manager. If the Care Managers cannot agree, a supervisor is consulted for a decision.

When assigned to a physical health Care Manager, they review the Member's clinical information to ensure the Member is receiving appropriate behavioral health care. If the Member does not appear to be receiving appropriate care, the Care Manager:

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

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

Coordination with External Programs

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

ONGOING MANAGEMENT

Plan of Care Development

The initial assessment serves as the foundation for the Member's care plan. The Care Team identifies issues and needs, and utilizing input from team participants, develops a proposed care plan. The care plan is developed in conjunction with the Member, the Member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the

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care plan as needed. Prioritized goals are established and barriers to meeting goals are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of discharge planning as applicable, support systems to assist in the home setting, community resources/services availability, and the potential for Member adherence to the prescribed care plan.

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

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

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

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

Monitoring and Evaluation

Once the plan of care is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Revisions to the care plan are made when necessary, e.g., when the Member's condition progresses or regresses, when goals are reached. Significant revisions to the plan of care are also shared with the PCP. A schedule for follow up and monitoring of the Member's progress

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is developed, using as a minimum the intervals defined according to priority level and current needs. The Care Manager may assign tasks to other members of the Care Team, such as a Care Navigator to manage or assist with social determinants of health issues or a Care Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

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

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

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

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

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

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The Care Manager completes a re-assessment at any time the Member has a significant change of condition or, at a minimum, once per year if the Member remains active in care management.

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If the Member loses eligibility for more than 30 days, then a new assessment is performed upon enrollment back into the complex care management program to ensure the Member is being assessed for current care management needs. The plan of care is also updated at these times and shared with the PCP, as applicable.

The Care Manager implements necessary changes to the care team care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, or other members of the health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The care team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the Member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved are in agreement with changes to the care plan to ensure ongoing success. The care team also monitors the case on an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement Department.

Discharge from Care Management

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

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

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

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

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A letter noting the Member is discharged from Care Management is generated and sent to the PCP and the Member. The letter documents the reason for discharge and includes, if the Member has not terminated with the Plan, a reminder to contact the care team in the future should medical concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented. A Member satisfaction survey may be initiated by email, text, or phone.

PROGRAM ASSESSMENT AND IMPACT MEASUREMENT

Population Health Assessment

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

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

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

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

Member Experience with Care Management

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

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program, which may be part of the annual Quality Improvement and/or Utilization Management program evaluation as described below.

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

Outcomes

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

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

The Plan measures effectiveness of Complex Care Management no less than annually using at least three (3) measures that assess the process or outcomes of care for Members in Complex Care Management. Measures of effectiveness may include indicators such as:

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

The Care Management program is evaluated at least annually and modifications to the program are made, as necessary. The Plan evaluates the impact of the Care Management program by using:

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

The evaluation covers all aspects of the Care Management program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Quality Improvement Utilization Management (QIUM) Committee for review, action and follow-up.

Condition Specific CM and Chronic Condition Management Programs

Members in condition specific Care/Chronic Condition Management programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The Care Management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation,

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coordination with behavioral health, and discharge from Care Management when not specifically addressed in the Program. Chronic Condition Management has been delegated to the Centene Corporate Disease Management team and the Plan Care Manager coordinates care and Member interaction to prevent duplication of contacts and services.

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

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

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

- Asthma
- Diabetes
- Heart Failure

SPECIAL PROGRAMS
CalAIM

CalAIM is a multi-year 5+ framework program developed by the Department of Health Care services (DHCS) encompassing a broad-based delivery system, program, and payment reform across Medi-Cal. The focus is to address the complex challenges facing the Plan's most vulnerable Members. It also provides for non-clinical interventions focused on the whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities. Enhanced Care Management (ECM) and Community Supports are the first two programs that launched on January 01, 2022. Populations of Focus (POF) in 2022 and 2023 were those Members that were previously in (WPC) or (HHP); Adults and Their Families Experiencing Homelessness; Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization; Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; Adults with Intellectual or Developmental Disabilities (I/DD); Adults who are Pregnant or Postpartum; Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; Adult Nursing Facility Residents Transitioning to the Community; Adults without Dependent Children/Youth Living with Them Experiencing Homelessness; Children & Youth Populations of Focus. Populations of Focus for 2024 were Birth Equity; Individuals Transitioning from Incarceration; and Pre-Release Medi-Cal Services.

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

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Personal Care Services and Homemaker Services; Recuperative Care; Respite Services; Short-Term Post-Hospitalization Housing; and Sobering Centers.

Members can self-refer to ECM and assigned staff will make contact to determine if they fall within the POF. If they are, staff will send notification to the assigned ECM provider to outreach to the Member. Care Management staff may also refer Members to ECM services if they identify Members in a POF and would benefit from ECM services. Care Management staff also regularly refer Members to CS. Members accepted into ECM cannot be in the Plan's Complex Care Management program due to duplication of services, but can still be referred to Community Support services, Condition Specific Disease Management programs, and the Transitional Care Services Program.

Transitional Care Services (TCS)

The purpose of Transitional Care Services (TCS) is to provide a comprehensive, integrated transition process that supports Members during movement between levels of care. Care Transition Interventions may include 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 Care Manager works to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a Member-centric approach, the model incorporates three evidenced-based care elements of inter-disciplinary communication and collaboration, Member/participant engagement, and enhance post-acute care follow-up.

TCS includes:

- Conducting an initial outreach call within 72 hours of inpatient referral to complete an inpatient discharge risk assessment
- A minimum of two follow-up calls are made to the Member within 15 days of discharge
- Initiating Community Support referrals as appropriate
- Focus on the Member's goals and treatment preferences during the discharge process
- Review of the Member's disease symptoms or "red flags" that indicate a worsening condition and strategies for 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 Member's self-management role
- Educating the Member to follow up with the PCP/and or specialist within 7 days of discharge, and providing scheduling assistance if not listed on the post-discharge instructions
- Ensuring Member transition is successful and needs are met
- Actively engages the Member in medication reconciliation including how to respond to medication discrepancies

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Deleted: The purpose of the TOC program 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. TOC Care Manager responsibilities including information sharing, discharge risk assessment, discharge planning documentation, medication reconciliation, referrals, are addressed when updating the Transition of Care policy and procedures. Care Transition interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post-discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post-discharge stay is essential in navigating the health care continuum and addressing barriers to post-discharge success for the member.¶
The TOC program ensures a smooth transition from one setting to another and reduces 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

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Ensuring member transition is successful and needs are met¶
Post-discharge medication reconciliation

During the post-discharge period, staff evaluate the Member to provide effective support to the Member in managing their continued needs. Members are referred to Care Management, Complex Care Management programs, or ECM as appropriate for ongoing/longer term support.

CalViva Pregnancy Program

The pregnancy program incorporates the concepts of care management, care coordination, chronic condition management, and health promotion, teaching members how to have a healthy pregnancy through 60 days postpartum. In addition, the program supports the following:

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

The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for the baby. High-risk pregnancies receive additional care management services.

First Year of Life (FYOL)

The FYOL program is available for children from birth to fifteen (15) months old. The purpose of the FYOL program is to increase HEDIS rates for Well Child Visits and immunizations, reduce unnecessary/inappropriate emergency room visits, and provide parent/caregiver support. The Program consists of Care Managers and Care Navigators with pediatric nursing and/or post-partum outreach experience. Telephonic outreach is completed at 2, 4, 6, 9, 12 and 15 months. Calls are completed two (2) weeks prior to each scheduled Well Child Visit. Program staff help with establishing pediatric care, complete age-appropriate assessments, and provide education.

REFERENCES: NCQA 2024 Health Plan Standards and Guidelines

REVISION LOG

REVIEW TYPE (New, Annual, Ad Hoc)	REVISION SUMMARY	DATE APPROVED
New Policy Document	Program Segments: Complex Case Management Criteria section updated to reflect new Population Health Categories in ImpactPro. Program Assessment and Impact Measurement: updated to reflect Plan's overall population assessment - not limited to CM.	11/28/18

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	Member Experience with Case Management deleted or 60 days after >45 days. Condition Specific CM and DM programs deleted DM programs not offered. Attachments: removed reference to Complex CM Program Description as information is consolidated into one document. Other minor grammatical and formatting changes made throughout.	
Annual Review	Screening and Assessment: changed reference to outreach by priority to calendar days for all for consistency.	2/13/19
Annual Review	1. Goals of CM program added outcome measure for pre-term delivery and clarified goal percentage is percentage difference for the OB measures. 2. Infrastructure and Tools, Organizational Structure changed Chief Medical Director to VP Medical Affairs, updated VPCM to Sr. VPMM. 3. Care Team Staffing, changed average caseload of 40-50 to average active caseload of 62. 4. Screening and Assessment, paragraph 1, changed outreach initiated within 30 calendar days to 7 calendar days. Paragraph 5 changed to outreach is initiated within 7 calendar days and completed within 14 calendar days. 5. Discharge from Case Management, bullet 4, deleted WIC. 6. Outcomes, added pre-term delivery as an outcome measure for OB program. Condition Specific CM and DM programs, plan program list changed Post Hospitalization Follow-up Care to Transitional Care Management.	1/13/20
Annual Review	1. Levels of Case Management added header for Non-complex CM 2. Goals of CM program updated time frame for postpartum visit and clarified goal percentage for pre-term delivery. 3. Updated criteria for Complex CM, and Case Management. 4. Integrated care team meetings updated frequency and added weekly huddles. 5. Infrastructure and Tools, Organizational Structure added description for VPMM and updated reporting for Director CM. 6. Care Team Staffing, changed average active caseload to up to 70.	1/21/21

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	7. Members Experience with Case Management updated methods used to complete survey and related criteria. 8. Added Special Program section including subsections for TCM and Palliative Care References – updated NCQA standards to 2020.	
Annual Review	1. Changed Dept to Care Management 2. Updated criteria for Complex CM, and Case Management. 3. Care Team Staffing, changed average active caseload to up to 73. 4. Members Experience with Case Management updated methods used to complete survey and related criteria. 5. Updated what the TOC program includes 6. Updated template 7. Added CalAIM to special programs 8. Changed Disease Management program to Chronic Condition Management	1/4/22
Annual Review	1. Updated Dept to PHCO 2.Added information about medical home/PCP expectations in Purpose section. 3. Updated job titles for VP and SVP. 4. Updated levels of CM section to include Basic Pop Health management. 5. Added FYOL program in special programs. 6. Updated CalAIM info. 7. Updated DM and NurseWise teams to reflect change from EPC to Corporate. 8. updated all program references from Case Management to Care Management	1/9/23
Annual Review	1.Removed Palliative Care program, as this is now a benefit, 2. Updated job titles (removing VP PHCO and adding CM Director, changing VPMM to CMO), 3. Updated TOC program description, 4. Updated NCQA Standards reference to 2024. 5. Removed references to Member Connections.	1/16/24
Annual Review	1.Updated job titles in org structure and throughout 2.Updated TCS program elements as needed 3.Updated CM goals	1/7/25

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	4.Care Team Staffing, changed average active caseload to up to 75 for PH/BH CM, and 150 for OB CM. 5.Added CalViva Pregnancy Program to Special Program section.	

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Please note: This Microsoft Word File is not 36 CFR 1194, Section *508 Compliant and not meant for electronic distribution. For an electronic PDF file of this policy, please refer to the Medical Management Remediation Work Process (MM.PM.03)*

POLICY AND PROCEDURE APPROVAL

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

Attachment

REPORT SUMMARY TO COMMITTEE

TO: CalViva QI/UM Committee

FROM: Carrie-Lee Patnaude, Care Management

COMMITTEE DATE: February 20, 2025

SUBJECT: Care Management (CM) Program Description Change Summary

Summary:

CM Redline Page #	Section/Paragraph name	Description of change
1	Title page	Updated year from 2024 to 2025
5	CM goals	Updated CM goals
7-10	Organizational Structure	Added in CalViva QI/UM info and organization, updated health net job titles (removed VP PHCO and added CM Director, VPMM changed to CMO), removed Member Connections.
11	Care Team Staffing	Care Team Staffing, changed average active caseload to up to 75 for PH/BH CM, and 150 for SSFB CM.
24	Transitional Care Services	Updated Transitional Care Services program section to reflect required elements
25	CalViva Pregnancy Program	Added CalViva Pregnancy Program to Special Program section.

Item #14
Attachment 14.A

Compliance

2024 Annual Compliance Program Evaluation

CALVIVA HEALTH
2024 ANNUAL REGULATORY AFFAIRS & COMPLIANCE EVALUATION

I. EXECUTIVE SUMMARY

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

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

The Compliance Program is guided by the Plan's mission "To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners." The Compliance Program is implemented by all Plan Departments: Compliance, Medical Management, and Finance. The Compliance Program results are the collective achievements of dedicated Plan staff members, the Plan's Administrator (Health Net Community Solutions, Inc.), providers, and community-based organizations working together to meet the needs of CalViva Health members and the communities it serves.

In 2024, the Compliance Program was focused on the following key activities and initiatives:

- Achieving National Committee for Quality Assurance (NCQA) Accreditation (July 19, 2024);
- Developing a Diversity, Equity, and Inclusion (DEI) training curriculum;
- Implementing DHCS' requirement to execute new Memoranda of Understanding (MOUs) with third-party entities;
- Responding to the 2023 Department of Health Care Services ("DHCS") Focused Audit Corrective Action Plan (CAP), and the 2024 DHCS Audit CAP;
- Responding to the 2022 DMHC Audit Final Report and CAP;

- Successfully completing the 2024 Health Services Advisory Group (HSAG) Network Validation Audit;

- Implementing the Plan's California Advancing and Innovating Medi-Cal (CalAim) Models of Care for the Children and Youth and Justice Involved populations of focus ("POF");

- Completing the carve-in of the Subacute Care Facilities and Intermediate Care Facilities (ICF) for individuals with developmental disabilities (ICF/DD Homes, ICF/DD-H Homes, and ICF/DD-N Homes).

Overall, the Plan maintained its network adequacy, compliance with timely access standards, In 2025, the Compliance Program will continue to focus on meeting the new regulatory requirements associated with the DHCS Contract and newly enacted statutes, applying for NCQA Health Equity Accreditation, closing out any open DHCS and DMHC CAPs and improving performance by maintaining overall operational effectiveness.

II. REGULATORY AFFAIRS

A. Administrative and Operational Regulatory Reporting

As a licensed health plan, CalViva Health is required to submit a wide variety of information and data for review and approval to the DMHC in compliance with Knox-Keene regulations, and to the DHCS in compliance with its contract, Medi-Cal regulations, and All Plan Letters ("APLs"). Regulatory filing activities include but are not limited to: DMHC's Knox-Keene license amendments (e.g., material modifications, annual timely access/annual network reports, changes in commission/committee members); and DHCS contractual requirements (e.g., annual network and subnetwork certification, fraud waste and abuse case submissions, member-informing materials, new benefit-associated deliverables, and required policies and procedures).

In 2024, CalViva Health made over 400 regulatory filings to DMHC and DHCS. These filings do not include the various "routine" monthly/quarterly program data reports or audit-related information that are sent to the two agencies. In addition to regulatory filings and report submissions, the Plan underwent an annual audit by DHCS and an annual DHCS HEDIS® audit. Any agency's findings were all addressed by the Plan through the regulatory agency's CAP process as needed.

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

1. Department of Health Care Services (DHCS):

- 2023 DHCS Focused Audit - On 8/30/24 the Plan received DHCS' Final Report, and on 9/6/2024 the Plan received DHCS CAP Request. There were nine deficiencies in total (4 for behavioral health and 5 for transportation). Since that time, the Plan

has submitted the required monthly status reports. The CAP will remain open until DHCS closes the CAP.

- 2024 DHCS Audit - On 10/3/2024 the Plan received DHCS' Final Audit Report and CAP request. There were two findings: The Plan did not ensure the delegate, Health Net, met the contractual requirement that written PA extension notices specify the information Health Net requested but did not receive, and the Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days. Since that time, the Plan has submitted the required monthly status reports. The CAP will remain open until DHCS closes the CAP.

- DHCS 2022-2023 EQR Performance Evaluation – On July 8, 2024 the Plan received DHCS' annual external quality review (EQR) Report and associated recommendations. There were two recommendations that focused on the following: working to resolve the findings from the DHCS 2022 annual audit and improving MY2022 HEDIS measures; The Plan submitted its response to how it would address the recommendations on August 2, 2024.

- DHCS 2024 Encounter Data Validation (EDV) Study – The Plan submitted records by the due date of 5/21/2024. The results were released on 12/19/2024. Overall, the Plan did not meet Encounter Data Completeness standard (i.e.,<10%) in the following categories: Procedure Code and Procedure Modifier. The Plan did not meet the Encounter Data Accuracy standard (>90%) in the following categories: Rendering Provider Name, All-Element Accuracy and All -Element Accuracy Excluding Rendering Provider Name. The Plan is working with Health Net on strategies to improve standards in 2025.

- DHCS RY 2023 Subnetwork Certification (SNC) – The Plan submitted RY 2023 SNC data on January 5, 2024. On 7/3/24, DHCS requested the Plan submit quarterly updates on the status of all CAPs the Plan previously issued to PPGs for not meeting time & distance standards in their networks. On 12/10/24, the Plan received written notice that all deficiencies had been corrected and the 2023 SNC was closed.

- 2023 DHCS Annual Network Certification (ANC) - The Plan submitted Phase 1 of the ANC in February 2024 and Phase 2 in March 2024. The Plan received DHCS approval on December 4, 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 audit was conducted on June 18, 2024, and the audit was closed on September 30, 2024, noting all items had been resolved.

- DHCS Contract Amendments - DHCS Medi-Cal contract amendments were executed between DHCS and CalViva Health in 2024:

- **Contract 23-30220 A02**- This amendment incorporates changes and new requirements for Medical Loss Ratio, Network Provider Agreements, Enhanced Care Management, Population Needs Assessment, justice Involved Reentry and Coordination, Transitional Care Services, FQHC Alternative Payment Model Risk Corridor, Unsatisfactory Immigration Status Risk Corridor, and Data Sharing.

- **Contract 23-30220 A03**- This amendment extends the contract to December 31, 2025. DHCS is obtaining a continuation of the services identified in the original agreement.

2. Department of Managed Health Care (DMHC):

- Measurement Year (MY) 2022 Timely Access Report (TAR) – On May 6, 2024, DMHC issued a Network Findings Report with two findings related to Geographic Access and Data Accuracy. The Plan submitted a response on August 1, 2024.

- Measurement Year (MY) 2023 Timely Access Report (TAR)- The Plan submitted its MY2023 TAR on May 1, 2024. Results of the 2023 DMHC Timely Access Provider Appointment Availability Survey (PAAS) and the Provider After-Hours Survey (PAHAS) indicated that the Plan met the compliance rate standards for all with the exception of the following: Urgent Care Appointment with a specialist (that requires prior authorization) within 96 hours; and Non-Urgent Care Appointment with a specialist within 15 business days. Health Net issued CAPs to five PPG and 6 Direct Network providers.

- DMHC Subdelegated Contract Review- On 4/24/24, DMHC requested CalViva to submit, under its DMHC license, Health Net's subdelegated contracted vendor agreements for vendors that perform various Knox-Keene functions on behalf of CalViva. The Plan needed to submit all current 19 vendor contracts as separate amendments to the DMHC and any new future subdelegated contracts.

C. DHCS Fraud, Waste and Abuse Required Reporting:

In 2024, the Plan and its delegate, Health Net's Special Investigations Unit (SIU), identified four (24) cases which were determined to reflect suspected fraud and/or abuse and all twenty-four cases were referred to the DHCS via the MC609 process. All Twenty-four cases were provider-related:

- Three (3) were participating providers billing a high volume of the non-medically necessary service, per health plan policy.
- Three (3) were regarding hospice facilities billing for duplicate and overlapping hospice services for the same member.
- Two (2) were non-participating providers billing and receiving payments for Lab services outside their active Clinical Laboratory Improvements Amendments (CLIA) Certificate of Waiver.

- Two (2) were participating providers reported through the hotline of fraudulent billing of services.
- One (1) was a participating provider who allegedly billed for services not rendered.
- One (1) was a participating durable medical equipment provider is allegedly up-coding services, had incomplete or did not have documentation to not support billings.
- One (1) was a participating behavioral health provider identified to have possible concerns related to conflicting information regarding the rendering provider, documentation does not support billings, and a possibility of services not rendered.
- One (1) was a non-participating provider suspected of knowingly rendering a non-covered service to a Medi-Cal member.
- One (1) a participating pain management provider reporting possible services not rendered.
- One (1) was a non-participating laboratory billing a non-covered service and is not enrolled to provide Medi-Cal Services.
- One (1) was a member allegedly has been placing fraudulent transportation requests for about 3 years.
- One (1) was a participating provider specializing in home health for possible kick-back scheme.
- One (1) was a participating DME provider identified through the EOB verification process by a member stating they did not receive services.
- One (1) was a non-participating durable medical equipment provider is allegedly billing services not rendered and billing for non-covered services.
- One (1) was a participating provider flagged for excessive billing and upcoding evaluations and management services.
- One (1) was a DOJ enforcement action regarding a provider allegation of unnecessary drug testing and Illegal renumeration of physicians.
- One (1) was a hospice provider possibly billing for services not rendered or a possible phantom provider.
- One (1) was a non-participating provider specializing in hospice services, due to concerns for members receiving hospice services for greater than six months. This concern was identified because of data analysis from another open investigation of a Home Health Agency.

D. Privacy and Security Oversight

1. Regulatory and Contractual Obligations

CalViva Health continued to review and refine its practices and processes to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) contractual obligations and any other privacy and security related laws and regulations. The following key activities were completed for 2024:

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

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

CalViva Health continued efforts in the oversight and monitoring of Business Associates (BA) who create, maintain and/or transmit protected health information (PHI) through the receipt and assessment of privacy incident reports (PIRs).

CalViva Health maintained a contract with a company to conduct security and vulnerability scans. From 2014-2023, CalViva Health utilized the SolarWinds platform for network vulnerability scans. For the purpose of network vulnerability scans, from 2023-present CalViva Health is utilizing the LogRhythm platform.

2. Reports of Possible Privacy and Security Incidents/Breaches

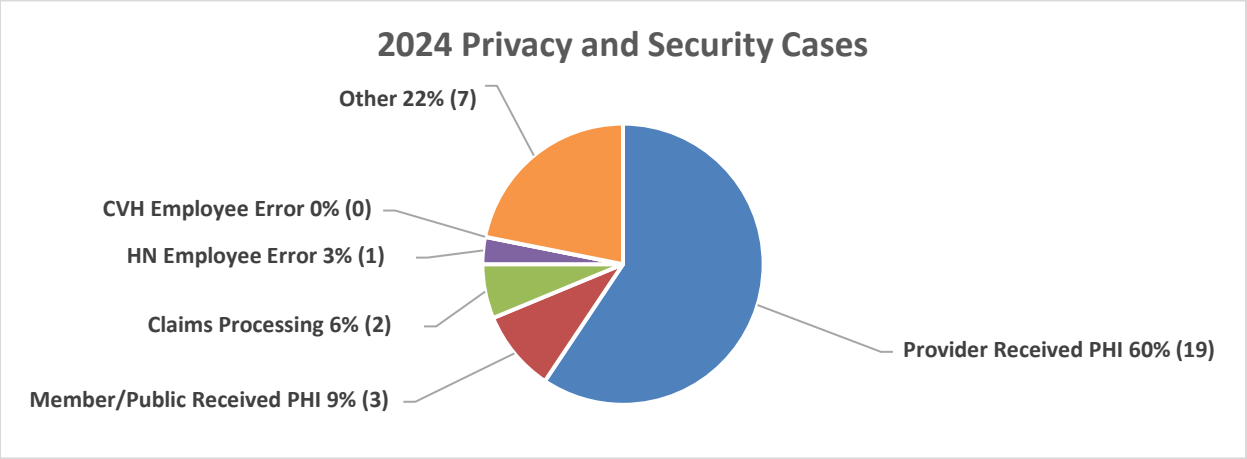
As described in the Plan's privacy and security policies and procedures, upon discovery of an incident/breach, CalViva Health must notify state and federal agencies of the incident/breach in accordance with regulatory requirements. In addition, the Plan must take prompt corrective action to mitigate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

In 2024, thirty two (32) privacy and security incidents were reported to the DHCS. Zero (0) incidents occurred within CalViva Health. All thirty two (32) incidents involved the Plan's Administrator. Nineteen (19) cases involved providers receiving PHI, three (3) cases involved members/public receiving PHI, two (2) case involved claims processing, and seven (7) cases were categorized as "other". Additionally, three (3) of the thirty two (32) cases were classified as high-risk breach cases. Any cases that have not been closed out by the DHCS will be followed and tracked until case closure.

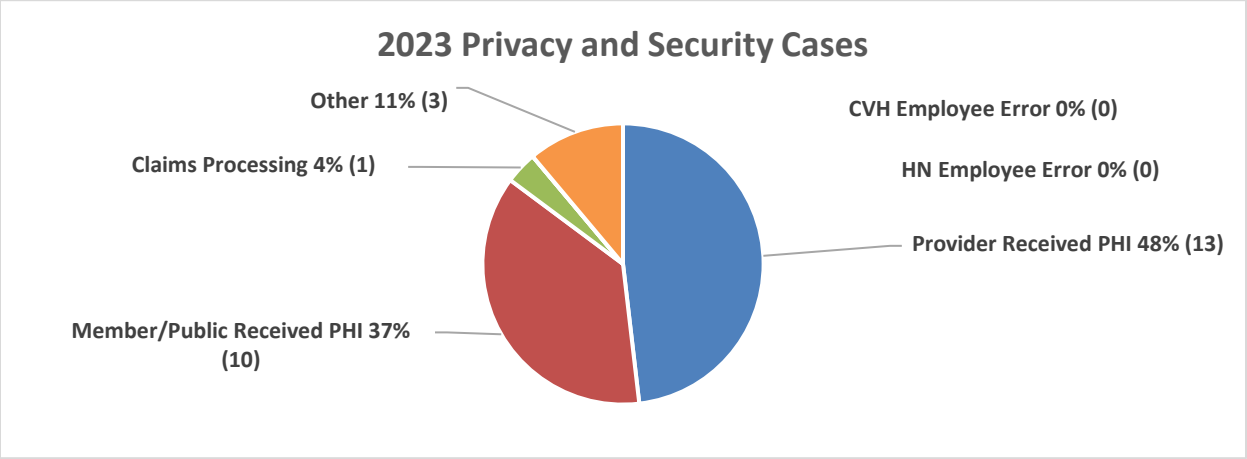
The Plan's administrator, Health Net, submitted Privacy Incident Reports to DHCS on 2/28/24 and 8/22/24 stating it had been impacted by the cybersecurity breach that occurred at its vendor, Change Healthcare. The scope of the impact was very broad as Change Healthcare contracts with many health care companies nationally. The impact is still being investigated and the number of CalViva Health members who may have been impacted has yet to be determined.

The first pie chart provides a high-level overview of the types of incidents which occurred in 2024. The second pie chart provides a high-level overview of the types of incidents which occurred in 2023 for comparison purposes:

2024 Privacy and Security Cases



2023 Privacy and Security Cases



The pie charts reveal that the total number of privacy and security incidents have increased between 2024 (32 incidents) and 2023 (28 incidents), with only a 14% increase in 2024. The number of incidents involving providers receiving PHI also experienced a 46% increase between 2023 and 2024. The number of incidents involving CalViva members and public receiving PHI had decreased by 70%.

3. CalViva Health Internal Audits

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

conducted during work hours to see if PHI is being exposed inappropriately or left unattended.

In 2024, there was one (1) incident where an employee was subject to disciplinary action due to a privacy and security non-compliance issue.

4. **CalViva Health Privacy Group Mailbox Oversight**
   CalViva Health monitors the privacy group mailbox that members contact for assistance. In 2024, the Plan received the following types of requests:
   - Authorization to Disclose PHI – 98
   - Confidential Communications – 15
   - "Other" Inquiries – 5

E. New or Expanded DHCS Benefits, and New Plan Coverage Requirements:

1. Community Supports (CS) - On 6/19/2024 DHCS approved the Plan's Community Supports MOC for those services that went live 7/1/24 [Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties); and Recuperative Care (Madera County]. Additionally, on 7/1/24, the Plan updated its CS Final Elections to indicate that the following CS would be going live 1/1/25 [Recuperative Care (Kings County); Recuperative Care (Madera County); Short-Term Post-Hospitalization Housing (Madera County); and Sobering Centers (Madera County).

2. Justice Involved (JI) Population of Focus (POF) – On January 1, 2024, the Plan launched the JI POF ECM benefit. The Plan continues to work on improving its JI ECM provider network by engaging with correctional facilities and ensuring network overlap of ECM networks with other Medi-Cal Plans. As it relates to the latter, on 7/18/24, the DHCS temporarily approved the Plan's JI contracting exception.

3. Adult Expansion - On January 1, 2024, DHCS expanded Medi-Cal eligibility to individuals who are 26 through 49 years of age. The Plan worked with providers to maintain PCP assignment.

4. Long-Term Care Phase II Carve-In – The Plan provides all Medically Necessary Covered Services for members residing in or obtaining care in an Intermediate Care Facility/Developmental Disabilities ("ICF/DD") and Subacute Care facilities. The Plan developed an adequate network in each of its counties and also submitted several key policy deliverables to DHCS. On 7/24/2024 the Plan received DHCS approval on Phase II Network Readiness deliverables related to executing contracts.

F. Plan Compliance with Key 2024 DHCS Contract Requirements

The Plan fulfilled several key requirements of the new 2024 DHCS Contract:

- Hiring a Health Equity Officer – On May 28, 2024, the Plan hired a Health Equity Officer.

- Developing a Diversity, Equity, and Inclusion (DEI) training curriculum – Per DHCS contract requirement, CalViva Health staff received DEI training on 11/1/2024.

  Received NCQA Health Plan Accreditation - On July 19, 2024, the Plan received NCQA Accreditation.

- Submitted fully executed MOUs with third-party entities (i.e., Local Government Agencies, Health Departments, etc.) –In 2024 The Plan executed and submitted to DMHC and DHCS the following MOUs: Fresno County MHP DMC-ODS; Fresno County WIC; Kings County WIC; Kings County DMC MOU and Kings County MHP. The Plan will continue to execute and submit MOUs in 2025. The Plan is also required to submit an Annual MOU Report every January.

- Submitted a Population Health Management Strategy – CalViva Health submitted its PHM Strategy deliverable on 11/22/24. The Plan is required to submit the PHM Strategy Deliverable to DHCS annually. The purpose of the annual PHM Strategy Deliverable is for MCPs to demonstrate their engagement in local health jurisdictions' (LHJs) community health assessments (CHAs) and community health improvement plans (CHIPs) and provide other updates on the MCP's implementation of the PHM Program to inform DHCS' monitoring efforts.

III. Compliance Program Activities

A. Program Document Reviews/Updates:

CalViva Health continued to operate a comprehensive Compliance Program in 2024. The Plan's Compliance Program includes the following written descriptions which were reviewed and approved in 2024.

- Compliance Program Description
- Code of Conduct
- Compliance Committee Charter
- Fraud Prevention Program
- Privacy and Security Plan
- Compliance Policies and Procedures
- Emergency Preparedness and Crisis Response Plan

B. Oversight and Monitoring of Delegated Activities:

The Plan continues to provide oversight and work closely with Health Net on an ongoing daily basis to ensure CalViva members have information and access to services.

1. Delegation Oversight Audits and CAPS

The table below lists the Plan's 2024 completed oversight audits of functions delegated to Health Net. Audits included desk reviews of any applicable functions subdelegated by Health Net, policies and procedures, reports, and evidence submitted to meet the required audit elements.

Appeals and* Grievances	Claims*	FWA
Credentialing*	Provider* Disputes	Pharmacy
Health Education	Utilization* Management	Provider* Network
Privacy and* Security	Emergency* Room	Quality* Improvement
Behavioral Health	Marketing	Health Equity
Member Rights		

* CAPs were required for the above functions.

2. Periodic Monitoring of Health Net

During 2024, CalViva Health staff continued a wide variety of activities to provide oversight and monitoring of the functions performed by Health Net and Health Net's delegated provider groups and subcontracted health plans on CalViva Health's behalf. These activities included:

- Monthly management oversight meetings with Health Net key management staff to review reports, discuss issues and any improvement actions needed.
- Monthly/Quarterly monitoring and analysis of key performance measures and reports from delegated entities for timeliness, accuracy and issues.
- Ongoing workgroup collaborations with Health Net to ensure process integrity and contract deliverables in the following areas:

    - Grievance System
    - Quality Improvement, Utilization Management and Credentialing
    - Encounter Data Integrity
    - Access and Availability
    - NEMT and NMT Transportation
    - Behavioral Health

- On-going oversight of subdelegated functions through report dashboards of comprehensive performance metrics accompanied by narrative reports explaining outlier data or issues.

C. 2024 CalViva Internal Audit

During 2024, the Compliance Department conducted an internal audit of employee,

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

D. CalViva Health Staff Trainings

A primary requirement of a successful Compliance Program is conducting ongoing education and training programs. Ongoing training helps CalViva Health staff to carry out daily Plan operations in an efficient and compliant manner. During 2024, the Plan conducted training for one new hire as well as the following mandatory annual staff trainings on December 17th and 19th:

Compliance Program	Fraud Prevention Program
Privacy and Security Program	Code of Conduct

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

Drug Free Workplace Statement	Confidentiality Agreement
Conflict of Interest Statement	

All employees successfully completed all required Compliance trainings.

E. Member Communications

CalViva Health maintains a process for the review and approval of communications with members. In 2024, 47 communications were reviewed by CalViva Health. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2024 Annual Mailing was distributed to members in 2024. The 2025 Member Handbook/Evidence of Coverage (EOC) was developed and approve by both DHCS and DMHC and was scheduled to be posted to the Plan's website on January 1, 2025.

F. Provider Communications

CalViva Health maintains a process for the review and approval of communications to contracted providers within the CalViva Health service area. In 2024, contracted providers were sent approximately 305 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 22 informational letter templates and 22 forms intended for provider use.

H. Provider Engagement

In 2024, there were over 6,000 Provider interactions (e.g., Phone, email, on-line, in-person, join oversight meetings, etc.). These interactions assist providers with any operational, quality improvement or training issues.

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

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

The following table summarizes the number and type of A&G cases received in 2023, and the percent resolved within the compliance turnaround times (TAT) standards. For instances of non-compliance, corrective action was implemented to ensure there would not be future similar occurrences.

	No. of Cases Received	**No. of Cases Resolved †**	**% of Cases Resolved within TAT (No.)**
Expedited Grievances	84	86	100 % (86)
Standard Grievances	2034	2048	99.95% (2047)
Expedited Appeals	25	25	100% (25)
Standard Appeals	459	430	100 % (430)
Total:	**2599**	**2589**	**99.96% (2588)**
SPD Appeals & Grievances *	766	754	98.6% (753)
Exempt Grievances #	2201	2201	100%

† Total will not match as some cases received in December 2024 may remain open at the start of 2025, and the resolved case number may include some cases received in December 2023 and resolved in 2024.

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

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

J. Independent Medical Reviews (IMRs) and State Hearings

The following table summarizes the number of DMHC IMR and DHCS State Hearing requests processed by the Plan in 2024. All cases were submitted within the required turnaround times.

Cases Received	2024 Total	% Cases Submitted w/in the TAT
DMHC Cases	**65**	**100%**
DHCS State Hearings	**37**	**100%**
Total:	**102**	**100%**

IV. 2025 ACTIVITIES

In 2025, the Compliance Program will continue to focus on meeting additional regulatory requirements associated with the 2024 DHCS Contract and all newly enacted statutes such as the following:

- Senate Bill 923 regarding transgender, gender diverse or intersex cultural competency training program and provider directory requirements;
- Senate Bill 225 regarding network adequacy standards and methodology for RY2025;
- Assembly Bill 186 regarding Skilled Nursing Facility Workforce Quality Incentive Program;
- Applying for NCQA Health Equity and Health Equity Plus Accreditation;
- Development and maintenance of a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided;
- Submitting Emergency Preparedness and Response Plan (EPRP) deliverables to DHCS.

In 2025, the Plan will once again be audited by DHCS, and will also submit to a DMHC's 18-month follow-up audit on 5/5/2025.

APPROVAL:

Date: February 20, 2025

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

Date: February 20, 2025

Name: Jeffrey Nkansah
Title: Chief Executive Officer

Date: February 20, 2025

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

Item #14
Attachment 14.B

Compliance

2025 Compliance Program Description

REPORT SUMMARY TO COMMITTEE

TO: RHA Commission

FROM: Mary Lourdes Leone

COMMITTEE DATE: February 20, 2025

SUBJECT: Compliance Program Description Change Summary

Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Inserted year 2025
Page 4	IV.B. RHA Commission Roles	Change Anti-Fraud Plan to Fraud Prevention Program
Page 7	VI.A. Policies and Procedures	Change Anti-Fraud Plan to Fraud Prevention Program; Updated Table 2 to include Emergency Preparedness and Crisis Response Plan
Page 8	VI.B. Activities Monitored by CalViva Table 3	Added Call Center, ER, Privacy and Security and Transportation
Page 9	VI.C. Education and Training	Updated Table 4 to include Emergency Preparedness and Crisis Response Plan; Clarified language related to external distribution of Compliance Program documents.

20254
COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

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Fresno, CA 93711
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(559) 540-7856

Last Reviewed/Revised 2/20/2025~~2/15/2024~~

CALVIVA HEALTH COMPLIANCE PROGRAM

I. CALVIVA HEALTH OVERVIEW

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010, as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties. On December 11, 2023, RHA executed a new contract with DHCS with a start date of January 1, 2024.

CalViva Health's compliance commitment not only includes its own internal operations but also extends to its oversight of its First Tier, Downstream and Related Entities ("FDRS"). These FDRs perform administrative functions and/or provide health care services to CalViva Health's members under the Plan's DHCS contract, and are required to have programs, standards, policies, and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

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

CalViva Health also contracts with several local government health departments and agencies to provide ~~provide~~ health care services to CalViva Health members.

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

II. Compliance Program Purpose and Objectives

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

Table 1 presents the primary objectives implicit in this purpose.

Table 1. Program Objectives

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

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

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

III. Scope

CalViva's Compliance Program oversight extends to the members of the Commission and

the Commission's subcommittees, CalViva's employees and CalViva's delegated subcontractors, including contracted Knox-Keene licensed health plans (i.e., HNCS), participating providers, and suppliers.

IV. AUTHORITY AND OVERSIGHT

A. GOVERNMENT AGENCIES

The following are some of the state and federal agencies that have legal authority to regulate various aspects of health care and health care plans.

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

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

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

B. RHA COMMISSION

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

C. THE COMPLIANCE COMMITTEE

1. Oversees CalViva's Compliance Program and advises the CCO on Compliance Program adequacy.
2. Reviews the Compliance Program annually, including the Privacy and Security Plan, the Fraud Prevention Program, and the Code of Conduct and recommends revisions as needed.

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

D. CHIEF COMPLIANCE OFFICER (CCO)

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

V. COMPLIANCE RISK AREAS

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

A. Access & Availability, and Quality of Care:

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

B. Data Collection and Submission:

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

C. Member Grievance and Appeal Procedures:

- Failure to ensure that members are properly notified of their grievance and appeal rights;
- Failure to respond and resolve member grievances and appeals within the required timeframes.

D. Emergency Services:

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

E. Kickbacks and Other Inducements:

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

F. False Claims:

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

G. Confidentiality:

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

H. Excluded Providers:

- Contractual or employment relationships with persons or entities which are suspended, excluded or otherwise not eligible to participate in federal or state

health care programs;

- Improper reimbursement for items or services furnished, ordered, prescribed, or supplied by an excluded person or entity;
- Failure to take appropriate corrective action upon subsequently learning of a person's or entity's excluded status.

I. Member Dis-Enrollment:

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

J. Marketing

- Improper or misleading marketing materials

VI. COMPLIANCE PROGRAM ELEMENTS

A. POLICIES AND PROCEDURES

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

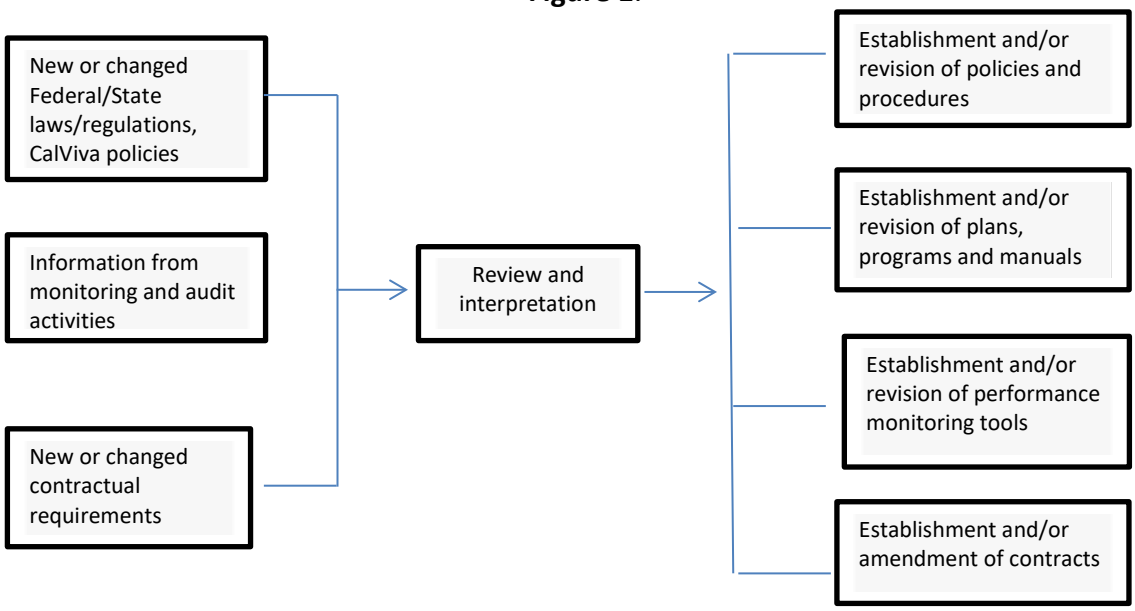
Table 2. Key Compliance-Related Policy Topics

Code of Conduct	**Quality Improvement**
Conflict of Interest	**Utilization Management**
Privacy and Security	**Credentialing**
Fraud Prevention	**Peer Review**
Appeals and Grievances	**Delegation Oversight**
Claims	**Provider Disputes**
Population Health Management	**Health Equity**
Emergency Preparedness and Crisis Response Plan	

Figure 1 below shows the factors that may precipitate changes in various policies,

procedures, and ancillary documents.

Figure 1.



B. MONITORING

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

Table 3. Activities Monitored by CalViva

Provider Network ~~Integrity~~ and Provider Relations~~Contracting~~	Member Appeals and Grievances	Practitioner and Provider Credentialing
Provider Access and Availability	Facility Site Reviews & Medical Record Reviews	Encounter Data
Member Rights/Member Experience	Health Equity	Claims Payment
Marketing	Provider Grievances and Disputes	Utilization Management & Case Management
Health Education	Privacy and Security~~Mental Health & Behavioral Health Services~~	Quality Improvement
Pharmaceutical Services	Provider Training	Continuity of Care
Fraud, Waste & Abuse	Behavioral Health	Call Center

Emergency Room	NEMT/NMT	~~Privacy & Security~~

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

C. Education and Training

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

Table 4. Program Documents

Compliance Program Description	Code of Conduct	Conflict of Interest	Fraud Prevention
Privacy and Security Plan	Confidentiality Agreement	Drug and Alcohol Policy	Emergency Preparedness and Crisis Response Plan

When applicable, CalViva Health directly ~~C~~contracted vendors or consultants who have direct member or member records contact ~~also~~ will receive copies of the Compliance Program, Fraud Prevention Program~~Anti-Fraud Plan~~, Privacy and Security Plan, and Code of Conduct. They must sign a certification statement acknowledging that they have read and understand the documents. In some vendor relationships, only a Business Associate's Agreement (BAA) may be needed.

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

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

D. Reporting Noncompliance

Fundamental to the effectiveness of CalViva's Compliance Program is the concept of nonretaliation. All persons associated with CalViva, including its Commission

members, Committees, employees, subcontractors, consultants, and vendors are free to come forward and report suspected noncompliance with the Code of Conduct, Program Documents, CalViva policy and procedures, and state and federal regulations without fear of retaliation or retribution. The following types of noncompliance are of particular concern for expeditious reporting and corrective action:

1. **Criminal and Civil Violations of Law**: CalViva conducts fact-finding activities, and reports to the proper authorities for further investigation and action, all credible, suspected occurrences of fraud, waste, abuse, kickbacks, and unauthorized uses and disclosures of protected information, including PHI.

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

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

E. Response and Corrective Action

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

VII. Summary

CalViva's Compliance Program employs a comprehensive approach to ensuring its

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

VIII. AUTHORITY

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

IX. Program Documents

1. Code of Conduct
2. Fraud Prevention Program ~~(fmr. Anti-Fraud Plan)~~
3. Privacy and Security Plan
4. CalViva Health Policies & Procedures
5. Emergency Preparedness and Crisis Response Plan

X. APPROVAL

February 20~~15~~54, 2025

_____ _____

Name: Mary Lourdes Leone Date

Title: Chief Compliance Officer

February 20~~15~~54, 2025

_____ _____

Name: Jeffrey Nkansah Date

Title: Chief Executive Officer

February 2015, 2024

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

DOCUMENT HISTORY	
Date	**Comments**
03/01/2011	New Program Description
02/09/2012	Annual Update of Program Description
01/17/2013	Annual Update of Program Description
02/06/2014	Annual Review: Changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
01/26/2015	Annual Review: Changes to clarify monitoring and auditing activities
02/08/2016	Annual Review, added reference document
02/02/2017	Annual Review: Program Description is replaced in its entirety. Overall content is the same; reduced duplication with other program plans, formatting, editorial and organizational enhancements to all sections.
2/1/2018	Annual Review: Deleted "Privacy & Security Officer" from the CCO's responsibilities. CalViva's COO will now serve as the "Privacy & Security Officer", and this is reflected in the Privacy and Security Plan.
01/07/19	Annual Review: No changes.
01/21/20	Added additional Discrimination language to V. Compliance Risk areas, Section A.
10/22/20	Annual Review: Edited IV, D. (3.) to reflect current practice of preparing the annual Compliance Program Evaluation.
2/7/22	Annual Review: Updated CCO to Mary Lourdes Leone and CEO to Jeffrey Nkansah; added "Privacy Officer" to Section IV. D.; added Fraud, Waste & Abuse to Table 3.
1/29/23	Annual review; No changes
1/25/24	Annual Review: Section I, added new 2024 DHCS Contract; Section VI.A, added Population Health Management and Health Equity; Section VI.B, added Member Experience and Behavioral Health Oversight audits, and changed C&L to Health Equity.

1/29/2025	Annual Review: Changed Anti-Fraud Plan to Fraud Prevention Plan throughout; Section VI A. Table 2 added Emergency Preparedness and Response; Section VI.B Added additional activities monitored by CVH; Section VI C. Table 4 added Emergency Preparedness and Response Plan, and also clarified language regarding external distribution of Compliance Program documents.

Item #14
Attachment 14.C

Compliance

2025 Fraud Prevention Program

REPORT SUMMARY TO COMMITTEE

TO: RHA Commission

FROM: Mary Lourdes Leone

COMMITTEE DATE: February 20, 2025

SUBJECT: Fraud Prevention Program Change Summary

Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Inserted year 2025
Page 4	Section I.1	Added language regarding the corresponding P&P "CO-005 Fraud and Abuse Prevention and Detection Investigation"
Page 5	Section II.1	Corrected name for Fraud Prevention Program. Added reference to P&P "CO-005 Fraud and Abuse Prevention and Detection Investigation"
Page 6	Section II.1	Added #10 to specify that the CCO will "Submit reports of suspected fraud, waste and abuse to the RHA Commission"
Page 9	Section II.4.2	Added "clinicians" to team members
Page 9	Section II.7	Added reference to P&P "CO-005 Fraud and Abuse Prevention and Detection Investigation". Updated language regarding Preliminary Report.
Throughout	Throughout	Minor grammatical edits

FRAUD PREVENTION PROGRAM

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

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
MLLeone@calvivahealth.org
Phone: 559-540-7856

Table of Contents

I. CalViva Health Overview

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

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

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

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

1. Statement of Purpose:

The purpose of the RHA/CalViva Health ("CalViva" or the "Plan") Fraud Prevention Program is to organize and implement an anti-fraud strategy to identify and reduce costs to the Plan, providers, members, and others caused by fraudulent and abusive activities, and to

protect members and the public in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. Through the Fraud Prevention Program, CalViva also seeks to prevent violations of the Federal False Claims Act, as codified in Section 3729 of Title 31 of the United States Code. The Plan's Fraud Prevention Program will also comply with the federal Medicaid managed care requirements in 42 CFR 438.608, Health & Safety Code Section 1348 and the 2024 DHCS-CalViva Health Plan Contract (No. 23-30220, 12/20/23).

CalViva's Fraud Prevention Program is a key component of CalViva's overall Compliance Program (Ref. CalViva Health's Compliance Program Description) and is supported by the corresponding policy and procedure, "CO-005 Fraud and Abuse Prevention Detection Investigation", which details all the requirements and procedures for complying with various laws and regulations under the DHCS Contract relating to Fraud Waste and Abuse.

2. Definitions:

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

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

Some examples of fraud include:

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

See Appendix A for a more extensive set of examples.

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

Some examples of abuse include**:**

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

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

II. Scope of Fraud Prevention Program:

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

The Fraud Prevention Program is part of CalViva's comprehensive Compliance program and includes the following:

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

1. Responsibilities for the Fraud Prevention Program:

The RHA Commission has ultimate responsibility for this Fraud Prevention Program. The Fraud Prevention Program~~Anti-Fraud Plan~~ will be submitted to the Commission for annual approval. An annual report will be made to the Commission regarding the Plan's Anti-Fraud activities, subject to any confidentiality protections which may be required. (ref. "CO-005 Fraud and Abuse Prevention Detection Investigation").

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

The address for the CEO, the CCO, and the Chairperson of the RHA Commission is:

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

The CCO will serve as the Fraud prevention Officer and have the following duties:

1. Receive information (formal and informal) on cases of suspected fraud,
2. Provide oversight of activities and investigations carried out on CalViva's behalf by Health Net and other delegated entities,
3. Receive information from Health Net and other delegated entities on cases of suspected fraud and abuse related to CalViva and investigated by the delegated entities' SIU,
4. Provide oversight and receive information from delegated organizations on cases of suspected fraud and abuse related to CalViva,
5. Report to the CEO on suspected cases of fraud, plan of investigation, timelines, and resources required,
6. Maintain logs to assure timely investigations and reporting,
7. Review and approve training and other anti-fraud materials sent to participating providers on CalViva's behalf,
8. When directed by the CEO or legal counsel, make referrals to appropriate law enforcement agencies,
9. Participate in DHCS' quarterly program integrity meetings, as scheduled.
~~9.~~10. Submit reports of suspected fraud, waste and abuse to the RHA Commission.

2. General Fraud Prevention Oversight Mechanisms:

The general oversight mechanisms of the Plan's Fraud Prevention Program include the following:

1. CalViva Health will conduct background checks on all employees, which includes staff designated to handle funds and prepare financial statements,
2. Policies and procedures for identifying, investigating, and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program,
3. Development and implementation of corrective actions addressing fraud and abuse issues as appropriate,
4. Ongoing monitoring and oversight by the CalViva Compliance Committee,
5. Provide contracted providers with anti-fraud information including how to report suspected fraud incidents,
6. Provide members with information on how to report suspected fraud incidents such as in the CalViva Health EOC/Member Handbook,

7. Investigate cases of suspected fraud with the most appropriate internal or external resources, appropriate to the problem,
8. Ensure that conflicts of interest are not present in the investigation of suspected fraud cases,
9. Ensure that findings from independent audits and regulatory audits and surveys are followed up promptly by both the Plan as well as the subcontractors who may be cited; and identify any recurring trends,
10. Monitor member and provider issues, tracking and trending types of grievances and settings; and implementing corrective action when necessary,
11. Perform an annual file audit of a sample of contracted providers credentialed by Health Net and their delegated entities which have delegated credentialing responsibilities,
12. Monitor and review fraud cases/issues reported by delegated organizations,
13. Conduct formal and informal ongoing monitoring of the administrative services contracted to Health Net and delegated entities through the review of performance reports, annual audits, and quarterly member service verification reports; and developing corrective action plans, when appropriate,
14. Review the Fraud Prevention Program annually and, if revised, maintain documentation that approval has been received from the Department of Managed Health Care (DMHC),
15. Review Health Net's annual anti-fraud report to the DMHC,
16. Prepare and submit the annual CalViva Health Anti-Fraud Report and submit it to the DMHC,
17. Ensure that Medicaid/Medi-Cal or Medicare terminated or suspended providers do not receive program funds,

3. Procedures for Investigating Suspected Fraud:

Processes used to investigate suspected cases of fraud are described in CalViva's policies and procedures (CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation, and RX-120 Drug Utilization Review).

1. The procedure for undertaking an investigation includes:
   A. A review of all identified related documents;
   B. Consultation, if necessary, with internal or external resources with knowledge of applicable law, regulations or policies, procedures or standards; and
   C. Interviews with persons with knowledge of the alleged activity.
2. A description of the investigation process is included in Plan policies and procedures. The policies and procedures are reviewed annually and revised as needed.
3. The Compliance Committee reviews reports of fraud, waste and abuse cases investigated and any corrective actions implemented.

4. All cases of suspected fraud, waste and/or abuse where there is reason to believe that an incident of fraud, waste and/or abuse has occurred by subcontractors, members, providers, or employees will be reported to the DHCS.
5. In addition, in situations where fraud is confirmed, disciplinary action may be taken and reports to appropriate third parties may be made, including the following:
   A. For employees, incidents may be grounds for immediate dismissal, and, if appropriate, referral to law enforcement agencies;
   B. For contracted providers, disciplinary action may include terminating any contracted relationship between the Plan and the provider or, in the case of a group or institutional provider, removal of the provider's subcontractor or employee from providing services with respect to CalViva members; and
   C. For Medi-Cal members, disciplinary action will include referral to the Department of Health Care Services and, if appropriate, the initiation of procedures to disenroll the member from CalViva, according to provisions of the Medi-Cal managed care contract.
6. Appropriate local, State or Federal authorities will be notified as necessary.
7. A summary report of cases and outcomes is provided quarterly to the Compliance Committee and summary reports are included in the regular compliance reports to the RHA Commission.
8. To prevent repeat offenses, the CCO, and if applicable, in consultation with Health Net, may create new policies, procedures and employee training programs to address new issues regarding the Anti-Fraud Plan's implementation as they arise.

4. Use of External Resources for Special Investigations:

The following external resources are utilized by the Plan:

1. **CalViva Employee, Consultant and Contractor Investigations**: CalViva has retained Epperson Law Group, PC to provide its General Counsel services. The law firm has municipal and litigation attorneys experienced in matters involving public agency ethics rules, restrictions on self-dealing, and prohibited financial transactions. Cases involving alleged fraud and improprieties by CalViva employees, officers, directors, consultants or contractors will be referred to Epperson Law Group, PC for investigation as needed.
2. **CalViva Member and Provider Investigations**: As described in Section I, *CalViva Health Overview*, in accordance with the ASA and CPSA between CalViva and Health Net, the Special Investigations Unit (SIU) for Health Net performs fraud and abuse investigations (i.e. prepay reviews; retrospective reviews, etc.) related to potential fraud cases involving CalViva members or providers. Health Net also conducts routine reviews of provider's billing/coding practices to ensure compliance with state and federal regulations. In addition, Health Net will review claim reports to ensure that codes and practices used in billing are correct and that the Plan has paid health care providers appropriately. The SIU team has a diverse range of qualifications that stem

from the legal, healthcare, loss prevention, law enforcement, medical and other experience/educational backgrounds. Several members of the team are also credentialed as Accredited Health Care Fraud Investigators ("AHFI"), Certified Professional Coders ("CPC"), ~~and~~ Certified Fraud Examiners ("CFE") and clinicians.

5. Additional Internal and External Resources:

Other internal and external investigative resources available to the Plan include the following:

1. The Plan's Chief Medical Officer, Chief Financial Officer and other Plan staff,
2. The Plan's independent financial audit firm,
3. DHCS audits and surveys,
4. DMHC audits and surveys.

6. Freedom from Retaliation and Avoiding Conflicts of Interest:

CalViva will promote an environment free from retaliation or threats of retaliation against individuals who report suspected fraud. The Plan will comply with Section 3730(h) of Title 31 of the United States Code, which prohibits employer discrimination against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the False Claims Act. In training sessions with employees regarding the Plan's anti-fraud efforts, employees will be informed that there is no retaliation against employees for reporting fraudulent activities. Employees are also notified in writing of the procedures for reporting potentially fraudulent activities, and that there is no retaliation against individuals for reporting those activities. If the reporting party still has concerns about retribution, the reporting party may choose to remain anonymous.

If the CEO, CCO, or member of the RHA Commission has a conflict of interest regarding an incident of suspected fraud, the individual must report the conflict of interest to the Chairperson of the RHA Commission and disassociate him/herself from the relevant investigation. If appropriate, the investigation will be referred to outside counsel for investigation.

7. Investigation Reports and Referrals (ref. "CO-005 Fraud and Abuse Prevention Detection Investigation"):

1. **Preliminary Fraud, Waste and Abuse Report**: On CalViva's behalf, the Health Net SIU will investigate suspected Fraud, Waste and Abuse cases and provide the Plan with a ~~P~~preliminary ~~R~~report of the results. ~~CalViva retains the discretion to determine if potential fraud and abuse claims are reportable to DHCS.~~ The Plan's CCO will review

the preliminary report with other Plan executives. ~~as appropriate to determine if the results involve a matter of suspected Fraud, Waste or Abuse.~~ The CCO or designated Compliance staff will submit reports of suspected Fraud, Waste or Abuse to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity via the preliminary report. The report will be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that is emailed to DHCS' Program Integrity Unit (PIU): PIUCases@DHCS.ca.gov.

2. **Completed Investigation Report**: Within 10 working days of completing the Fraud, Waste or Abuse investigation (including both CalViva-initiated and DHCS-initiated, referrals), CalViva will submit a completed report to the DHCS' PIU.

3. **Receipts of a Credible Allegation from DHCS:** CalViva may be notified by DHCS when there has been a credible allegation of fraud against a provider that is part of the Plan's provider network. In these cases, CalViva must take one or more of the following four actions and submit all supporting documentation to the PIUCases@DHCS.ca.gov inbox:

    a. Terminate the provider from its network
    b. Temporarily suspend the provider from its network pending resolution of the fraud allegation
    c. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
    d. Conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

4. **Removed, Suspended, Excluded, or Terminated Provider Report:** CalViva/delegated organizations are prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. CalViva/delegated organizations will check the list of suspended and ineligible providers maintained in the Medi-Cal Provider Manual, which is updated monthly and available online and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). CalViva/delegated organizations are deemed to have knowledge of any providers on these lists. CalViva will notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report will be emailed to DHCS' at PIUCases@DHCS.ca.gov.

5. **Referrals to Other Regulatory Authorities**: If the occurrence of fraudulent activity is highly suspected or confirmed, CalViva may refer cases to the appropriate local, state or federal authority for prosecution of health care fraud committed by enrollees, providers, agents, company employees and other individuals. Such referrals include but are not limited to:
    a. Local police departments,
    b. U.S. Postal Inspector,
    c. Federal Bureau of Investigation,
    d. Office of the Inspector General of the U.S. Department of Health and Human Services,
    e. Internal Revenue Service
    f. Local departments of Public Health in Fresno, Kings, or Madera counties,
    g. DMHC,
    h. Centers for Medicare and Medicaid Services,
    i. State medical licensing and disciplinary boards or
    j. Any other appropriate authorities or agencies.

6. **Prosecution**: In the event of fraud, the CEO or the RHA Commission will evaluate the appropriateness of pursuing civil prosecution. The Plan will consult with legal counsel, as described in section II.4.1.

8. Staff Training and Education:

CalViva recognizes that the most effective way to combat fraud is to increase staff awareness through education. The Plan is therefore committed to ensuring the education and training of its staff, the staff of its administrative contractor, and providers on fraud and fraud prevention.

The CEO and CCO, in consultation with the RHA Commission, and other executive staff as applicable, will develop a strategic approach to educating CalViva and its community about fraudulent activities that occur in health care environments. CalViva will work closely with Health Net to ensure that appropriate fraud prevention strategies are in place and that staff are trained and educated to detect, deter, and refer instances of suspected fraud to the appropriate levels of the organization.

1. CalViva will provide information regarding the detection, prevention, and investigation of fraudulent activity to all new staff during initial employment orientation. Employees will also be notified in writing of the procedures for reporting fraud and that there is no retribution taken against individuals reporting fraud.
2. An annual training session will be required for all CalViva staff. External experts for training will be consulted, as necessary, to augment and implement the training program.

9. Public Awareness:

CalViva members and their families are the ultimate victims of any fraud activity occurring within the Plan. It is therefore essential for them to be aware of activities that may constitute fraud and to have avenues to report suspected fraudulent activities in order to assist with the prevention and cessation of such activities. Information is included in the Member Handbook/Evidence of Coverage and articles regarding health care fraud and CalViva's efforts to prevent fraud will be sent out in periodic newsletters to members.

The Plan will publicize a fraud reporting telephone number. Potential fraud, waste and abuse incidents may be reported directly to CalViva via one of the following methods:

Toll-free Phone: 1-866-863-2465
Fax: 559-446-1998
Mail: Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
Email: fraudtips@calvivahealth.org

CalViva is sensitive to providing a quick response to any member service concerns that may arise for health plan members. Plan employees will convey any complaints, grievances and/or customer service concerns to the CCO, its administrative subcontractor, Health Net, or, if necessary, to the appropriate regulatory or law enforcement agency.

Concerns expressed are documented and investigation is initiated immediately. If appropriate, within 30 days, a letter is sent out to the originator to acknowledge receipt of the concern and to provide a brief status update.

Medi-Cal anti-fraud information resources are also available on the Department of Health Care Services website: dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

The Medi-Cal Program has a hotline maintained by the Department of Health Care Services: Medi-Cal Fraud Hotline: 1-800-822-6222

10. Participating Health Care Provider Awareness:

The Plan contracts with health care provider organizations, Health Net and may contract with other delegated organizations to provide services to CalViva members through their network of health care providers. These provider networks include but are not

limited to primary care providers, medical specialists, mental health specialists, acute care hospitals, skilled nursing facilities, clinical laboratories, pharmacies and other ancillary providers. Providers are given information about fraud prevention, how to report suspected fraud or abuse incidents, and how the Plan and/or contracted organizations respond to fraudulent activity.

11. Report to the Department of Managed Health Care (DMHC):

In compliance with California Health & Safety Code Section 1348, CalViva will annually file with the DMHC a written **Anti-Fraud Fraud Report** regarding the Plan's anti-fraud activities, including, but not limited to:

1. CalViva's efforts to deter, detect and investigate fraud, and report cases of fraud to law enforcement agencies,
2. The cases reported to law enforcement agencies, a listing of the number of cases prosecuted and the status of prosecution if known,
3. Recommendations to further improve and refine the Plan's Anti-Fraud Plan.

12. Reports to the Department of Health Care Services (DHCS):

In compliance with the 2024 DHCS-CalViva Health Plan Contract, Exhibit A Attachment III, 1.3.2 (No. 23-30220, 12/20/23), CalViva will submit a **Quarterly Report** on all Fraud, Waste and Abuse investigative activities within 10 working days after the close of every calendar quarter. (ref. "CO-005 Fraud and Abuse Prevention Detection Investigation").

III. Authority

- Health & Safety Code Section 1348
- Code of Federal Regulations, 42 CFR 438.608, 42 CFR 438.610 and 42 CFR 455.2
- United States Code, 31 U.S.C. Section 3729 and 42 USC Section 1396a(a)(68)
- Welfare & Institutions Code Section 14043.1(a) and (i), and Section 14115.75
- DHCS All Plan Letters 08-007, 15-026, 21-003, 23-026
- The 2024 DHCS-CalViva Health Plan Contract, Exhibit A Attachment III, 1.3.2 (No. 23-30220, 12/20/23)

IV. References

- CalViva Health Compliance Program
- CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation
- RX-120 Drug Utilization Review

APPENDIX A

Types of Fraudulent Acts and Examples/Indicators of Potential Fraud (Adapted from National Health Care Anti-Fraud Association publications)

I. Types of Fraudulent Acts

It is virtually impossible to itemize every conceivable health care fraud; any opportunity to bill for services is an opportunity to commit health care fraud and every fraud scheme has its own unique characteristics. Most health care frauds, however, fall into one or more broad categories of activity, including the outright fabrication of claims and the falsification of claims.

A. Fabrication of Claims

In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or adds to otherwise legitimate claims fictitious charges for treatments or services that were never provided. Some examples of such fabrication are:

1. An individual provider who, using existing information on his/her patients creates claims for office visits or treatments that never took place.
2. A provider who, in the case of billing for patient treatments, adds charges for x-rays or lab tests that were never performed.
3. A contracted service provider/institution bills for services that were ordered but did not occur due to unforeseen circumstances (patient refused or was unable to make the appointment).

B. Falsification of Claims

In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more element(s) of information in a claim for the purpose of obtaining, a payment (or a higher payment) to which he/she is not entitled. Examples of outright falsifications include:

1. Falsifying patients' symptoms or diagnosis and/or the procedures performed as a pretext for obtaining payment for otherwise non-covered services (i.e.: alternative therapies; elective cosmetic surgeries etc.) and/or performing medically unnecessary services solely in order to submit claims and be paid.
2. Falsifying the dates on which service was provided so as to fall within a given coverage period.

3. Falsifying the identity of the provider of the service in an attempt to obtain payment for services rendered by a non-covered and/or non-licensed provider (i.e.: billing for massages as licensed physical therapy or counseling by a Social Worker as psychiatric treatment).
4. "Upcoding" or falsifying the nature of services provided to obtain a higher rate on payment (i.e.: filling a prescription with the generic equivalent but billing for the higher-priced brand-name drug).
5. "Unbundling" or deliberately billing separately for the various elements of a given medical procedure to which one all-encompassing billing code applies, so as to obtain a higher aggregate payment.

II. Examples of Indicators of Potential Fraud

Indicators of potential claims fraud are as varied as they are numerous, ranging from the obvious to more subtle signs. Visibly discernible alterations or handwriting anomalies on a given claim are examples of an obvious indicator. A subtler indicator would be an inconsistency of diagnosis and treatment or an unusually high incidence of a given condition among a provider's patients.

Deciding what factors represent indicators of potential fraud is a subjective matter that varies widely. There is no formulaic or universal set of such indicators. The presence of one or more indicators in and of itself does not necessarily signify fraud, it merely serves to call attention to a claim or situation that is out of the ordinary and therefore requires further review.

The following examples illustrate some of the signs that might represent indicators of potential fraud on the part of a dishonest provider, a provider employee and/or a dishonest claimant:

1. Misspelled medical terminology on claim.
2. Similarity of patient/provider handwriting.
3. Apparent alteration of dates, amounts and/or other claim information.
4. Claims for non-emergency services dated Sundays or holidays.
5. Inconsistency between treatment billed and patient's diagnosis, age, gender etc.
6. Inconsistency between provider type and treatment billed.
7. Inconsistency between patient diagnosis and prescription billed.
8. Inconsistency between patient's medical history and treatment billed.
9. Consistent submission of photocopied claims.
10. Provider's lack of support documentation for claim selected for audit.
11. High-dollar claim for service dated either soon after effective date of coverage or just before the termination of coverage.
12. Unusual time lapse between date of service and date claim submitted.
13. Anonymous and/or persistent telephone inquiries re: status of claims.
14. Undue pressure to pay claims quickly.
15. Payments to P.O. Box not under provider or claimant name.

16. Any confirmed cases based on Service Verification (SV) member reporting.

APPENDIX B

CalViva Health Referral Form for Incident of Suspected Fraud

Please Note: CalViva Health will not discriminate against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the Federal or California False Claims Act, including an investigation for, initiation of, testimony for, or assistance in such an action.

Name: _____ Contact Phone: _____

Department: _____

Please indicate here if you wish to remain anonymous: _ Yes, I wish to remain anonymous

Case Type: __ Provider __ Member __ Employee ___ Subcontractor ____Other ____

INFORMATION ABOUT THE SUSPECTED INDIVIDUAL/ENTITY

Name of Individual or Provider or Other: _____

Address: _____

Phone: _____

Other Identifying Information (Member ID Number, Date of Service, etc.) _____

Please describe how you were informed of the incident: _____

_____

_____

Please provide a description of the suspect incident: _____

_____

_____

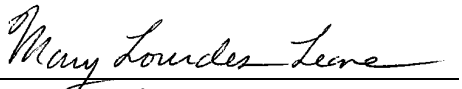
_____

_____

Signed: _____ Date: _____

The completed form should be put in an envelope marked "Confidential, for CalViva Health Chief Compliance Officer and submitted to CalViva Health, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711

APPROVAL:

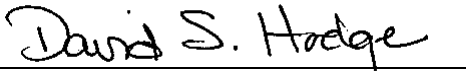


Date: **February 2015, 2024**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

Date: **February 2015, 2024**

Name: Jeffery Nkansah
Title: Chief Executive Officer



Date: **February 2015, 2024**

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

Program Description History		
Date	**Section #**	**Comment(s)**
3/1/2011		New Program Description
4/30/2012	Replaces former version	Annual review; changes to clarify and reflect current activity
1/7/2013	various	Annual review, clarified descriptions of activities
6/7/13	Cover page, sections 8 & 9	Changes to address DMHC requirements
2/6/14	Various	Annual review, changes to clarify current contractual relationships and activities
1-26-15	Sections 5, 6, 7, 8, 11, 13 and 15	Annual review, changes to update General Counsel information, clarify several sections to better reflect current activities and correct typographical errors

2-18-16	Section 11 and office address throughout	Updated office address and phone numbers and added information from APL15-026
2-17-17	Various	Clarified the overview and operational structure of CalViva Health. Removed reference to Optum as Health Net no longer uses Optum in their SIU activity.
2-15-18	Various	Annual Review, minor grammatical changes and added a reference to the COO and Operations Department staff.
01/07/19	Section II 7.	Inserted PIU e-mail address.
2-20-20	Overview; Sections II.4.1; II.7, 1 & 4	Clarified contractual relationships related to anti-fraud activity; updated external resources information; added revisions to reflect new requirements specified in DHCS–CalViva Contract (10-87050 A12) and made other minor editorial changes (grammar, regulatory citations, clarification to reflect current activities, etc.).
7/8/20	Section II # 9	Updated the DHCS website URL. Deleted an obsolete DHCS URL.
10/20/20	Section II, 2(6. And 13.); Section II, 6; Section II, 7(1. And 3); and Appendix A. II (16.)	Section II, 2(6. And 13.) added reference to EOC, and new Service Verification (SV) language; Section II, 7(1.) deleted typo and added "Promptly" reported and "Substantiated" preliminary to paragraph. Section II, 7(3.) added correct department name for mailing, "Managed Care Operations Division." Appendix A, II, #16 added reference to Service Verification (SV) reporting.
1/17/22	Cover Page and throughout	Updated the CCO to Mary Lourdes Leone and the CEO to Jeffery Nkansah; Under References, specifically added the name of CalViva's policy (CO-005).
1/29/23		Annual Review; No Changes
1/18/2024	Whole document	Revised the report title to "Fraud Prevention Program" to be consistent with the 2024 DHCS Contract; Updated and/or added language regarding reporting requirements to both DMHC and DHCS; Updated current method of electronically submitting referrals to DHCS' PIU; Added citation to the 2024 DHCS Contract; Reorganized and formatted the contents for easier flow/readability; Updated Table of Contents.
9/18/2024	Referenced CO-005 throughout; Section II.7.1	Referenced CalViva's policy CO-005. Updated Section II.7.1. ("Preliminary Fraud, Wast and Abuse Report") to reflect current procedure.
1/9/2025	Sections II 1-7	Added references to P&P "CO-005 Fraud and Abuse Prevention and Detection Investigation"; Corrected name for Fraud Prevention Plan; Added additional duty for Fraud

		Prevention Officer; Updated language regarding preliminary report; Minor edits throughout.

Item #14
Attachment 14.D

Compliance

2025 Privacy and Security Plan

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health Compliance Committee

FROM: Steven Si, Compliance Manager

COMMITTEE DATE: February 20, 2025

SUBJECT: 2025 Privacy and Security Plan Change Summary

Clean Page #	Section/Paragraph name	Description of change
5	Section II., 1, Designation of Privacy and Security Officer	• Clarifies CCO serves as Privacy and Security Officer.
14	Section IV., 1. Policies and Procedures	• Replaced CVH's Contingency Plan with Business Continuity and Disaster Recovery Controls.
14	Section IV., 2. Permitted Uses and Disclosures	• Added text regarding permissible disclosures per AB 352, Civil Code Section 56.110(a).
16	Section Iv., 3., B., 4. Implementing Security Measures	• Replaced CVH's Contingency Plan with Business Continuity and Disaster Recovery Controls.

PRIVACY AND SECURITY PLAN

For inquiries regarding this Privacy and Security Plan, please contact:

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mlleone@calvivahealth.org
Phone: 559-540-7856

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I. CalViva Health Overview

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

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

All of the processes and activities performed by contracted or delegated entities on CalViva Health's behalf are performed in compliance with CalViva Health's Privacy and Security Plan described in the following pages. These entities agree to the same restrictions and conditions that apply to CalViva Health with respect to Protected Health Information (PHI) and applicable provisions governing the use of PHI are incorporated into CalViva Health's service and/or business associate agreements with contracted or delegated entities.

1. **Statement of Purpose**:

   The purpose of CalViva Health's Privacy and Security Plan is to safeguard the Confidentiality of personal information (PI) and Protected Health Information (PHI) while not impeding the exchange of information needed to provide quality health care treatment, payment and operations. To that end, CalViva Health develops and implements policies and procedures designed to enable compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the American Recovery and Reinvestment Act (ARRA) California's Information Practices Act of 1977 (IPA) and Confidentiality of Medical Information Act (CMIA). CalViva Health is committed to creating a culture that effectively encourages its employees and associates to comply with applicable laws, regulations and policies related to privacy of health information and to perform work duties with a conscious regard for the privacy rights of its members.

CalViva Health ensures that member health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

Everyone has a responsibility for monitoring and reporting any activity that appears to violate this program or the supporting policies and procedures. Failure to follow the Privacy and Security Plan and related policies and procedures are grounds for appropriate discipline, which may include immediate termination.

2. **Confidentiality Guideline:**

CalViva Health and its business associates have adopted a strict guideline regarding the Confidentiality of certain information provided to CalViva Health employees and business associates. This guideline applies to all CalViva Health employees/business associates:

All employees/associates are prohibited from any unauthorized access to, use or Disclosure of patient ("Member") Protected Health Information (PHI), health care provider confidential information, or CalViva Health proprietary information. This includes but is not limited to: medical records, claims, benefits or other administrative data that is personally identifiable, CalViva Health Compliance program cases, peer review cases, quality improvement and utilization management programs, reports and disease management information containing PHI (hereinafter, collectively referred to as "Confidential Information"). All employees/associates are prohibited from disclosing medical information related to sensitive services to anyone other than the enrollee without the individual's express written authorization, including the policyholder or parent of a minor patient.

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

The Plan is prohibited from releasing medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

The Plan is prohibited from knowingly disclosing, transmitting, transferring, sharing, or granting access to medical information in an electronic health records system, or through a health information exchange, that would identify an individual, and that is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an

abortion that is lawful under California law to any individual or entity from another state, unless authorized under Section 56.110.

As it regards California AB 254, the Plan does not currently offer a reproductive or sexual health digital device. The Plan will deem any business that offers a "reproductive or sexual health digital service" to its members for the purpose of allowing individuals to manage their individual information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider subject to the requirements of the Confidentiality of Medical Information Act.

Employees/associates must hold in strict confidence, and not copy, disclose or permit the Disclosure to any person of any PHI or Confidential Information disclosed or delivered to them by CalViva Health or any provider except that which is allowable based on employee job role, by regulation, or by contractual and business associate agreements.
Employees/associates must comply with all CalViva Health policies and procedures concerning the maintenance of all Confidential Information made known to them as a CalViva Health employee/associate.

Employees must comply with all applicable state and federal laws and regulations regarding the Confidential Information. CalViva Health limits access to CalViva Health employee data to a subset of employees who are permitted the use and Disclosure of other employee confidential information as required in the scope of their duties.

Any violation of statutes, regulations, policies and/or procedures designed to safeguard the Confidentiality of the Confidential Information may include a range of disciplinary and corrective actions up to and including immediate discharge from CalViva Health. Failure to comply with this guideline and all applicable policies, laws, and regulations may result in legal action brought against the violating employee/associate.

II. OVERSIGHT AND EVALUATION OF PLAN

1. Designation of Privacy and Security Officer:

CalViva Health has appointed a Chief Compliance Officer ("CCO") to serve as the ~~focal point~~ Privacy and Security Officer ~~for privacy and security activities~~ and report directly to the Chief Executive Officer and to the RHA Commission. The CCO is charged with the responsibility for developing, operating and monitoring the Privacy and Security Plan. This includes establishing and overseeing an auditing and monitoring plan, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities; assisting management with formulation of corrective action plans and overseeing and/or verifying implementation of corrective action. The CCO works with a Compliance Committee to assist in implementation

of the Privacy and Security Plan.

The CCO responsibilities include:

A. Serving as the Privacy and Security Officer

B. Ensuring a Privacy and Security Plan is developed along with any applicable policies and procedures;

C. Ensuring Risk Analyses and Risk Mitigation plans are implemented;

D. Ongoing oversight and monitoring of Privacy and Security activities;

E. Preparing and overseeing distribution of the Notice of Privacy Practices;

F. Reporting on a regular basis to the RHA Commission on implementation and compliance;

G. Developing, coordinating and participating in an educational and training program on the elements of the Plan and ensuring that employees and managers are informed;

H. Developing an atmosphere to encourage employees to report possible noncompliance to CalViva Health, DHCS, or the Secretary of HHS without fear of retaliation;

I. Acting on matters related to privacy compliance, with the authority to design and coordinate internal reviews and any resulting need for corrective action;

J. Coordinating with the CEO regarding disciplinary sanctions for violations of the Privacy and Security Plan, policies and procedures;

K. Coordinating mitigation efforts in the event of a Disclosure that violates the privacy laws; and

L. Periodically evaluating and revising the Privacy and Security Plan and policies and procedures in light of changes at CalViva Health or in response to changes in federal or state requirements.

2. CalViva Health's Compliance Committee:

CalViva Health has a Compliance Committee to advise the Privacy and Security Officer and to assist in the implementation of the Privacy and Security Plan. The Committee is composed of the Plan's Chief Officers and meets at least quarterly and more frequently, as necessary. The

Chief Compliance Officer ("CCO") serves as chairperson of the meeting. The Committee shall maintain minutes of all its meetings to document its activities and recommendations.

The Committee's responsibilities include:

A. Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy and security policies and procedures as part of daily operations;

B. Determining the appropriate strategy/approach to promote compliance with the Privacy and Security Plan and detection of any potential violations, such as through hotlines and other reporting mechanisms;

C. Developing a system to solicit, evaluate and respond to complaints and problems;

D. Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;

E. Reviewing and tracking of possible Confidentiality Breaches that may be identified through incident reports, reports from CalViva Health's CCO, reports from contractors, appeals and grievances, etc.;

F. Overseeing the analysis and data collection of business processes, systems and relationships to understand the cause of a Breach;

G. Creating or revising policies to better prevent or address privacy and security Breaches; and

H. Overseeing development of resolutions to Breach issues.

When a potential problem is identified, the CCO may also select various individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

3. CalViva Health Management:

Chief Officers and Directors must be available to discuss with each employee under their direct supervision and every contractor/business associate with which they are the primary liaison:

A. The content and procedures in the Privacy and Security Plan and any applicable Policies and Procedures

B. The legal requirements applicable to Employees' and Contractors' job functions or

contractual obligations, as applicable

C. That adherence to the Plan and Policies and Procedures is a condition of employment

D. That CalViva Health shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with CalViva Health, for violation of the principles and requirements set forth in the Privacy and Security Plan and applicable law and regulations

The Chief Compliance Officer will include any significant privacy and Security issues as part of the operations reports to the RHA Commission (CalViva Health's governing board).

4. Auditing and Monitoring of Delegated Activities and Internal Operations:

CalViva Health is committed to aggressive monitoring of its Privacy and Security Plan and applicable policies and procedures. Routine and random audits will be conducted to identify problems, reduce identified problems and maintain a high level of privacy.

The CCO along with Department staff are responsible for ensuring the implementation of the Privacy and Security Plan and all associated policies and procedures, performance standards and activities. This includes oversight and monitoring activities of CalViva Health internal business units and subcontractors (i.e. administrative services contractors, delegated providers).

Oversight monitoring of delegated entities is done to ensure that delegated responsibilities and services comply with requirements and the appropriate state and federal regulatory requirements. Any deficiencies identified during the monitoring process will result in corrective action plans. The corrective action plan developed will identify the deficiency, outline how the deficiency will be corrected and set a time frame for implementing the corrective actions.

III. DEFINITIONS, MISSION, AND GOALS AND OBJECTIVES

1. Definitions:

A. Abuse – Incidents or practices of a provider, which although are not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary cost to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.

B. Access and Uses – Allows employee access to PHI subject to qualifying job requirements. Each employee is provided appropriate levels of Security to perform their job duties.

C. Authorization – Written authorization for any use or Disclosure of PHI that is not for treatment, payment, health care operations or otherwise permitted or required by regulations and/or statutes.

D. Breach – The acquisition, access, use, or Disclosure of Protected Health Information, where the Security or privacy of an individual's information is compromised; the compromise shall be presumed to be a breach unless CalViva Health or one of its Business Associates as applicable demonstrates that there is a low probability that the Protected Health Information has been compromised based on a Risk Assessment. See 45 C.F.R. § 164.402.

a. "Breach" excludes three scenarios:

- Any unintentional acquisition, access, or use of Protected Health Information by a CalViva Health employee or person acting under the authority of CalViva Health or one of its business associates, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or Disclosure.

- Any inadvertent Disclosure between employees of CalViva Health or of a CalViva Health business associate, where both employees are authorized to access such Protected Health Information, and where the information received as a result of such Disclosure is not further used or disclosed.

- A Disclosure of Protected Health Information where CalViva Health or one of its business associates has a good faith belief that an

unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

E. **Confidentiality** – The obligation of the holder of personal information to protect an individual's privacy. This obligation is determined by common practice, federal and state laws and regulations.

F. **Data Aggregation** – The combining of PHI created or received by the Plan on behalf of DHCS with PHI received by CalViva Health in its capacity as the contractor of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

G. **Disclosure** – The release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

H. **Medical information** - Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

I. **Protected Health Information (PHI)** – Individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic and social needs data collected from an individual, that relates to: 1) the individual's past, present or future physical or mental health or condition, 2) the provision of health care to the individual, or 3) the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

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

K. **Reproductive or sexual health application information** - Information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy

outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.

L. Risk Assessment/Analysis – The process of identifying, prioritizing, and estimating risks of organizational operations (including mission, functions, image, and reputation), organizational assets, individuals, other organizations, and the Nation, resulting from the operation of an information system.

M. Risk Management – The program and supporting processes to manage information Security risk to organizational operations (including mission, functions, image, reputation), organizational assets, individuals, other organizations, and the Nation, and includes: (i) establishing the context for risk-related activities; (ii) assessing risk; (iii) responding to risk once determined; and (iv) monitoring the risk over time.

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

O. Security – Security or security measures encompassing all of the administrative, physical and technical safeguards in an information system. It relates to the extent to which information can be stored and provided with access limited to those who are authorized and have a legitimate "need to know".

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

Q. Social Needs Data – Includes information related to financial insecurity, food insecurity, housing stability, access to transportation, interpersonal safety, barriers to accessing health care, including experiences with discrimination, bias or racism, or access to technology-based services, race, ethnicity, language, gender identity, and sexual orientation information.

R. Threat – Any circumstance or event with the potential to adversely impact organizational operations (including mission, functions, image or reputation), organizational assets, individuals, other organizations, or the Nation through an information system via unauthorized access, destruction, Disclosure, or modification of information, and/or denial of service.

S. Vulnerability – Weakness in an information system, system Security procedures, internal controls, or implementation that could be exploited by a threat source and

lead to a compromise in the integrity of that system.

2. **Mission:**

CalViva Health has incorporated the HIPAA General Administrative Privacy Rule Requirements, the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the HITECH Act and the National Institute of Standards and Technology (NIST) Risk Management Guide for Information Technology systems into its Privacy and Security Plan. CalViva Health has administrative and management arrangements or procedures, including a Privacy and Security Plan, which is designed to guard against the unauthorized access and/or use of PHI. This document provides a description of these requirements, which are as follows:

A. Written standards of conduct, policies, and procedures, which promote CalViva Health's commitment to comply with all applicable Federal and State standards.
B. The designation of a Privacy and Security Officer and ~~c~~Compliance ~~c~~Committee responsible for implementing and monitoring privacy and security activities.
C. Effective lines of communication with the organization's employees
D. Conducting ongoing education and training programs
E. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.
F. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.
G. Monitoring and auditing processes to assess the effectiveness of the Privacy and Security Plan.
H. An internal reporting system for receiving complaints and for prompt response to detected offenses.
I. Mechanisms for enforcing compliance standards through well-publicized disciplinary guidelines.
J. The implementation of appropriate measures to prevent future offenses.

The elements of the mission allow CalViva Health to:

A. Ensure that Member's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.
B. Comply with the requirements of ARRA including, but not limited to, Member requests for restrictions and accounting of disclosures.
C. Protect the public's health and well-being.
D. Adhere to the HIPAA General Administrative Privacy Rule Requirements as published in the final rule on December 28, 2000 and amended on March 27, 2002 and August 14, 2002. These requirements are found in 45 C.F.R. Part 160 and Part 164, sections 101 through 106 (otherwise known as Subparts A, B and C).
E. Adhere to the HIPAA General Administrative Security Rule as published in the final rule on February 20, 2003. These requirements are found in 45 C.F.R. Part 160,

162 and 164.

F. Adhere to the HIPAA Omnibus Rule as published on January 25, 2013.

G. Comply with the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

H. Comply with the California Civil Code sections 1798.29(a) and 1798.82(a), California Confidentiality of Medical Information Act, Assembly Bill 1184, Civil Code 56 et seq. and California Health and Safety Code sections 1364.5 and 1386 (b) (15) requirements and the California information Practices Act of 1977.

I. Comply with the California Department of Health Care Services (DHCS) contract requirements Exhibit G; Department of Managed Health Care (DMHC), California Civil Code section 1798.82, Center for Medicare and Medicaid Services (CMS); and, the HITECH Act Breach reporting requirements.

J. Ensure privacy and Security training is provided to CalViva Health employees, management and business associates.

K. Ensure Risk Analyses and Risk Mitigation Implementation Plans are conducted and implemented.

3. **Goals and Objectives:**

The goal is to assure that a CalViva Health member's personal health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

CalViva Health's Privacy and Security Plan incorporates the following objectives:

A. Provides oversight and monitoring of responsibilities delegated to contracted and sub- contracted entities.

B. Implement corrective action plans to address deficiencies in the safeguard or use of Protected Health Information.

C. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.

D. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.

E. Conduct internal monitoring and auditing of CalViva Health operations and functions to assess compliance with state and federal requirements.

F. Identify and investigate potential privacy and Security Breaches. Take appropriate action(s) to resolve and report Breaches.

G. Provide education and other available resources to assist contracted providers and sub- contractors in becoming compliant with privacy and information Security requirements.

H. Educate staff and enforce adherence to CalViva Health's Code of Conduct standards, privacy and Security policies and procedures and mission.

I. Provide new legislation updates to providers and contractors that specify required actions to ensure contractual compliance and makes available additional information about privacy and Security activities and requirements on an ongoing basis as needed.

Anyone with questions or concerns about the Privacy and Security Plan or a particular policy or procedure should seek the guidance of the Privacy and Security Officer. The Privacy and Security Officer provides support in CalViva Health's ongoing commitment to provide quality services in compliance with the health information privacy and Security laws.

IV. SCOPE OF PLAN

1. Policy and Procedures:

CalViva Health has adopted a set of Privacy and Security policies and procedures. The policies and procedures are available to employees and business associates. Employees and business associates are able to access the policies in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Privacy and Security Plan and outline areas such as:

A. How PHI is used and disclosed
B. The individual's rights to PHI
C. CalViva Health's relationship with contractors and sub-contractors
D. CalViva Health's response plan for complaints and privacy Breaches
E. CalViva Health's training programs
F. CalViva Health's Risk Analyses and Risk Mitigation measures
G. CalViva Health's ~~contingency~~ Business Continuity and Disaster Recovery Controls~~plans~~
H. CalViva Health's utilization of technology to communicate with members, providers, consumers, and employees.

2. Permitted Uses and Disclosures:

CalViva Health's Privacy and Security Plan covers the permitted uses and disclosures pertaining to Protected Health Information. This includes sending a Notice of Privacy Practice to members upon enrollment and annually thereafter explaining how CalViva Health uses and discloses Protected Health Information. CalViva Health is permitted to use and disclose Protected Health Information for activities that are directly connected with the administration of the Plan's healthcare program, which includes but is not limited to establishing eligibility and methods of reimbursement, and providing services for members. CalViva Health extends this commitment to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners. CalViva Health provides DHCS with a list of external entities, including persons, organizations, and agencies to which it discloses PHI annually. The guiding principles of CalViva Health's Permitted Uses and Disclosures of PHI include:

A. Use/Disclosure of PHI for CalViva Health management and administration
B. Use/Disclosure of PHI by CalViva Health for Data Aggregation services to DHCS
C. Use/Disclosure of PHI by CalViva Health for conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan's healthcare program
D. Use/Disclosure of PHI by CalViva Health for legislative investigations/audits related to the administration of the Plan's healthcare program

Additionally, The Plan is permitted to disclose medical information, as specified under Civil Code Section 56.110(a), to any of the following: (a) a patient, or their personal representative, consistent with the Patient Access to Health Records Act, (b) in response to an order of a California or federal court, but only to the extent clearly stated in the order and consistent with Penal Code Section 1543, if applicable, and only if all information about the patient's identity and records are protected from public scrutiny through mechanisms, including but not limited to, a sealed proceeding or court record, and (c) when expressly required by federal law that preempts California law, but only to the extent expressly required.

3. CalViva Health Responsibilities:

CalViva Health has made several commitments in its Privacy and Security Plan, policies and procedures and business operations. CalViva Health takes steps to ensure a member's Medi-Cal status is not divulged without prior approval except for treatment, payment and operations, or as required by law. CalViva Health's commitment to privacy and security of PHI also includes:

A. Implementing Safeguards – CalViva Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in both electronic and hard-copy form. CalViva Health employees are trained in methods to assure that they use all reasonable measures to safeguard Protected Health Information from any use or Disclosure that would violate the HIPAA or state regulations or CalViva Health's privacy and security policies. CalViva Health's employees have limited access to Protected Health Information through role-based access and password protections. CalViva Health also has firewalls to protect information from those who do not need to access the Protected Health Information to perform their job functions.

B. Implementing Security Measures – CalViva Health employees working with PHI sign a confidentiality agreement; undergo a background check and use workstations and laptops with encryption mechanisms. CalViva Health enforces the "minimum necessary" principle in regards to PHI and ensures employees send secure emails or utilize another appropriate secure method (i.e. secure file transfer protocol ("FTP") when PHI is involved. CalViva Health uses the latest antivirus software and security patches on their workstation and/or laptops. Any uses of removable media devices or remote access used by CalViva Health associates for PHI are encrypted. CalViva Health incorporates a data destruction method consistent with the Department of Defense standard methods and assigns unique usernames and passwords to users accessing PHI. CalViva Health enforces security measures in several ways:

1. **Use of System Security Controls –** CalViva Health will ensure computer systems automatically timeout after no more than 20 minutes of inactivity. CalViva Health will make sure all systems containing PHI display a warning banner stating that

data is confidential, systems are logged, and system use is for business purposes only. CalViva Health's systems will include system-logging functions, access controls, transmission encryption and host-based intrusion detection. Logs and user activities are maintained by CalViva Health in accordance with the Plan's document and data retention policy and procedures.

2. **Use of Audit Controls –** CalViva Health will conduct system security reviews of all systems processing and/or storing PHI. The audit controls in place include reviewing systems logs for unauthorized access and ensuring there is a documented change control procedure in place.

3. **Use of Paper Document Controls –** CalViva Health's paper document controls includes protection of data by making sure PHI in paper form is locked in a file cabinet rather than left unattended. CalViva Health also escorts visitors to areas in which PHI is housed. CalViva Health confidentially shreds and destroys PHI in paper form and never removes PHI from the premises except for routine business purposes or with the express written permission of a state and/or federal agency. Faxes containing PHI are never left unattended and outgoing faxes include a confidentiality statement notifying the recipient receiving to destroy faxes received in error. PHI is mailed using secure means and for large volume mailings of PHI, CalViva Health uses a bonded courier with signature required on receipt.

4. **Use of ~~a Contingency~~ Business Continuity and Disaster Recovery Controls~~Plan~~ –** CalViva Health's ~~contingency~~ Business Continuity ~~plan~~ measures include~~s~~ an ability to enable continuation of critical business processes and protection of the Security of electronic PHI in the event of an emergency. CalViva Health makes sure all sensitive data including PHI is backed up regularly. Data backups are stored offsite, which allows for restoration of data in the event of an outage.

C. **Notification and Investigation of Incidents and/or Breaches -** CalViva Health is committed to compliance with HIPAA and state health information compliance laws and to correcting violations. Upon discovery of a suspected Security incident and/or Breach, CalViva Health notifies the applicable state and federal agencies without unreasonable delay. CalViva Health takes prompt corrective action to mitigate any risks or damages involved with the Breach. Refer to the Plan's Privacy and Security policies and procedures for detailed descriptions of the Breach investigation and notification processes.

1. **Investigation and Corrective Action -** If there is a report of noncompliance, the Privacy and Security Officer, a member of the Compliance Committee or a Plan employee/associate discovers credible evidence of a violation, an investigation will immediately ensue. When CalViva Health substantiates a reported violation, it is the policy to institute corrective action.

2. **Initiating Systemic Changes to Correct Problems** - After a problem has been identified and corrected, the Privacy and Security Officer and Compliance Committee will review the circumstances to determine 1) whether similar problems have been uncovered elsewhere and 2) whether modifications of the policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy and Security Officer will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

4. Education and Training Programs:

CalViva Health will ensure that training is provided to all employees and business associates. All employees with access to Protected Health Information are required to attend and participate in privacy and security training sessions. Adherence to the provisions of this plan, such as attending training sessions, will be a factor in the annual evaluation of each employee. All new employees will be provided training within a reasonable period after orientation.

5. Risk Analysis and Risk Management:

CalViva Health understands a Risk Analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security rule. CalViva Health works to ensure an accurate and thorough assessment of the potential risks and vulnerabilities to the Confidentiality, integrity and availability of PHI held by the Plan.

CalViva Health implements these steps when conducting a Risk Analysis:

a. Step 1: System Characterization
b. Step 2: Threat Identification
c. Step 3: Vulnerability Identification
d. Step 4: Control Analysis
e. Step 5: Likelihood Determination
f. Step 6: Impact Analysis
g. Step 7: Risk Determination
h. Step 8: Control Recommendations
i. Step 9: Results Documentation

The steps referenced above are consistent with the methodologies described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30 Risk Management Guide for Information Technology Systems and NIST SP 800-66 An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security rule.

Along with risk analyses, CalViva Health maintains a Risk Management protocol which provides a structure for the evaluation, prioritization, and implementation of risk-reducing Security measures. CalViva Health has a team of individuals in place who are knowledgeable about the organization's Privacy and Security policies, procedures, training program, computer system set up, and technical Security controls.

APPROVAL:

Date: **February 2015, 20254**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

Date: **February 2015, 20254**

Name: Jeffrey Nkansah
Title: Chief Executive Officer

Date: **February 2015, 20254**

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

Program Description History		
Date	**Section #**	**Comment(s)**
1/1/2012		New Program Description
3/1/2013		Updated entire document to properly reflect Privacy and Security Measures
2/6/2014		Changes to the Breach and Protected Health Information definition to align with the HIPAA FINAL Rule published on January 17, 2013; added language pertaining to the Risk Management Team; clarification to identify the Chief Compliance Officer is also the Privacy and Security Officer and other minor changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
1/5/2015		Annual Review; No Changes Needed
2/18/2016		Annual Review; Updated the contact information for the Compliance Officer. Minor edits to clarify current practices.

2/16/2017		Annual Review; Updated overview clarify current contractual relationships and activities. Updated the name of document from Privacy and Security Program to Privacy and Security Plan.
2/15/2018		Annual Review; Updated the officer responsible for the Privacy and Security Plan, added a reference to comply with California's Data Breach Security Reporting Requirements, Updated the Department Responsible for the Plan and the reference to the name of the report which would be provided to the RHA Commission. Re-arranged sections for readability.
2/21/2019		Annual Review; No Changes Needed
2/20/2020		Annual Review; Added language referencing new policy HI-031 Member Communications under Telephone Consumer Protections Act (TCPA). Clarified a definition and a publishing date for a previously released regulatory law.
2/18/2021		Annual Review; No Changes Needed
2/3/2022		Annual Review; Updated the CCO to Mary Lourdes Leone and the CEO to Jeffery Nkansah
2/16/2023		Annual Review; Updated language to capture Assembly Bill 1184 surrounding requests for confidential communication, added definition of protected individual and sensitive services.
2/15/2024		Annual Review; Updated language to capture Assembly Bill 352 surrounding privacy of personal reproductive decisions, Assembly Bill 254 reproductive or sexual health information, and Senate Bill 107 surrounding gender-affirming care and mental health care for children. Updated/added definition of PHI, Social Needs Data, reproductive/sexual health information, and medical information.
2/20/2025	Sections II., and IV	Annual Review: In section II.1 deleted "focal point" and inserted Privacy and Security Officer; - In section IV.1.G replaced "Contingency plans" with "Business Continuity and Disaster Recovery Controls; In section IV.2. added text regarding permissible disclosures per AB 352, Civil Code Section 56.110(a).

Item #14
Attachment 14.E

Compliance

2025 Emergency Preparedness
& Crisis Response Plan

REPORT SUMMARY TO COMMITTEE

TO: RHA Commission

FROM: Mary Lourdes Leone

COMMITTEE DATE: February 20, 2025

SUBJECT: Emergency Preparedness and Response Plan Change Summary

Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Inserted year 2025
Page 5	I.D. Constituents	Updated to include members in LTC facilities.
Page 8	III. Functional Area Responses	Updated with more precise language applicable to each function.
Page 17	IV. References	Listed applicable CalViva Health policies
Throughout		Minor edits to grammar.

EMERGENCY PREPAREDNESS & CRISIS RESPONSE PLAN

For inquiries regarding this Plan, please contact:

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EMERGENCY PREPAREDNESS & CRISIS RESPONSE PLAN

I. INTRODUCTION

A. OVERVIEW

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

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

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

B. PURPOSE

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

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

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

C. TYPES OF EMERGENCIES

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

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

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

In this document several words are defined as:

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

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

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

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

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

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

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

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

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

D. CONSTITUENTS

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

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

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

- **Employees**
  The Emergency Preparedness and Crisis Response outlines plans and procedures to adequately prepare employees to educate and inform members and providers with the latest emergency or disaster information and respective recovery details as well as the

Plan's directives. This includes the support of employees who are personally affected by emergency situations and addressing challenges related to the redistribution of workload and office availability.

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

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

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

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

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

II. Disaster & Emergency Preparedness Protocol

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

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

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

A. Emergency Response Leadership Team

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

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

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

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

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

Oversight of the Emergency Preparedness & Crisis Response

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

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

Daniel Maychen	Facilities, Claims, Information Technology, Enrollment,

B. Policies and Procedures

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

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

C. Monitoring Functional Area Responses

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

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

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

III. FUNCTIONAL AREA RESPONSES

A. Appeals and Grievances

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting th~~e~~is function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

B. Call Center (Member and Provider Services)

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

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

1. Informing members that certain ~~R~~requirements may be relaxed to better serve ~~members~~ them during a crisis.
2. Adding emergency messaging or pointing to a shared resource if appropriate to triage calls.

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting this~~e~~ function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

C. Claims

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

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

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

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

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

D. Community and Government Relations

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

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

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

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

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

E. Compliance

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting ~~the~~ any essential administrative or operational functions within Health Net where it has been determined the impact will also impact CalViva Health business.

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

F. Enrollment

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

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

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

CalViva Health requires ~~that~~ Health Net to notifyies the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting thise function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

G. Facilities

CalViva Health has one ~~building~~ facility located at 7625 N. Palm Ave., Fresno CA 93711. The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer and the Office Director regarding any emergency crises which impact thise facility~~CalViva Health office~~.

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

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

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

CalViva Health requires ~~that~~ Health Net to notifyies the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting ~~the function~~ any administrative or operational functions within Health Net facilities where it has been determined the impact will also impact CalViva Health business.

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

H. Human Resources

The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer and the Human Resources Director regarding any emergency crises which impact the CalViva Health office. Health Net has a Human Resources team which will respond to an emergency or crisis.
Upon the official notification that there is an emergency or disaster impacting thise function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

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

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

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

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

I. Information Technology

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

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

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

Health Net Information Technology capability consists of over 200 IT security and risk personnel assigned all aimed at recovering as quickly as possible, including those related

to member care and provider payment services within 24 hours from the time the disaster is declared.

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting any administrative or operational ~~the~~ functions within Health Net where it has been determined the impact will also impact CalViva Health business.

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

J. ~~Marketing and~~ Communications

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

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

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

CalViva Health also requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting thi~~s~~e

function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

K. Pharmacy

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

L. Population Health and Utilization Management

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

M. Provider Network

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting this~~e~~ function within Health Net where it has been determined the impact will also impact CalViva Health business.

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

N. Security

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

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

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

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

CalViva Health requires ~~that~~ Health Net to notify~~ies~~ the CalViva Health E~~L~~RLT team immediately of any notification where there is an emergency or disaster impacting any administrative or operational ~~the~~ functions within Health Net where it has been determined the impact will also impact CalViva Health business.

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

IV. References

1. Health Net Emergency Preparedness and Crises Response Plan
2. CalViva Health Policies and Procedures related to Risk Management and Business Continuity:

   - HI-023 – Risk Assessment and Management
   - HI-027 – Information Security Safeguards
   - HI-029 – Business Continuity and Disaster Recovery
   - HI-030 – IT Asset Inventory, Capacity Planning, Configuration Management

~~2.~~3. CalViva Health Policies and Procedures related to the following Functional Areas:

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

APPROVAL:

Date: **February ~~15~~20, 202~~4~~5**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

Date: **February ~~15~~20, 202~~4~~5**

Name: Jeffrey Nkansah
Title: Chief Executive Officer

Date: **February ~~15~~20, 202~~4~~5**

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

Program Description History		
Date	**Section #**	**Comment(s)**
2/16/2023		New Program Description
2/15/2024		Annual Review: No changes
2/20/2025	Sections I, III and IV.	Updated section I.D. Members to include members in LTC facilities; Updated section III Functional Area Responses with more precises language applicable to each function; Updated section IV References by including applicable CalViva policies and procedures; made minor edits to grammar throughout.

Item #15
Attachment 15.A

Financials as of 12/31/24

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of December 31, 2024

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	378,307,012.89
5	Total Bank Accounts	$ 378,307,012.89
6	Accounts Receivable	
7	Accounts Receivable	200,218,702.27
8	Total Accounts Receivable	$ 200,218,702.27
9	Other Current Assets	
10	Interest Receivable	1,156,676.39
11	Investments - CDs	0.00
12	Prepaid Expenses	1,162,955.14
13	Security Deposit	0.00
14	Total Other Current Assets	$ 2,319,631.53
15	Total Current Assets	$ 580,845,346.69
16	Fixed Assets	
17	Buildings	5,794,219.27
18	Computers & Software	26,444.36
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	132,598.61
22	Total Fixed Assets	$ 9,114,681.34
23	Other Assets	
24	Investment -Restricted	301,574.76
25	Lease Receivable	1,775,900.90
26	Total Other Assets	$ 2,077,475.66
27	TOTAL ASSETS	$ 592,037,503.69
28	LIABILITIES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	66,619,565.58
33	Accrued Admin Service Fee	4,763,396.00
34	Capitation Payable	135,806,186.67
35	Claims Payable	22,080.46
36	Directed Payment Payable	1,843,869.76
37	Total Accounts Payable	$ 209,055,098.47
38	Other Current Liabilities	
39	Accrued Expenses	1,013,869.28
40	Accrued Payroll	96,101.82
41	Accrued Vacation Pay	423,796.90
42	Amt Due to DHCS	20,250,000.00
43	IBNR	392,978.19
44	Loan Payable-Current	0.00
45	Premium Tax Payable	0.00
46	Premium Tax Payable to BOE	325,404.28
47	Premium Tax Payable to DHCS	187,343,750.00
48	Total Other Current Liabilities	$ 209,845,900.47
49	Total Current Liabilities	$ 418,900,998.94
50	Long-Term Liabilities	
51	Renters' Security Deposit	25,906.79
52	Subordinated Loan Payable	0.00
53	Total Long-Term Liabilities	$ 25,906.79
54	Total Liabilities	$ 418,926,905.73
55	Deferred Inflow of Resources	1,359,784.44
56	Equity	
57	Retained Earnings	161,689,933.96
58	Net Income	10,060,879.56
59	Total Equity	$ 171,750,813.52
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 592,037,503.69

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2024 - December 2024

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Earned	5,782,822.67	2,200,000.00	3,582,822.67
3	Premium/Capitation Income	996,362,296.19	918,764,911.00	77,597,385.19
4	**Total Income**	**1,002,145,118.86**	**920,964,911.00**	**81,180,207.86**
5	Cost of Medical Care			
6	Capitation - Medical Costs	671,793,787.53	596,910,102.00	74,883,685.53
7	Medical Claim Costs	2,926,260.14	3,000,000.00	(73,739.86)
8	**Total Cost of Medical Care**	**674,720,047.67**	**599,910,102.00**	**74,809,945.67**
9	**Gross Margin**	**327,425,071.19**	**321,054,809.00**	**6,370,262.19**
10	Expenses			
11	Admin Service Agreement Fees	28,791,411.00	27,295,950.00	1,495,461.00
12	Bank Charges	0.00	3,600.00	(3,600.00)
13	Computer/IT Services	71,667.45	128,980.02	(57,312.57)
14	Consulting/Accreditation Fees	38,838.00	199,999.98	(161,161.98)
15	Depreciation Expense	169,246.08	186,000.00	(16,753.92)
16	Dues & Subscriptions	121,408.50	148,800.00	(27,391.50)
17	Grants	2,627,643.55	2,784,092.00	(156,448.45)
18	Insurance	173,873.10	223,785.48	(49,912.38)
19	Labor	2,142,331.48	2,494,476.00	(352,144.52)
20	Legal & Professional Fees	63,794.58	161,400.00	(97,605.42)
21	License Expense	744,057.36	712,578.48	31,478.88
22	Marketing	606,805.05	750,000.00	(143,194.95)
23	Meals and Entertainment	13,094.46	15,812.50	(2,718.04)
24	Office Expenses	44,256.60	57,000.00	(12,743.40)
25	Parking	214.98	780.00	(565.02)
26	Postage & Delivery	841.70	2,460.00	(1,618.30)
27	Printing & Reproduction	1,337.81	2,460.00	(1,122.19)
28	Recruitment Expense	(549.00)	78,750.00	(79,299.00)
29	Rent	0.00	6,000.00	(6,000.00)
30	Seminars and Training	9,854.21	15,800.00	(5,945.79)
31	Supplies	5,153.10	6,499.98	(1,346.88)
32	Taxes	281,875,000.00	281,875,000.02	(0.02)
33	Telephone	27,589.76	21,000.00	6,589.76
34	Travel	11,969.65	14,800.00	(2,830.35)
35	**Total Expenses**	**317,539,839.42**	**317,186,024.46**	**353,814.96**
36	**Net Operating Income**	**9,885,231.77**	**3,868,784.54**	**6,016,447.23**
37	Other Income			
38	Other Income	175,647.79	217,500.00	(41,852.21)
39	**Total Other Income**	**175,647.79**	**217,500.00**	**(41,852.21)**
40	**Net Other Income**	**175,647.79**	**217,500.00**	**(41,852.21)**
41	**Net Income**	**10,060,879.56**	**4,086,284.54**	**5,974,595.02**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2025 vs FY 2024

		Total	
		July 2024 - Dec 2024	July 2023 - Dec 2023 (PY)
1	Income		
2	Interest Earned	5,782,822.67	4,015,566.99
3	Premium/Capitation Income	996,362,296.19	705,802,197.53
4	**Total Income**	**1,002,145,118.86**	**709,817,764.52**
5	Cost of Medical Care		
6	Capitation - Medical Costs	671,793,787.53	665,972,143.62
7	Medical Claim Costs	2,926,260.14	692,825.13
8	**Total Cost of Medical Care**	**674,720,047.67**	**666,664,968.75**
9	**Gross Margin**	**327,425,071.19**	**43,152,795.77**
10	Expenses		
11	Admin Service Agreement Fees	28,791,411.00	28,831,209.00
12	Computer/IT Services	71,667.45	68,782.50
13	Consulting Fees	38,838.00	32,800.00
14	Depreciation Expense	169,246.08	163,768.20
15	Dues & Subscriptions	121,408.50	118,304.25
16	Grants	2,627,643.55	2,367,727.25
17	Insurance	173,873.10	175,534.24
18	Labor	2,142,331.48	1,815,015.55
19	Legal & Professional Fees	63,794.58	42,616.21
20	License Expense	744,057.36	632,523.49
21	Marketing	606,805.05	566,174.44
22	Meals and Entertainment	13,094.46	8,831.61
23	Office Expenses	44,256.60	33,956.02
24	Parking	214.98	109.00
25	Postage & Delivery	841.70	1,102.04
26	Printing & Reproduction	1,337.81	933.65
27	Recruitment Expense	(549.00)	842.13
28	Rent	0.00	0.00
29	Seminars and Training	9,854.21	4,449.14
30	Supplies	5,153.10	6,932.88
31	Taxes	281,875,000.00	(446.53)
32	Telephone	27,589.76	15,247.80
33	Travel	11,969.65	9,522.64
34	**Total Expenses**	**317,539,839.42**	**34,895,935.51**
35	**Net Operating Income/ (Loss)**	**9,885,231.77**	**8,256,860.26**
36	Other Income		
37	Other Income	175,647.79	243,293.27
38	**Total Other Income**	**175,647.79**	**243,293.27**
39	**Net Other Income**	**175,647.79**	**243,293.27**
40	**Net Income/ (Loss)**	**10,060,879.56**	**8,500,153.53**

Item #15
Attachment 15.B

Medical Management

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2024

Current as of End of the Month: December
Revised Date: 01/22/2025

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	7	6	7	20	4	11	10	25	7	6	1	14	84	126
Standard Grievances Received	145	132	147	424	218	198	164	580	193	180	174	547	205	140	138	483	2034	1761
Total Grievances Received	**160**	**140**	**149**	**449**	**225**	**204**	**171**	**600**	**197**	**191**	**184**	**572**	**212**	**146**	**139**	**497**	**2118**	**1887**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	1	1	2	1	0	0	1	3	10
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**	**99.4%**	**99.6%**	**99.5%**	**100.0%**	**100.0%**	**99.8%**	**99.85%**	**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	7	6	7	20	4	11	10	25	7	6	3	16	86	126
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Standard Grievances Resolved Compliant	160	125	133	418	166	213	178	557	191	170	171	532	186	198	156	540	2047	1702
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.95%**	**99.9%**
Total Grievances Resolved	**173**	**134**	**136**	**443**	**174**	**219**	**185**	**578**	**195**	**181**	**181**	**557**	**193**	**204**	**159**	**556**	**2134**	**1829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**153**	**118**	**120**	**391**	**154**	**183**	**156**	**493**	**165**	**161**	**158**	**484**	**154**	**176**	**143**	**473**	**1841**	**1468**
Access - Other - DMHC	25	24	10	59	23	29	19	71	26	23	29	78	18	30	15	63	271	270
Access - PCP - DHCS	7	4	4	15	13	15	13	41	10	17	20	47	16	14	4	34	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	3	3	4	10	9	4	7	20	12	6	4	22	71	78
Administrative	25	30	36	91	30	34	49	113	48	39	32	119	28	38	41	107	430	186
Balance Billing	23	18	14	55	32	33	25	90	23	20	16	59	26	24	25	75	279	NA
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	16	23	19	58	17	13	13	43	11	17	12	40	181	122
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	5	11	28	16	13	12	41	5	15	14	34	15	14	12	41	144	339
Pharmacy/RX Medical Benefit	1	1	1	3	2	0	0	2	1	2	1	4	0	0	0	0	9	1
Transportation - Access	18	7	10	35	11	14	3	28	9	9	11	29	18	6	10	34	126	175
Transportation - Behavior	8	1	4	13	0	1	1	2	9	8	3	20	3	6	2	11	46	89
Transportation - Other	12	9	12	33	8	18	11	37	8	11	12	31	7	21	18	46	147	86
Quality Of Care Grievances	**20**	**16**	**16**	**52**	**20**	**36**	**29**	**85**	**30**	**20**	**23**	**73**	**39**	**28**	**16**	**83**	**293**	**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	1	0	1	2	1	0	0	1	3	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	1	0	1	2	4
Behavioral Health	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	2	0
Other	2	3	5	10	4	3	2	8	5	4	2	11	5	4	2	11	40	60
PCP Care	8	5	5	18	7	13	13	33	9	5	6	20	13	13	4	30	101	94
PCP Delay	1	3	4	8	4	7	5	16	10	5	9	24	12	5	6	23	71	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	1	7	6	14	3	4	4	11	5	5	3	13	47	60
Specialist Delay	2	3	0	5	3	6	2	11	2	1	1	4	3	0	1	4	24	24
Exempt Grievances Received	146	135	176	**457**	224	185	211	**620**	196	219	211	**626**	198	153	147	**498**	**2201**	1885
Access - Avail of Appt w/ PCP	4	1	2	**7**	7	3	4	**14**	5	2	4	**11**	5	5	1	**11**	**43**	15
Access - Avail of Appt w/ Specialist	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	3	**3**	0	4	1	**5**	2	0	3	**5**	2	0	1	**3**	**16**	7
Access - Wait Time - in office for appt	0	1	0	**1**	0	1	1	**2**	0	0	0	**0**	0	3	1	**4**	**7**	2
Access - Panel Disruption	0	0	2	**2**	4	2	0	**6**	3	10	4	**17**	4	0	1	**5**	**30**	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	2	0	**2**	0	1	0	**1**	**3**	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**	3	0	0	**3**	0	0	0	**0**	**4**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	**1**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	0
Attitude/Service - Health Plan Staff	0	1	1	**2**	5	1	0	**6**	1	2	4	**7**	3	1	0	**4**	**19**	14
Attitude/Service - Provider	6	9	16	**31**	13	9	27	**49**	18	20	28	**66**	16	5	6	**27**	**173**	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**	6	0	6	**12**	6	9	4	**19**	0	1	0	**1**	**38**	4
Attitude/Service - Health Plan	0	1	3	**4**	3	2	1	**6**	0	4	1	**5**	1	1	1	**3**	**18**	12
Authorization - Authorization Related	0	2	1	**3**	0	4	7	**11**	3	4	1	**8**	1	0	2	**3**	**25**	6
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	2	1	**4**	0	1	0	**1**	0	0	0	**0**	**5**	4
Eligibility Issue - Member not eligible per Provider	2	1	4	**7**	17	10	6	**33**	4	8	7	**19**	8	8	4	**20**	**79**	48
Health Plan Materials - ID Cards-Not Received	19	17	20	**56**	26	22	38	**86**	30	29	42	**101**	51	26	30	**107**	**350**	210
Health Plan Materials - ID Cards-Incorrect Information on Card	0	2	0	**2**	4	2	0	**6**	0	1	0	**1**	1	0	1	**2**	**11**	2
Health Plan Materials - Other	0	0	0	**0**	1	0	2	**3**	0	1	0	**1**	0	0	0	**0**	**4**	4

Behavioral Health Related	2	3	4	**9**	3	8	9	**20**	10	11	11	**32**	0	0	0	**0**	**61**	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	50	48	49	**147**	82	61	67	**210**	62	64	69	**195**	46	59	53	**158**	**710**	652
PCP Assignment/Transfer - HCO Assignment - Change Request	15	15	19	**49**	21	18	8	**47**	12	15	6	**33**	22	12	10	**44**	**173**	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**	7	7	1	**15**	3	2	3	**8**	1	2	0	**3**	**45**	37
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	**1**	7
PCP Assignment/Transfer - Mileage Inconvenience	0	1	0	**1**	2	1	1	**4**	1	1	0	**2**	3	1	0	**4**	**11**	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**	1	0	1	**2**	1	1	3	**5**	1	0	1	**2**	**26**	65
Transportation - Access - Provider Late	2	2	1	**5**	1	0	0	**1**	0	2	2	**4**	0	0	2	**2**	**12**	32
Transportation - Behaviour	4	0	1	**5**	0	0	1	**1**	0	0	0	**0**	0	0	4	**4**	**10**	76
Transportation - Other	2	4	3	**9**	0	1	3	**4**	1	1	2	**4**	5	3	0	**8**	**25**	53
OTHER - Other	1	4	5	**10**	4	5	2	**11**	7	6	3	**16**	5	6	8	**19**	**56**	14
Claims Complaint - Balance Billing from Provider	28	15	18	**61**	15	22	24	**61**	24	22	13	**59**	23	18	21	**62**	**243**	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	1	1	2	4	2	3	1	6	1	4	4	9	25	34
Standard Appeals Received	22	17	32	71	39	40	43	122	50	38	46	134	52	38	42	132	459	331
Total Appeals Received	**24**	**19**	**34**	**77**	**40**	**41**	**45**	**126**	**52**	**41**	**47**	**140**	**53**	**42**	**46**	**141**	484	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**99.4%**
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**	1	1	2	**4**	2	3	1	**6**	1	4	4	9	25	35
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**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	11	57	30	39	40	109	49	45	36	130	46	46	42	134	430	325
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**99.8%**
Total Appeals Resolved	**18**	**31**	**14**	**63**	**31**	**40**	**42**	**113**	**51**	**48**	**37**	**136**	**47**	**50**	**46**	**143**	**455**	**361**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**18**	**31**	**14**	**63**	**31**	**40**	**42**	**113**	**51**	**48**	**37**	**136**	**46**	**49**	**46**	**141**	**453**	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	1	4	6	11	8	2	4	14	5	2	1	8	33	9
DME	2	3	3	8	7	6	8	21	9	8	7	24	5	13	5	23	76	37
Experimental/Investigational	0	0	3	3	0	0	2	2	1	0	3	4	0	2	2	4	13	0
Mental Health	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Advanced Imaging	11	18	0	29	15	14	15	44	15	21	14	50	18	12	9	39	162	162
Other	1	4	4	9	1	7	4	12	5	9	4	18	8	11	21	40	79	35
Pharmacy/RX Medical Benefit	2	3	2	7	2	0	2	7	8	5	3	16	5	2	3	10	40	47
Surgery	2	3	2	7	5	6	5	16	5	2	2	9	5	7	5	17	49	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**	**1**	**1**	**1**	**3**	**3**	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	1	1	1	3	3	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**	11	20	18	49	21	16	12	49	10	23	18	51	171	156
Uphold Rate	**44.4%**	**25.8%**	**42.9%**	**34.9%**	**35.5%**	**50.0%**	**42.9%**	**43.4%**	**41.2%**	**33.3%**	**32.4%**	**36.0%**	**21.3%**	**46.0%**	**39.1%**	**35.7%**	**37.6%**	**43.2%**
Overturns - Full	9	22	7	**38**	20	18	22	**60**	28	30	21	**79**	31	25	25	**81**	258	194
Overturn Rate - Full	**50.0%**	**71.0%**	**50.0%**	**60.3%**	**64.5%**	**45.0%**	**52.4%**	**53.1%**	**54.9%**	**62.5%**	**56.8%**	**58.1%**	**66.0%**	**50.0%**	**54.3%**	**56.6%**	**56.7%**	**53.7%**
Overturns - Partials	1	1	1	**3**	0	2	2	**4**	2	0	3	**5**	3	2	2	**7**	19	10
Overturn Rate - Partial	**5.6%**	**3.2%**	**7.1%**	**4.8%**	**0.0%**	**5.0%**	**4.8%**	**3.5%**	**3.9%**	**0.0%**	**8.1%**	**3.7%**	**6.4%**	**4.0%**	**4.3%**	**4.90%**	**4.2%**	**2.8%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	2	1	**3**	3	0	1	4	**7**	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.2%**	**2.7%**	**2.2%**	**6.4%**	**0.0%**	**2.2%**	**2.8%**	**1.5%**	**0.3%**
Membership	434,122	434,443	434,459		434,072	433,828	434,041		435,904	435,734	435,142		434,808	433,290	431,077			430,517
Appeals - PTMPM	0.04	0.07	0.03	0.05	0.07	0.09	0.10	0.09	0.12	0.11	0.09	0.10	0.11	0.12	0.11	0.11	0.09	0.09
Grievances - PTMPM	0.40	0.31	0.31	0.34	0.40	0.50	0.43	0.44	0.45	0.42	0.42	0.43	0.44	0.47	0.37	0.43	0.41	0.24

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	6	4	5	15	3	8	9	20	6	6	0	12	69	107
Standard Grievances Received	117	109	131	357	173	167	149	489	161	154	152	467	160	116	110	386	1699	1447
Total Grievances Received	**130**	**116**	**133**	**379**	**179**	**171**	**154**	**504**	**164**	**162**	**161**	**487**	**166**	**122**	**110**	**398**	**1768**	**1554**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	1	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.3%**	**99.8%**	**99.4%**	**100.0%**	**100.0%**	**99.7%**	**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	6	4	5	15	3	8	9	20	6	6	2	14	71	107
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Standard Grievances Resolved Compliant	130	102	110	342	153	163	152	468	172	140	146	458	163	154	128	445	1713	1389
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.9%**	**99.9%**
Total Grievances Resolved	**141**	**110**	**113**	**364**	**160**	**167**	**157**	**484**	**175**	**148**	**155**	**478**	**169**	**160**	**130**	**459**	**1785**	**1497**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**124**	**97**	**98**	**319**	**142**	**137**	**133**	**412**	**149**	**132**	**137**	**418**	**134**	**139**	**115**	**388**	**1537**	**1194**
Access - Other - DMHC	21	19	9	49	22	22	16	60	22	16	26	64	16	25	14	55	228	225
Access - PCP - DHCS	4	4	3	11	11	14	11	36	9	15	18	42	13	13	1	27	116	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	2	3	4	9	8	3	7	18	11	6	0	17	62	69
Administrative	24	24	30	78	28	28	39	95	43	32	28	103	23	28	37	88	364	160
Balance Billing	19	17	11	47	30	28	22	80	22	19	14	55	25	16	21	62	244	
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	16	15	18	49	17	12	12	41	10	14	8	32	155	97
Behavioral Health	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0
Other	9	5	10	24	16	9	10	35	5	14	11	30	12	12	8	32	121	283
Pharmacy/RX Medical Benefit	1	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	3	1
Transportation - Access	13	6	6	25	8	6	3	17	8	7	8	23	14	6	7	27	92	126
Transportation - Behaviour	7	1	3	11	0	0	1	1	8	6	2	16	3	5	2	10	38	70
Transportation - Other	7	4	11	22	7	12	8	27	7	8	11	26	7	14	17	38	113	61
Quality Of Care Grievances	**17**	**13**	**15**	**45**	**18**	**30**	**24**	**72**	**26**	**16**	**18**	**60**	**35**	**21**	**15**	**71**	**248**	**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	1	1	1	0	0	1	2	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Behavioral Health	0	0	0	0	0	0	1	1	0	1	0	1	0	0	0	0	2	0
Other	1	2	4	7	4	1	0	5	5	3	2	10	3	3	2	8	30	51
PCP Care	6	5	5	16	6	13	11	30	9	3	5	17	13	10	4	27	90	78
PCP Delay	1	2	4	7	4	6	5	15	8	5	6	19	11	5	5	21	62	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	4	6	10	2	3	4	9	5	3	3	11	39	54
Specialist Delay	2	3	0	5	3	6	1	10	2	1	0	3	2	0	1	3	21	17

CalViva Health Appeals and Grievances Dashboard (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	1	0	2	3	2	2	1	5	1	3	4	8	22	32
Standard Appeals Received	16	10	26	52	33	30	35	98	41	32	42	115	43	30	35	108	373	278
Total Appeals Received	**18**	**12**	**28**	**58**	**34**	**30**	**37**	**101**	**43**	**34**	**43**	**120**	**44**	**33**	**39**	**116**	395	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.6%**
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	1	0	2	3	2	2	1	5	1	3	4	8	22	32
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**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	8	38	25	32	29	**86**	41	39	30	**110**	39	40	33	**112**	346	280
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**13**	**20**	**11**	**44**	**26**	**32**	**31**	**89**	**43**	**41**	**31**	**115**	**40**	**43**	**37**	**120**	**368**	**312**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**13**	**20**	**11**	**44**	**26**	**32**	**31**	**89**	**43**	**41**	**31**	**115**	**39**	**42**	**37**	**118**	**366**	**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	1	4	5	10	7	2	3	12	4	1	1	6	28	8
DME	1	2	2	5	4	6	7	17	6	7	7	20	4	12	5	21	63	36
Experimental/Investigational	0	0	2	2	0	0	1	1	0	0	3	3	0	1	2	3	9	0
Behavioral Health	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	1
Advanced Imaging	8	9	0	17	15	10	10	35	14	19	11	44	16	12	6	34	130	137
Other	1	4	4	9	0	4	3	7	5	8	3	16	7	10	16	33	65	32
Pharmacy/RX Medical Benefit	1	2	1	4	2	3	0	5	7	4	2	13	5	1	2	8	30	39
Surgery	2	3	2	7	4	5	5	14	4	0	2	6	3	5	5	13	40	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**	**1**	**1**	**1**	**3**	**3**	**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
Behavioral 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	1	1	1	3	3	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**	10	15	14	**39**	17	12	9	**38**	7	20	16	**43**	134	139
Uphold Rate	**38.5%**	**25.0%**	**36.4%**	**31.8%**	**38.5%**	**46.9%**	**45.2%**	**43.8%**	**39.5%**	**29.3%**	**29.0%**	**33.0%**	**17.5%**	**46.5%**	**43.2%**	**35.8%**	**36.4%**	**44.6%**
Overturns - Full	7	14	6	**27**	16	15	16	**47**	24	27	19	**70**	28	22	19	**69**	213	167
Overturn Rate - Full	**53.8%**	**70.0%**	**54.5%**	**61.4%**	**61.5%**	**46.9%**	**51.6%**	**52.8%**	**55.8%**	**65.9%**	**61.3%**	**60.9%**	**70.0%**	**51.2%**	**51.4%**	**57.5%**	**57.9%**	**53.5%**
Overturns - Partials	1	1	1	**3**	0	2	1	**3**	2	0	2	**4**	3	1	1	**5**	15	6
Overturn Rate - Partial	**7.7%**	**5.0%**	**9.1%**	**6.8%**	**0.0%**	**6.3%**	**3.2%**	**3.4%**	**4.7%**	**0.0%**	**6.5%**	**3.5%**	**7.5%**	**2.3%**	**2.7%**	**4.2%**	**4.1%**	**1.9%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	2	1	**3**	2	0	1	**3**	6	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.9%**	**3.2%**	**2.6%**	**5.0%**	**0.0%**	**2.7%**	**2.5%**	**1.6%**	**0.0%**
Membership	347,177	347,177	347,194		346,867	346,814	346,990		348,462	348,258	347,545		347,067	345,502	343,177			**345,319**
Appeals - PTMPM	0.04	0.06	0.03	0.04	0.07	0.09	0.09	0.09	0.12	0.12	0.09	0.11	0.12	0.12	0.11	0.00	0.06	0.06
Grievances - PTMPM	0.41	0.32	0.33	0.35	0.46	0.48	0.45	0.47	0.50	0.42	0.45	0.46	0.49	0.46	0.38	0.00	0.32	0.26

CalViva Health Appeals and Grievances Dashboard (Kings County)

Kings 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	0	1	0	1	0	2	2	4	1	1	1	3	0	0	0	0	8	9
Standard Grievances Received	11	11	6	28	18	11	7	36	14	15	6	35	20	10	14	44	143	151
Total Grievances Received	**11**	**12**	**6**	**29**	**18**	**13**	**9**	**40**	**15**	**16**	**7**	**38**	**20**	**10**	**14**	**44**	**151**	**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%**	**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%**	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	2	2	4	1	1	1	3	0	0	0	0	8	9
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**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	4	20	10	34	9	13	13	35	7	19	13	39	144	148
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	100.00%
Total Grievances Resolved	**17**	**10**	**10**	**37**	**4**	**22**	**12**	**38**	**10**	**14**	**14**	**38**	**7**	**19**	**13**	**39**	152	157
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**9**	**10**	**33**	**4**	**19**	**9**	**32**	**9**	**14**	**13**	**36**	**6**	**18**	**12**	**36**	**137**	128
Access - Other - DMHC	0	3	1	4	1	2	2	5	2	1	2	5	1	2	1	4	18	22
Access - PCP - DHCS	2	0	0	2	0	1	1	2	0	2	1	3	0	0	1	1	8	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	1	0	0	1	0	0	0	0	2	5
Administrative	1	2	5	8	0	3	2	5	3	3	3	9	4	5	2	11	33	11
Balance Billing	3	1	0	4	1	1	2	4	1	0	0	1	0	4	3	7	16	
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	5	0	5	0	1	1	2	0	1	1	2	11	10
Behavioral 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	2	1	3	0	1	3	4	0	0	2	2	9	25
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	1	1	2	0	0	0	0	2	0
Transportation - Access	1	0	1	2	2	2	0	4	1	1	0	2	1	0	2	3	11	22
Transportation - Behaviour	1	0	1	2	0	0	0	0	0	2	1	3	0	0	0	0	5	6
Transportation - Other	4	3	1	8	0	3	1	4	1	2	1	4	0	6	0	6	22	20
Quality Of Care Grievances	**3**	**1**	**0**	**4**	**0**	**3**	**3**	**6**	**1**	**0**	**1**	**2**	**1**	**1**	**1**	**3**	**15**	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
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	4
PCP Care	2	0	0	2	0	0	2	2	0	0	0	0	0	0	0	0	4	11
PCP Delay	0	0	0	0	0	0	0	0	1	0	1	2	1	0	1	2	4	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	2	0	2	0	0	0	0	0	1	0	1	3	4
Specialist Delay	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	1

CalViva Health Appeals and Grievances Dashboard (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	1	0	1	0	0	0	0	0	1	0	1	2	0
Standard Appeals Received	1	1	1	3	2	1	3	6	3	0	1	4	2	4	2	8	21	11
Total Appeals Received	**1**	**1**	**1**	**3**	**2**	**2**	**3**	**7**	**3**	**0**	**1**	**4**	**2**	**5**	**2**	**9**	23	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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**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	1	0	1	0	0	0	0	0	1	0	1	2	1
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	2	2	0	4	1	2	1	4	4	2	0	6	2	1	4	7	21	11
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	100.00%
Total Appeals Resolved	**2**	**2**	**0**	**4**	**1**	**3**	**1**	**5**	**4**	**2**	**0**	**6**	**2**	**2**	**4**	**8**	**23**	0
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**2**	**0**	**4**	**1**	**3**	**1**	**5**	**4**	**2**	**0**	**6**	**2**	**2**	**4**	**8**	**23**	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	1	1	0	2	2	1
DME	0	1	0	1	0	0	0	0	1	0	0	1	0	0	0	0	2	1
Experimental/Investigational	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	0
Behavioral 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	1	1	2	1	0	0	1	0	0	0	0	5	4
Other	0	0	0	0	0	2	0	2	0	0	0	0	0	1	4	5	7	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	1	0	0	1	1	2	0	3	1	0	0	1	5	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
Behavioral 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	2	0	**2**	2	2	0	**4**	0	1	2	**3**	11	5
Uphold Rate	**50.0%**	**50.0%**	**0.0%**	**50.0%**	**0.0%**	**66.7%**	**0.0%**	**40.0%**	**50.0%**	**100.0%**	**0.0%**	**66.7%**	**0.0%**	**50.0%**	**50.0%**	**37.5%**	**47.8%**	41.70%
Overturns - Full	1	1	0	**2**	1	1	1	**3**	2	0	0	**2**	1	1	2	**4**	11	7
Overturn Rate - Full	**50.0%**	**50.0%**	**0.0%**	**50.0%**	**100.0%**	**33.3%**	**100.0%**	**60.0%**	**50.0%**	**0.0%**	**0.0%**	**33.3%**	**50.0%**	**50.0%**	**50.0%**	**50.0%**	**47.8%**	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**	1	0	0	**1**	1	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%**	**50.0%**	**0.0%**	**0.0%**	**12.5%**	**4.3%**	0
Membership	38,436	38,757	38,756		38,740	38,515	38,259		38,274	38,149	38,066		38,058	38,084	38,193			38436
Appeals - PTMPM	0.05	0.05	-	0.03	0.03	0.08	0.03	0.04	0.10	0.05	-	0.05	0.05	0.05	0.10	0.07	0.05	0.026019
Grievances - PTMPM	0.44	0.26	0.26	0.32	0.10	0.57	0.31	0.33	0.26	0.37	0.37	0.33	0.18	0.50	0.34	0.34	0.33	0.33536

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	1	0	0	1	0	2	0	2	1	0	1	2	7	10
Standard Grievances Received	17	12	10	39	27	20	8	55	18	11	16	45	25	13	14	52	191	163
Total Grievances Received	**19**	**12**	**10**	**41**	**28**	**20**	**8**	**56**	**18**	**13**	**16**	**47**	**26**	**13**	**15**	**54**	**198**	173
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**90.9%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**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	1	0	0	1	0	2	0	2	1	0	1	2	7	10
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	13	14	13	40	9	30	16	55	10	17	12	39	16	25	15	56	190	0
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**15**	**14**	**13**	**42**	**10**	**30**	**16**	**56**	**10**	**19**	**12**	**41**	**17**	**25**	**16**	**58**	**197**	**175**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**12**	**12**	**39**	**8**	**27**	**15**	**50**	**7**	**15**	**8**	**30**	**14**	**19**	**16**	**49**	**168**	**146**
Access - Other - DMHC	4	2	0	6	0	5	1	6	2	6	1	9	1	3	0	4	25	27
Access - PCP - DHCS	1	0	1	2	2	0	1	3	1	0	1	2	3	1	2	6	13	9
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	1	0	1	1	0	4	5	7	4
Administrative	0	4	1	5	2	3	8	13	2	4	1	7	1	5	2	8	33	15
Balance Billing	1	0	3	4	1	4	2	7	0	1	2	3	1	4	1	6	20	
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	3	1	4	0	0	0	0	1	2	3	6	15	15
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	0	1	4	0	2	1	3	0	0	0	0	3	2	2	7	14	31
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	0	0	1	1	0	2	0	0	0	0	4	0
Transportation - Access	4	1	3	8	1	6	0	7	0	1	3	4	3	0	1	4	23	27
Transportation - Behaviour	0	0	0	0	0	1	0	1	1	0	0	1	0	1	0	1	3	13
Transportation - Other	1	2	0	3	1	3	1	5	0	1	0	1	0	1	1	2	11	5
Quality Of Care Grievances	**0**	**2**	**1**	**3**	**2**	**3**	**1**	**6**	**3**	**4**	**4**	**11**	**3**	**6**	**0**	**9**	**29**	**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	1	0	0	1	0	0	0	0	1	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	1	0	1	1	0
Behavioral 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	1	1	2	0	1	0	1	2	1	0	3	8	5
PCP Care	0	0	0	0	1	0	0	1	0	2	1	3	0	3	0	3	7	5
PCP Delay	0	1	0	1	0	1	0	1	1	0	2	3	0	0	0	0	5	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	1	1	0	2	1	1	0	2	0	1	0	1	5	2
Specialist Delay	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	1	2	6

CalViva Health Appeals and Grievances Dashboard (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	1	0	1	0	0	0	0	1	2
Standard Appeals Received	5	6	5	16	4	9	5	18	6	6	3	15	7	5	5	17	66	38
Total Appeals Received	**5**	**6**	**5**	**16**	**4**	**9**	**5**	**18**	**6**	**7**	**3**	**16**	**7**	**5**	**5**	**17**	67	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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1	6
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	9	3	15	4	5	10	**19**	4	4	6	**14**	5	5	5	**15**	63	31
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**3**	**9**	**3**	**15**	**4**	**5**	**10**	**19**	**4**	**5**	**6**	**15**	**5**	**5**	**5**	**15**	**64**	**37**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**9**	**3**	**15**	**4**	**5**	**10**	**19**	**4**	**5**	**6**	**15**	**5**	**5**	**5**	**15**	**64**	**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	1	1	1	0	1	2	0	0	0	0	3	0
DME	1	0	1	2	3	0	1	4	2	1	0	3	1	1	0	2	11	0
Experimental/Investigational	0	0	1	1	0	0	1	1	0	0	0	0	0	1	0	1	3	0
Behavioral 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	3	4	7	0	2	3	5	2	0	3	5	27	21
Other	0	0	0	0	1	1	1	3	0	1	1	2	1	0	1	2	7	1
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	2	2	1	1	1	3	0	1	1	2	9	6
Surgery	0	0	0	0	0	1	0	1	0	0	0	0	1	2	0	3	4	9
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral 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**	1	3	4	**8**	2	2	3	**7**	3	2	0	**5**	25	12
Uphold Rate	**33.3%**	**22.2%**	**66.7%**	**33.3%**	**25.0%**	**60.0%**	**40.0%**	**42.1%**	**50.0%**	**40.0%**	**50.0%**	**46.7%**	**60.0%**	**40.0%**	**0.0%**	**33.3%**	**39.1%**	**32.4%**
Overturns - Full	2	7	1	**10**	3	2	5	**10**	2	3	2	**7**	2	2	4	**8**	35	20
Overturn Rate - Full	**66.7%**	**77.8%**	**33.3%**	**66.7%**	**75.0%**	**40.0%**	**50.0%**	**52.6%**	**50.0%**	**60.0%**	**33.3%**	**46.7%**	**40.0%**	**40.0%**	**80.0%**	**53.33%**	**54.7%**	**54.1%**
Overturns - Partials	0	0	0	**0**	0	0	1	**1**	0	0	1	**1**	0	1	1	**2**	4	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**10.0%**	**5.3%**	**0.0%**	**0.0%**	**16.7%**	**6.7%**	**0.0%**	**20.0%**	**20.0%**	**13.3%**	**6.3%**	**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		48,465	48,499	48,792		49,168	49,327	49,531		49,683	49,704	49,707			**46,762**
Appeals - PTMPM	0.06	0.19	0.06	0.10	0.08	0.10	0.20	0.13	0.08	0.10	0.12	0.10	0.10	0.10	0.10	0.10	0.11	0.06
Grievances - PTMPM	0.31	0.29	0.27	0.29	0.21	0.62	0.33	0.38	0.20	0.39	0.24	0.28	0.34	0.50	0.32	0.39	0.33	0.31

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	1	4	5	0	1	4	5	1	3	1	5	19	42
Standard Grievances Received	22	29	29	80	47	72	67	186	59	57	57	173	69	55	49	173	612	564
Total Grievances Received	**23**	**32**	**29**	84	**47**	**73**	**71**	**191**	**59**	**58**	**61**	**178**	**70**	**58**	**50**	**178**	**631**	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.65%**
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	1	4	5	0	1	4	5	1	3	1	5	19	42
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0
Standard Grievances Resolved Compliant	28	18	30	76	35	67	65	167	72	53	53	178	58	67	61	186	607	550
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.1%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**
Total Grievances Resolved	**29**	**21**	**30**	**80**	**36**	**68**	**69**	**173**	**72**	**54**	**57**	**183**	**59**	**70**	**62**	**191**	627	592
Grievance Descriptions - Resolved Cases	**29**	**21**	**30**	**80**	**36**	**68**	**69**	**173**	**72**	**54**	**57**	**183**	**59**	**70**	**62**	**191**	627	592
Access to primary care	0	0	1	1	2	7	5	14	5	4	5	14	2	2	2	6	35	41
Access to specialists	7	6	6	19	0	9	13	22	15	10	14	39	2	2	3	7	87	169
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral Health	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	0
Other	3	4	3	10	8	2	5	15	7	10	3	20	14	42	50	106	151	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	2	5	8	15	7	2	3	12	11	7	0	18	55	60
QOS Non Access	13	9	18	22	24	45	37	106	38	28	32	98	30	17	7	54	280	164
Exempt Grievances Received	9	6	5	**20**	19	9	21	**49**	30	21	26	**77**	18	12	11	**41**	**187**	**88**
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	**1**	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**	1	0	1	**2**	0	0	1	**1**	**4**	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	1	0	**1**	0	0	0	**0**	**1**	0
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	1	0	**1**	0	1	0	**1**	1	0	0	**1**	**3**	0
Attitude/Service - Provider	1	2	1	**4**	3	2	2	**7**	4	0	7	**11**	2	0	0	**2**	**24**	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**	5	0	2	**7**	4	5	4	**13**	0	2	0	**2**	**22**	1
Attitude/Service - Health Plan	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	1	**1**	1	2	0	**3**	1	0	0	**1**	**5**	0
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	0
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	2	1	1	**4**	1	1	0	**2**	0	0	0	**0**	**6**	2
Health Plan Materials - ID Cards-Not Received	0	0	0	**0**	1	1	4	**6**	2	6	3	**11**	4	1	4	**9**	**26**	20
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	**1**	0
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Behavioral Health	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**	4	0	0	**4**	0	0	1	**1**	3	3	2	**8**	**18**	19
PCP Assignment/Transfer - HCO Assignment - Change Request	1	0	1	**2**	1	0	7	**8**	5	3	5	**13**	0	0	2	**2**	**25**	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

Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	0	0	**2**	**2**	5
OTHER - Other	0	0	1	**1**	1	2	0	**3**	5	1	1	**7**	1	3	0	**4**	**15**	1
Claims Complaint - Balance Billing from Provider	4	1	1	**6**	0	1	4	**5**	7	1	4	**12**	2	3	2	**7**	**30**	13

CalViva Health Appeals and Grievances Dashboard (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	1	0	1	2	0	0	0	0	0	0	1	1	3	7
Standard Appeals Received	4	5	5	14	9	11	18	38	14	11	15	40	18	11	11	40	132	68
Total Appeals Received	**4**	**5**	**5**	**14**	**10**	**11**	**19**	**40**	**14**	**11**	**15**	**40**	**18**	**11**	**12**	**41**	135	**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%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	1	0	1	2	0	0	0	0	0	0	1	1	3	10
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	0	4	7	7	16	12	**35**	18	16	10	**44**	14	14	12	**40**	126	66
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**3**	**0**	**4**	**7**	**8**	**16**	**13**	**37**	**18**	**16**	**10**	**44**	**14**	**14**	**13**	**41**	**129**	**76**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**5**	**4**	**12**	**8**	**16**	**13**	**37**	**18**	**16**	**10**	**44**	**13**	**14**	**13**	**40**	**125**	**71**
Continuity of Care	0	0	0	0	0	8	0	8	0	0	0	0	0	0	0	0	8	5
Consultation	0	0	0	0	0	2	3	5	6	1	3	10	1	1	0	2	17	3
DME	1	2	0	3	2	3	2	7	6	7	2	15	3	6	3	12	37	13
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0
Behavioral 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	3	0	4	7	1	5	4	10	4	3	0	7	29	22
Other	0	1	1	2	0	1	1	2	2	2	1	5	4	3	9	16	25	6
Pharmacy/RX Medical Benefit	0	1	0	1	0	1	0	1	2	1	0	3	0	1	0	1	6	14
Surgery	0	0	1	1	3	1	3	7	1	0	0	1	1	0	0	1	10	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**	**1**	**0**	**0**	**1**	**1**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Behavioral 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	1	0	0	1	1	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**	2	6	6	**14**	7	6	4	**17**	2	6	7	**15**	51	30
Uphold Rate	**66.7%**	**0.0%**	**25.0%**	**71.4%**	**25.0%**	**37.5%**	**46.2%**	**37.8%**	**38.9%**	**37.5%**	**40.0%**	**38.6%**	**14.3%**	**42.9%**	**53.8%**	**36.6%**	**39.5%**	**39.5%**
Overturns - Full	1	3	2	**6**	6	9	7	**22**	10	8	4	**22**	10	7	5	**22**	72	44
Overturn Rate - Full	**33.3%**	**0.0%**	**50.0%**	**85.7%**	**75.0%**	**56.3%**	**53.8%**	**59.5%**	**55.6%**	**50.0%**	**40.0%**	**50.0%**	**71.4%**	**50.0%**	**38.5%**	**53.7%**	**55.8%**	**57.89%**
Overturns - Partials	0	0	0	**0**	0	1	0	**1**	1	0	2	**3**	1	1	0	**2**	6	2
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.3%**	**0.0%**	**2.7%**	**5.6%**	**0.0%**	**20.0%**	**6.8%**	**7.1%**	**7.1%**	**0.0%**	**4.9%**	**4.7%**	**2.6%**
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	2	0	**2**	1	0	1	**2**	5	0
Withdrawal Rate	**0.0%**	**0.0%**	**25.0%**	**14.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**12.5%**	**0.0%**	**4.5%**	**7.1%**	**0.0%**	**7.7%**	**4.9%**	**3.9%**	**0.0%**
Membership	49,987	49,987	47,341		46,869	46,960	283,020		47,677	47,677	47,961		48,099	48,523	48,765			**49,899**
Appeals - PTMPM	0.06	-	0.08	0.00	0.17	0.34	0.05	0.00	0.38	0.34	0.21	0.31	0.29	0.29	0.27	0.28	0.15	0.06
Grievances - PTMPM	0.58	0.42	0.63	0.00	0.77	1.45	0.24	0.00	1.51	1.13	1.19	1.28	1.23	1.44	1.27	1.31	0.65	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	Grievances related to health plan benefit, paln authorization or access issues
Balance Billing	Member billing for Par and Nonpar providers.
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
Behavioral 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
Behavioral 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
Behavioral 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
Behavioral Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.

Surgical	Denied service due to medical necessity, lack of coverage.
Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

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

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

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

Item #15
Attachment 15.C

Medical Management

Key Indicator Report

Attachment

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 12/01/2024 to 12/31/2024

Report created 1/21/2025

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

Exhibits:

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Loren Hillburn
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.con

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 12/01/2024 to 12/31/2024
Report created 1/21/2025

ER utilization based on Claims data	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
MEMBERSHIP														Quarterly Averages									Annual Averages		
Expansion Mbr Months	115,570	119,572	119,992	120,073	120,279	120,769	122,044	122,125	122,163	122,244	121,961	121,430		116,736	120,103	120,009	117,513	118,378	120,374	122,111	121,878		118,590	120,685	
Adult/Family/O TLIC Mbr Mos	262,709	267,059	267,730	267,209	266,454	266,050	266,607	265,991	264,882	264,720	263,023	261,420		267,795	271,513	269,846	265,076	265,833	266,571	265,827	263,054		268,558	265,321	
Aged/Disabled Mbr Mos	46,270	47,506	47,234	46,940	46,026	46,962	47,175	47,366	47,622	47,822	48,280	48,512		45,552	49,671	49,807	49,092	47,003	46,643	47,388	48,205		48,531	47,310	
COUNTS																									
Admits - Count	2,254	2,112	2,170	2,020	2,190	2,177	2,268	2,217	2,142	2,097	2,008	2,096		2,072	2,105	2,111	2,104	2,179	2,129	2,209	2,067		2,098	2,146	
Expansion	756	692	671	669	743	750	757	769	700	687	660	700		600	660	684	667	706	721	742	682		653	713	
Adult/Family/O TLIC	921	856	944	860	929	903	939	910	969	896	868	902		897	904	907	910	907	897	939	889		904	908	
Aged/Disabled	577	564	555	491	518	524	572	538	473	514	480	494		575	541	520	528	565	511	528	496		541	525	
Admits Acute - Count	1,414	1,437	1,433	1,380	1,445	1,418	1,499	1,445	1,354	1,342	1,338	1,413		1,343	1,350	1,418	1,407	1,434	1,414	1,433	1,364		1,388	1,410	
Expansion	552	546	514	527	587	590	596	592	554	527	533	572		489	536	543	520	537	568	581	544		522	558	
Adult/Family/O TLIC	451	459	492	451	463	419	462	408	409	408	423	413		437	435	423	461	467	444	426	415		439	438	
Aged/Disabled	411	432	427	402	395	409	441	445	391	407	382	428		417	436	429	427	423	402	426	406		428	414	
Readmit 30 Day - Count	239	258	240	223	256	274	237	257	230	254	227	144		242	229	242	240	246	251	241	208		238	237	
Expansion	94	92	94	87	108	123	100	101	82	83	86	59		94	88	98	94	93	106	94	76		93	92	
Adult/Family/O TLIC	37	48	35	49	51	44	36	43	45	51	37	22		51	44	37	39	40	48	41	37		43	42	
Aged/Disabled	108	118	111	87	97	107	101	113	103	120	104	63		97	97	107	107	112	97	106	96		102	103	
**ER Visits - Count	13,751	13,720	14,720	14,856	15,825	14,936	14,666	14,269	14,535	14,226	12,917	6,970		13,296	14,764	13,970	14,233	14,064	15,206	14,490	11,371		14,066	13,783	
Expansion	3,763	3,518	3,821	3,941	4,170	4,213	4,416	4,312	4,259	4,095	3,502	2,014		3,551	3,902	3,935	3,724	3,701	4,108	4,329	3,204		3,778	3,835	
Adult/Family/O TLIC	8,165	8,315	8,929	8,954	9,607	8,628	8,113	8,130	8,525	8,458	7,853	4,235		8,157	8,905	8,090	8,666	8,470	9,063	8,256	6,849		8,455	8,159	
Aged/Disabled	1,823	1,887	1,970	1,961	2,048	2,095	2,137	1,827	1,751	1,673	1,562	721		1,587	1,958	1,945	1,843	1,893	2,035	1,905	1,319		1,833	1,788	
PER/K																									
Admits Acute - PTMPY	40.0	39.7	39.5	38.1	40.1	39.2	41.3	39.8	37.4	37.0	37.1	39.3		37.5	36.7	38.7	39.1	39.9	39.1	39.5	37.8		38.2	39.0	
Expansion	57.3	54.8	51.4	52.7	58.6	58.6	58.6	58.2	54.4	51.7	52.4	56.5		50.2	53.6	54.3	53.1	54.5	56.6	57.1	53.6		52.8	55.4	
Adult/Family/O TLIC	20.6	20.6	22.1	20.3	20.9	18.9	20.8	18.4	18.5	18.5	19.3	19.0		19.6	19.2	18.8	20.9	21.1	20.0	19.2	18.9		19.6	19.8	
Aged/Disabled	106.6	109.1	108.5	102.8	103.0	104.5	112.2	112.7	98.5	102.1	94.9	105.9		109.9	105.3	103.4	104.5	108.1	103.4	107.8	101.0		105.7	105.1	
Bed Days Acute - PTMPY	221.5	208.6	212.5	203.6	201.2	205.1	204.4	196.2	182.4	173.9	184.8	170.6		202.8	198.5	202.9	218.4	214.2	203.3	194.3	176.5		205.6	197.0	
Expansion	328.7	313.5	318.6	321.2	291.2	337.0	314.9	280.0	275.6	236.8	276.8	249.8		298.0	293.8	315.8	314.8	320.2	316.5	290.2	254.5		305.6	295.1	
Adult/Family/O TLIC	80.8	74.6	82.8	72.8	81.5	66.3	71.6	68.4	69.8	73.4	70.9	71.3		74.1	75.1	68.8	78.2	79.4	73.6	69.9	71.8		74.0	73.7	
Aged/Disabled	752.6	697.7	677.8	647.0	658.8	652.1	669.3	697.5	570.0	569.6	573.4	507.8		715.6	642.1	657.5	745.3	709.1	652.6	645.4	550.2		689.4	638.7	
ALOS Acute	5.5	5.3	5.4	5.3	5.0	5.2	5.0	4.9	4.9	4.7	5.0	4.3		5.4	5.4	5.2	5.6	5.4	5.2	4.9	4.7		5.4	5.0	
Expansion	5.7	5.7	6.2	6.1	5.0	5.7	5.4	4.8	5.1	4.6	5.3	4.4		5.9	5.5	5.8	5.9	5.9	5.6	5.1	4.8		5.8	5.3	
Adult/Family/O TLIC	3.9	3.6	3.8	3.6	3.9	3.5	3.4	3.7	3.8	4.0	3.7	3.8		3.8	3.9	3.7	3.7	3.8	3.7	3.6	3.8		3.8	3.7	
Aged/Disabled	7.1	6.4	6.2	6.3	6.4	6.2	6.0	6.2	5.8	5.6	6.0	4.8		6.5	6.1	6.4	7.1	6.6	6.3	6.0	5.4		6.5	6.1	
Readmit % 30 Day	10.6%	12.2%	11.1%	11.0%	11.7%	12.6%	10.4%	11.6%	10.7%	12.1%	11.3%	6.9%		11.7%	10.9%	11.5%	11.4%	11.3%	11.8%	10.9%	10.1%		11.3%	11.0%	
Expansion	12.4%	13.3%	14.0%	13.0%	14.5%	16.4%	13.2%	13.1%	11.7%	12.1%	13.0%	8.4%		15.6%	13.3%	14.4%	14.1%	13.2%	14.7%	12.7%	11.1%		14.3%	13.0%	
Adult/Family/O TLIC	4.0%	5.6%	3.7%	5.7%	5.5%	4.9%	3.8%	4.7%	4.6%	5.7%	4.3%	2.4%		5.6%	4.9%	4.0%	4.3%	4.4%	5.3%	4.4%	4.1%		4.7%	4.6%	
Aged/Disabled	18.7%	20.9%	20.0%	17.7%	18.7%	20.4%	17.7%	21.0%	21.8%	23.3%	21.7%	12.8%		16.9%	17.9%	20.6%	20.3%	19.9%	19.0%	20.0%	19.3%		18.9%	19.6%	
**ER Visits - PTMPY	388.7	379.2	406.1	410.6	438.8	413.2	403.8	393.2	401.3	392.6	357.8	193.9		371.0	401.5	381.3	395.6	391.4	420.8	399.4	315.0		387.4	381.7	
Expansion	390.7	353.1	382.1	393.9	416.0	418.6	434.2	423.7	418.4	402.0	344.6	199.0		365.1	389.8	393.5	380.3	375.1	409.5	425.4	315.4		382.3	381.4	
Adult/Family/O TLIC	373.0	373.6	400.2	402.1	432.7	389.2	365.2	366.8	386.2	383.4	358.3	194.4		365.5	393.6	359.8	392.3	382.3	408.0	372.7	312.4		377.8	369.0	
Aged/Disabled	472.8	476.7	500.5	501.3	534.0	535.3	543.6	462.9	441.2	419.8	388.2	178.3		418.1	473.0	468.6	450.4	483.4	523.5	482.4	328.3		453.3	453.5	
Services						TAT Compliance Goal: 100%													TAT Compliance Goal: 100%						TAT Compliance Goal: 100%
Preservice Routine	100.0%	100.0%	100.0%	100.0%	100.0%	88.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	99.1%	100.0%	94.6%	100.0%	100.0%				
Preservice Urgent	100.0%	100.0%	96.0%	94.0%	98.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.1%	100.0%	99.1%	98.2%	96.9%	99.1%	100.0%				
Postservice	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%	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%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		96.9%	100.0%	98.9%	100.0%	100.0%	99.1%	99.1%	100.0%				
Deferrals - Urgent	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%	100.0%				
Deferrals - Post Service	null	null	null	null	null	null	null	null	null	null	null	null		null	null	null	null	null	null	null	null				
	CCS ID RATE																CCS ID RATE						CCS ID RATE		
CCS %	7.56%	7.59%	7.63%	8.57%	8.53%	8.47%	8.50%	8.52%	8.51%	8.52%	8.55%	8.51%		8.17%	7.91%	7.87%	7.73%	7.59%	8.52%	8.51%	8.51%		7.92%	8.28%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand																Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand								
Births	14.6	12.8	13.8	12.6	13.9	14.8	15.3	15.6	16.7	15.4	13.8	14.8		13.7	13.4	14.3	13.8	13.7	-	-	-		13.8		
OB % Days	1.3%	2.1%	3.1%	3.4%	3.6%	3.2%	4.6%	5.3%	7.5%	7.5%	7.0%	11.5%		2.0%	3.4%	5.0%	4.5%	2.2%	-	-	-		17.0%		
OB % Admits	22.0%	21.1%	22.8%	22.0%	22.7%	23.8%	24.3%	25.2%	27.8%	26.1%	24.4%	25.2%		22.2%	23.0%	24.5%	23.4%	21.9%	-	-	-		30.0%		

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 12/01/2024 to 12/31/2024
Report created 1/21/2025

ER utilization based on Claims data	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
Perinatal Case Management																									
Total Number Of Referrals	320	203	163	280	257	64	134	137	203	196	157	134		472	598	476	386	686	601	474	487		318	2,248	
Pending	0	0	0	0	0	0	0	0	0	0	1	21		0	2	1	21	0	0	0	22		3	22	
Ineligible	10	21	9	10	9	18	17	13	14	27	17	15		18	32	10	19	40	37	44	59		5	180	
Total Outreached	310	182	154	270	248	46	117	124	189	169	139	98		454	564	465	346	646	564	430	406		310	2,046	
Engaged	226	137	103	145	160	41	103	105	87	71	77	51		157	224	183	137	466	346	295	199		228	1,306	
Engagement Rate	73%	75%	67%	54%	65%	89%	88%	85%	46%	42%	55%	52%		35%	40%	39%	40%	72%	61%	69%	49%		74%	64%	
Total Cases Managed	699	687	603	612	619	505	489	422	392	383	368	346		344	432	496	410	937	809	670	513		702	1779	
Total Cases Closed	151	184	136	152	153	119	164	102	68	88	58	82		136	154	182	180	471	424	334	228		150	1,457	
Cases Remained Open	547	509	442	439	467	388	318	295	306	287	291	247		199	263	263	224	442	388	306	247		547	247	
Physical Health Case Management																									
Total Number Of Referrals	186	274	314	268	343	189	224	272	173	313	177	153		799	840	612	407	774	800	669	643		2,658	2,886	
Pending	0	0	0	0	0	1	1	0	1	2	1	12		0	1	3	25	0	1	2	15		29	18	
Ineligible	25	23	33	37	79	18	4	25	14	12	8	4		194	164	101	73	81	134	43	24		532	282	
Total Outreached	161	251	281	231	264	170	219	247	158	299	168	137		605	675	508	309	693	665	624	604		2,097	2,586	
Engaged	78	123	138	119	123	77	103	107	67	114	69	82		343	422	338	215	339	319	277	265		1,318	1,200	
Engagement Rate	48%	49%	49%	52%	47%	45%	47%	43%	42%	38%	41%	60%		57%	63%	67%	70%	49%	48%	44%	44%		63%	46%	
Total Screened and Refused/Decline	36	33	39	29	38	15	26	43	27	62	35	16		172	132	76	32	108	82	96	113		412	399	
Unable to Reach	47	95	104	83	103	78	90	97	64	123	64	39		90	121	94	62	246	264	251	226		367	987	
Total Cases Closed	118	105	89	76	106	94	110	109	85	96	83	88		325	415	397	303	312	276	304	267		1,440	1,159	
Cases Remained Open	226	252	296	350	376	339	331	324	300	323	297	300		399	415	354	262	296	339	300	300		262	300	
Total Cases Managed	360	372	405	435	484	441	450	444	402	429	401	398		746	848	769	591	622	615	601	582		1723	1479	
Complex Case	65	59	64	62	65	65	62	51	46	45	45	40		61	94	95	84	99	86	69	60		161	176	
Non-Complex Case	295	313	341	373	419	376	388	393	356	384	356	358		685	754	674	507	523	529	532	522		1562	1303	
Transitional Care Services																									
Total Number Of Referrals	266	291	147	128	238	431	493	611	641	827	680	572		296	750	827	685	704	797	1745	2079		2,558	5,325	
Pending	0	0	0	0	0	0	0	0	0	2	8	117		0	0	0	17	0	0	0	127		17	127	
Ineligible	43	40	14	7	6	13	3	17	4	22	12	7		33	26	28	50	97	26	24	41		137	188	
Total Outreached	223	251	133	121	232	418	490	594	637	803	660	448		263	724	799	618	607	771	1721	1911		2,404	5,010	
Engaged	101	164	110	88	146	232	321	359	402	440	346	246		216	673	783	525	375	466	1082	1032		2,197	2,955	
Engagement Rate	45%	65%	83%	73%	63%	56%	66%	60%	63%	55%	52%	55%		82%	93%	98%	85%	62%	60%	63%	54%		91%	59%	
Total Screened and Refused/Decline	31	24	3	9	6	24	36	33	34	35	34	27		7	7	6	30	58	39	103	96		50	296	
Unable to Reach	91	63	20	24	80	162	133	202	201	328	280	175		40	44	10	63	174	266	536	783		157	1,759	
Total Cases Closed	77	64	138	114	87	97	212	273	310	343	354	326		195	476	645	500	279	298	795			1,816	2,395	
Cases Remained Open	29	132	107	92	109	233	305	386	423	490	419	383		19	73	69	12	107	233	423	383		12	383	
Total Cases Managed	126	204	260	211	245	387	608	735	849	938	932	797		265	695	901	654	399	587	1148	1560		2,248	2,981	
Behavioral Health Care Management																									
Total Number Of Referrals	78	94	73	68	138	81	115	122	83	98	94	88		235	166	128	104	245	287	320	280		633	1,132	
Pending	0	0	0	0	0	0	0	0	0	0	0	11		0	0	0	0	0	0	0	11		0	11	
Ineligible	7	5	2	2	5	6	2	6	5	3	2	1		21	16	10	16	14	13	13	6		63	46	
Total Outreached	71	89	71	66	133	75	113	116	78	95	92	76		214	150	118	88	231	274	307	263		570	1,075	
Engaged	37	73	52	35	65	52	73	82	58	78	68	52		139	108	100	58	162	152	213	198		405	725	
Engagement Rate	52.0%	82.0%	73.0%	53.0%	49.0%	69%	65%	71%	74%	82%	74%	68%		65%	72%	85%	66%	70%	55%	69%	75%		71%	67%	
Total Screened and Refused/Decline	2	2	1	7	10	1	1	5	0	1	3	1		6	12	4	5	5	18	6	5		27	34	
Unable to Reach	32	14	18	24	58	22	39	29	20	16	21	23		69	30	14	25	64	104	88	60		138	316	
Total Cases Closed	35	27	31	55	60	36	63	50	60	71	53	52		154	122	128	87	93	151	173	176		491	593	
Cases Remained Open	64	119	142	121	127	141	145	160	152	152	157	161		149	138	106	75	142	141	152	161		75	161	
Total Cases Managed	113	150	176	182	193	184	217	233	234	243	240	232		307	264	237	170	237	297	341	366		572	801	
Complex Case	14	11	10	10	15	13	17	14	19	20	18	16		13	17	20	18	19	19	25	23		32	51	
Non-Complex Case	99	139	166	172	178	171	200	219	215	223	222	216		294	247	217	152	218	278	316	343		540	750	

Key Indicator Report
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	First Year of Life Care Management													First Year of Life Care Management									st Year of Life Care Manageme		
Total Number Of Referrals	32	29	47	35	29	22	56	34	25	25	24	28		0	8	60	73	108	86	115	77		141	386	
Pending	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0		0	0	
Ineligible	1	1	0	0	1	0	0	2	0	0	0	0		0	1	0	3	2	1	2	0		4	5	
Total Outreached	31	28	47	35	28	22	56	32	25	25	24	28		0	7	60	70	106	85	113	77		137	381	
Engaged	31	28	47	35	28	22	46	32	25	24	24	28		0	3	60	65	106	85	103	76		128	370	
Engagement Rate	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	82.0%	100.0%	100.0%	96.0%	100%	100%		0.0%	43.0%	100.0%	93.0%	100.0%	100.0%	91.0%	99%		93.0%	97.0%	
Total Screened and Refused/Decline	0	0	0	0	0	0	4	0	0	1	0	0		0	2	0	2	0	0	4	1		4	5	
Unable to Reach	0	0	0	0	0	0	6	0	0	0	0	0		0	2	0	3	0	0	6	0		5	6	
Total Cases Closed	2	8	10	9	8	11	11	12	14	21	27	23		0	0	3	16	20	28	37	71		19	156	
Cases Remained Open	140	160	196	218	243	254	289	308	319	319	317	322		0	3	56	108	196	254	319	322		108	322	
Total Cases Managed	143	169	207	232	250	265	301	321	332	342	345	346		0	3	62	125	217	282	357	394		128	480	

Item #15
Attachment 15.D

Equity Report

Health Equity Oversight & Monitoring Activities:	Objective	Status
Mental Health and Substance Abuse training	Data: CVH does not meet minimum performance level for FUA/FUM (54.87/36.34). A majority of members in this population in Fresno and Madera are Hispanic, cultural drivers negatively impact follow up care rates. Goal: This is a Year over year Improvement project. HEQ Dept. goal is to provide assistance with development of Cultural training curriculum for ER staff such as Social Workers, CHWs and Substance Use Counselors to be receptive to the Hispanic patients' needs and to provide comprehensive treatment information and range of available treatment options to improve follow up care	9/2024- Working with PaoHoua (HN) in establishing a training curriculum and collaboration effort with Binational (CBO) to implement mental health and trauma informed training to healthcare staff members as it pertains to working with members. 11/2024 Training Curriculum by Binational was completed, Training Material and survey was sent to Saint Agnes, VP Community Health and Well-being 11/22/24.
Transgender, Gender Diverse or Intersex cultural Competency training (TGI training/ Senate Bill 923)	Provide Medi-Cal managed care plans (MCPs) with guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members	The TGI training is based on the requirement of the DHCS APL 24-017, Required by senate Bill (SB) 923 12/2024 OutCare was identified as the CBO that will be delivering the training curriculum

Current Health Equity Project(s) and Initiative(s):	Objective	Status
Network Improvement Community Schools with Fresno County Super Intendant Schools	Goal: Assist and/or serve as consultants with Fresno County Network Improvement Committee Pilot to address leading health indicators focusing on upstream measures such as risk factors and behaviors, rather than disease outcomes (focusing on pregnant moms, families with children ages 0-9) in the pre-determined zip codes 93722, and 93648 identified as rural and high poverty area. Overall school goal was to get 100% of the 53 identified students in these two-zip code reading at grade level by 6/2025, (currently only 39% are reading at grade level).	**Action**: ***Aug. 2024***- Children and families are set up with trained CHW to assist in community navigation. School liaison, Social workers, and school representatives received training from Fresno State to become CHW. CBOs, and policy makers identified as Community Thought Partners will assist with brainstorming different strategies to addressing with SoDH, improve health, wellness and academics outcomes ***Oct. 2024-*** Community Thought Partners came together to create a resource referral/ assistance structure to assist school with SoDH, improve health, wellness and academics outcomes. CVH specifically introduced Cal Aim and Find Help to Community Schools and CBOs to assist in addressing social risks and needs. 1/2025- Schools brought student cases to Community Thought partner team to assist with some of the concerns. 29% of the students had Chronic Absenteeism. The reasons behind

		student absence were due to health conditions and families felt it was not safe to allow their child to go to school if they were not present to manage medication. One example, a 3rd grader was diagnosed with Type 2 Diabetes in Q3, missing over 60% of school since Aug. 2024. Other concerns include 24 of the 53 students had suspension referral to the principal's office due to behavior. + There has been a 3% increase in students reading on grade level.
Live Well Madera (CHIP)	Madera County Community Health Improvement Plan Identified 4 health Priorities: Access to Carem Domestic Violence, Substance Use, and Diabetes and Heart Disease. Work groups are formed around these health priorities to strategize a work plan to address these health issues.	8/2024- First meeting Steering Committee meeting 12/2024- Appointed Co-Chair for Healthy People Strong Communities Workgroup, Diabetes and heart disease workgroup.
Women, Infant, and Children (WIC) Initiative	Goal: Maximize Medi-Cal Member enrollment in WIC and CalFresh by providing enrollment data of Medi-Cal Members to managed care plans (MCPs) to conduct targeted outreach and provide enrollment assistance	9/2024- Met with DHCS to review current State Data, Assessments 10/2024- Set Pilot goals and development implementation plan 12/2024 – Pilot transition per DHCS: WIC Pilot will be utilizing Center for Data Insights and Innovation (CDII) Collaborative efforts based on a grant for the WIC pilot scheduled to begin mid-2025.
West Fresno Drive	Collaborate with Central Valley Community Foundation to address Community needs in West Fresno to address health indicators focusing on upstream measures such as risk factors and behaviors.	Initiatives- 1. Edison Regional Youth Recreation – First Meeting held 11/2024. Planning to host a sports Camp and how can CalViva assist in bringing in connecting mobile health clinics to assist with vaccinations and/ or sports physical. 2. Mental Health in SW Fresno- First meeting 1/25 identify Mental and Behavior health gaps and identify core groups to address these gaps. Mental health Conference to come in April. Topic highlighted are: Indigenous approach to holistic healing, suicide youth prevention, Stigma on Our Childhood Trauma, Trauma informed approach and Neighborhood safety, Postpartum depression, maternal mental health for Hmong and Hispanic Population
Mobile Health Clinic	Identify existing mobile health clinics in our three counties, Kings, Fresno, and Madera; what services they provide and where they are located.	10 mobile health clinics were identified and are currently active. Some of the mobile health clinics have a monthly schedule where they are available in the same location. A few of them were open to the idea of working with CVH to

		identify Well-Child vaccination service area gaps and placing their clinics in the identified zip codes that needed better well-child vaccinations outcome.
Perimenopause/ Menopause Project- Hanford	The goal is to bring Perimenopause/ Menopause into the light through education, awareness and advocating for women's health needs.	Board and Committee DEI survey 8/2024 identified Women's Health specifically in perimenopause and menopause as an area that has not been focused on. Project Pilot will be focused on the 4,079 women between the ages of 40-60 in Kings County. First meeting is planned for 2/21/25.

Health Equity Accreditation	Status
Diversity, Equity and Inclusion Survey and training	8/2024- DEI Surveys distributed and completed for Board, Committee, and staff members. 11/2024- Mandatory Diversity, Equity, and inclusion training for all CalViva Staff Completed 12/2024- Implemented one DEI opportunities based on Survey Findings 12/2024- Submitted Diversity, Equity, and Inclusion training Curriculum to DHCS (APL-24-016)
NCQA Health Equity Accreditation-	12/2024- Completed gathering all required CVH evidence for NCQA Health Equity Accreditation. On Schedule for Submission for 3/11/2025 1/9/2025- Introductory Call with NCQA Surveyor was completed.

Item #15
Attachment 15.E

Executive Dashboard

	2023	2024	2024	2024	2024	2024	2024	2024	2024	2024	2024	2024	2024
Month	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
CVH Members													
Fresno	345,319	343,493	347,888	348,065	348,349	347,954	347,975	349,399	348,729	347,975	348,113	346,388	344,539
Kings	38,436	38,232	38,901	38,877	38,831	38,563	38,404	38,370	38,254	38,133	38,078	38,137	38,356
Madera	46,762	46,717	48,656	48,684	48,579	48,666	48,888	49,258	49,373	49,507	49,666	49,757	49,814
Total	430,517	428,442	435,445	435,626	435,759	435,183	435,267	437,027	436,356	435,615	435,857	434,282	432,709
SPD	49,899	47,393	47,212	47,029	46,869	46,763	46,841	47,066	47,185	47,411	47,615	48,116	48,373
CVH Mrkt Share	67.65%	67.15%	66.84%	66.83%	66.81%	66.83%	66.85%	66.90%	66.92%	66.92%	66.91%	66.87%	66.86%
ABC Members													
Fresno	151,942	151,485	155,843	155,594	155,721	155,374	155,027	155,215	154,520	154,078	154,265	153,460	152,518
Kings	24,901	25,311	25,600	25,550	25,522	25,234	25,053	24,915	24,819	24,689	24,659	24,681	24,705
Madera	29,018	28,693	29,862	29,595	29,230	28,949	28,785	28,665	28,541	28,385	28,149	27,966	27,944
Total	205,861	205,489	211,305	210,739	210,473	209,557	208,865	208,795	207,880	207,152	207,073	206,107	205,167
Kasier													
Fresno		3,562	3,998	4,627	5,075	5,467	5,931	6,269	6,645	6,936	7,161	7,601	7,873
Kings		2	54	67	87	98	102	113	121	129	154	153	171
Madera		574	673	800	884	918	987	1,054	1,098	1,151	1,202	1,253	1,302
Total		4,138	4,725	5,494	6,046	6,483	7,020	7,436	7,864	8,216	8,517	9,007	9,346
Default													
Fresno	54.90%	48.76%	57.21%	55.65%	57.56%	59.38%	64.17%	56.65%	59.99%	55.98%	58.51%	57.19%	
Kings	58.18%	62.64%	53.82%	55.67%	56.78%	57.36%	57.76%				54.02%		
Madera	56.41%	55.86%	54.76%	61.60%	65.92%	72.97%	77.26%	61.66%					
County Share of Choice as %													
Fresno	51.27%	66.82%	59.92%	62.71%	62.52%	62.40%	64.25%	62.86%	62.71%	62.50%	63.30%	63.27%	
Kings	69.21%	65.78%	62.47%	63.07%	65.75%	67.10%	65.56%			61.86%	69.74%	62.45%	
Madera	57.79%	69.02%	58.71%	60.62%	65.83%	58.80%	62.24%	65.38%	68.13%	69.84%	65.30%	64.17%	

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 Security Risk	**2**	Description: Average security risk for all hosts. 5 = High Severity. 1 = Low Severity
	Business Risk Score	**24**	Description: Business risk is expressed as a value (0 to 100). Generally, the higher the value the higher the potential for business loss since the service returns a higher value when critical assets are vulnerable.
	Average Age of Workstations	**4.1 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communication and Systems.		

Member Call Center CalViva Health Website		**Year**	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**34,897**	**34,875**	**41,520**	**36,270**	**38,251**	**33,900**
		# of Calls Answered	**34,595**	**34,533**	**41,114**	**36,104**	**37,970**	**33,610**
		Abandonment Level (Goal < 5%)	**0.90%**	**1.00%**	**1.00%**	**0.50%**	**0.70%**	**0.90%**
		Service Level (Goal 80%)	**88%**	**83%**	**85%**	**98%**	**96%**	**93%**
	Behavioral Health Member Call Center	**# of Calls Received**	**860**	**1,436**	**940**	**864**	**957**	**827**
		# of Calls Answered	**848**	**1,426**	**936**	**859**	**950**	**816**
		Abandonment Level (Goal < 5%)	**1.40%**	**0.70%**	**0.40%**	**0.60%**	**0.70%**	**1.30%**
		Service Level (Goal 80%)	**89%**	**95%**	**97%**	**94%**	**93%**	**88%**
	Transportation Call Center	**# of Calls Received**	**12,554**	**8,239**	**9,469**	**13,007**	**14,196**	**14,123**
		# of Calls Answered	**12,466**	**8,181**	**9,384**	**12,942**	**13,940**	**14,010**
		Abandonment Level (Goal < 5%)	**0.50%**	**0.50%**	**0.60%**	**0.40%**	**1.50%**	**0.60%**
		Service Level (Goal 80%)	**87%**	**86%**	**79%**	**86%**	**63%**	**82%**
	CalViva Health Website	**# of Users**	**40,000**	**45,000**	**54,000**	**53,000**	**64,000**	**69,000**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (61%)**	**Mobile (61%)**	**Mobile (61%)**	**Mobile (61%)**	**Mobile (67%)**	**Mobile (73%)**
		Session Duration	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	Q4 2024 numbers are available. At present time, there are no other significant issues or concerns as it pertains to the Plan's Call Center and Website activities.							

Provider Network & Engagement Activities	**Year**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**156**	**156**	**158**	**157**	**157**	**160**	**161**
	PCP	**406**	**409**	**418**	**423**	**433**	**434**	**435**
	PCP Extender	**413**	**413**	**442**	**440**	**455**	**447**	**439**
	Specialist	**1485**	**1531**	**1563**	**1565**	**1574**	**1612**	**1623**
	Ancillary	**285**	**302**	**312**	**315**	**315**	**316**	**332**
	Year	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Behavioral Health	**593**	**598**	**592**	**353**	**652**	**658**	**558**
	Vision	**104**	**110**	**104**	**108**	**116**	**113**	**114**
	Urgent Care	**14**	**14**	**16**	**16**	**16**	**16**	**17**
	Acupuncture	**4**	**4**	**3**	**3**	**3**	**3**	**2**
	ECM/CS							**43**
	Year	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**97%**	**97%**	**98%**	**96%**	**94%**	**94%**	**94%**
	% Of Specialists Accepting New Patients - Goal (85%)	**98%**	**98%**	**98%**	**98%**	**97%**	**98%**	**97%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**96%**	**97%**	**96%**	**93%**	**96%**	**97%**	**98%**
	Year	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Providers Interactions by Provider Relations	**628**	**498**	**638**	**546**	**588**	**450**	**354**
	Reported Issues Handled by Provider Relations	**7**	**10**	**6**	**4**	**2**	**5**	**1**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**64**	**93**	**36**	**26**	**13**	**22**	**1**
	Interventions Deployed for PCP Quality Performance Improvement	**64**	**93**	**36**	**26**	**13**	**22**	**1**
Message From the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network.							

Claims Processing	**Year**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	95% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	94% / 95% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% 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	N/A
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	100% / 100% NO	87% / 100% NO	76% / 100% NO	1% / 93% NO		
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	82% / 91% YES	91% / 97% NO	95% / 98% NO	99% / 99% NO	94% / 97% YES	88% / 99% YES	80% / 100% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	90% / 100% YES	83% / 98% YES	68% / 92% NO	47% / 89% YES	79% / 93% YES	99% / 100% NO	94% / 97% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 99% NO	100% / 100% NO	99% / 100% YES	98% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99%/100% NO	99% / 100% NO	100% / 100% YES	99% / 100% YES	98% / 100% NO	99% / 100% NO	100% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	64% / 100% NO	95% / 100% NO	79% / 100% NO	100% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure				100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q3 numbers are available. Management is working with PPG 2 on improving performance. All other areas met goal.							

Provider Disputes	**Year**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	98%	99%	99%	99%	98%	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%	100%	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%	78%	98%	89%		
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	84%	11%	31%	81%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	71%	40%	66%	65%	70%	93%	99%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	41%	55%	90%	97%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	43%	65%	85%	98%	97%	97%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	47%	63%	97%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	67%	95%	100%	100%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	99%	99%	100%	97%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)				N/A	100%	100%	100%
Message from the CEO	Q3 numbers are available. All areas met goal.							