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

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

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www.calvivahealth.org

DATE: March 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, March 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

Meeting materials have been emailed to you.

Currently, there are **14** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

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

Meeting Locations:

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

2) Family HealthCare Network
114 W Main Street office.
Visalia, CA 93291

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B Attachment 3.C Attachment 3.D Attachment 3.E	**Consent Agenda:** • Commission Minutes dated 2/20/25 • Finance Committee Minutes dated 11/21/24 • QI/UM Committee Minutes dated 11/21/24 • Public Policy Committee Minutes dated 12/4/24 • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
4 Action	*No attachment*	**Community Support & DHCS Reinvestment Program Ad-Hoc Committee Selection** • Select ad-hoc Committee *Action: Selection of Ad-Hoc Committee*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 5-6* ***One vote will be taken for combined items 5-6***	
5 Action	Attachment 5.A	**Population Health** • Population Health Management Program Strategy Description 2025 & Change Summary *Action: Approve the PHM Program Strategy Description*	P. Marabella, MD, CMO
6 Action	Attachment 6.A Attachment 6.B	**2025 Quality Improvement & Health Education** • 2025 Program Description & Change Summary • 2025 Work Plan *Action: Approve 2025 Quality Improvement & Health Ed Program Description, and 2025 Quality Improvement & Health Ed Work Plan*	P. Marabella, MD, CMO

7 Action		**Standing Reports**	
	Attachment 7.A	**Finance** • Financials as of January 31, 2025	D. Maychen, CFO
	Attachment 7.B	**Equity** • Health Equity Report	Sia Xiong-Lopez, EqO
	Attachment 7.C Attachment 7.D Attachment 7.E Attachment 7.F	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment 7.G	**Executive Report** • Executive Dashboard	J. Nkansah, CEO
		Action: Accept Standing Reports	
8		**Final Comments from Commission Members and Staff**	
9		**Announcements**	
10		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
11		**Adjourn**	D. Hodge, MD, Chair

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

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

Next Meeting scheduled for May 15, 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-E

Consent Agenda

3.A Commission Minutes 2/20/25
3.B Finance Minutes 11/21/24
3.C QIUM Minutes 11/21/24
3.D PPC Minutes 12/4/24
3.E Compliance Report

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
February 20, 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
	Garry Bredefeld, Fresno County Board of Supervisors	✓	**Aftab Naz,** M.D., Madera County At-large Appointee
✓	**David Cardona**, M.D., Fresno County At-large Appointee	✓	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
	Aldo De La Torre, Community Medical Center Representative	✓	**Lisa Lewis**, Ph.D., Kings County At-large Appointee
	Joyce Fields-Keene, Fresno County At-large Appointee	✓	**Rose Mary Rahn**, Director, Kings County Dept. of Public Health
✓	**John Frye**, Commission At-large Appointee, Fresno	✓	**David Rogers**, Madera County Board of Supervisors
✓●	**Soyla Griffin**, Fresno County At-large Appointee		**Jennifer Armendariz**, Valley Children's Hospital Appointee
✓	**David Hodge**, M.D., Chair, Fresno County At-large Appointee	✓	**Paulo Soares**, Commission At-large Appointee, Madera County
	Kerry Hydash, Commission At-large Appointee, Kings 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 1:33 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			
#3 Appointed / Reappointed Board of Supervisors Commissioners **Action** D. Hodge, MD, Chair	Fresno County has appointed Supervisor Garry Bredefeld as Commissioner, and Supervisor Brian Pacheco as alternate. Kings County has re-appointed Supervisor Joe Neves as Commissioner and Supervisor Rusty Robinson as alternate. In 2023, Madera County re-appointed Supervisor David Rogers as Commissioner and Supervisor Jordan Wamhoff as alternate for a term of three years.		***Motion**: Ratify BOS Commissioners.* *10 – 0 – 0 – 7* *(Rogers / Frye)* *A roll call was taken*
#4 Fresno County At-Large Seat Nomination **Action** D. Hodge, MD, Chair	John Frye was reappointed as the Fresno County At-Large representative for a three-year term ending in January 2028.		***Motion**: Approve reappointment of Fresno County At-Large seat.* *9 – 0 – 1 – 8* *(Griffin / Neves)* *(John Frye abstained from voting)* *A roll call was taken*
#5 Consent Agenda • *Commission Minutes dated 1/16/24.* • *Finance Committee Minutes dated 10/17/24.* • *QI/UM Committee Minutes dated 10/17/24.* • *Compliance Report* • *2025 Code of Conduct* Action D. Hodge, MD, Chair	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *10 – 0 – 0 – 7* *(Griffin / Neves)* *A roll call was taken*
#6 Closed Session	Jason Epperson, General Counsel, reported out of closed session. The Commission met in closed session to discuss item 6.A agendized for closed session		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	specifically Conference with Legal Counsel - Existing Litigation, pursuant to Government Code section 54596.9. Fresno County Superior Court Case No. 24CECG02996. The Commission had that discussion in closed session direction was given to staff. The Commission recessed 1:38 pm.		
#7 Annual Administration Information D. Hodge, MD, Chair	Dr. Hodge reminded the Commission the Form 700 is due on an annual basis, due this year on 4/1/25. Commissioners will receive notification from the Commission Clerk via email. Anyone due for an updated Ethics Certification will be notified.		***No Motion***
#8 Community Support Policy & Procedure Action J. Nkansah, CEO	Jeffrey Nkansah presented the new DHCS Community Reinvestment Requirements per DHCS APL 25-004 that will impact the Community Support Policy and Procedure. Changes to the policy include: • Add the DHCS phrases and requirements (i.e., "Community Reinvestment") to RHA Commission Policy and Procedure • Inform DHCS in P&P we will follow their requirements • Add Equity Officer to Ad-Hoc Committee • Adjust the excess amount to account for inflation and current environment. • Streamline policy and procedure • Insert DHCS Community Reinvestment Requirements • Insert DHCS Community Reinvestment Principles • Insert DHCS Community Reinvestment Categories • Insert DHCS Community Reinvestment required plan(s) which requires DHCS review and approval • Insert DHCS Community Reinvestment required reporting requirements which will be posted on the CalViva Health website • Revised RHA Commission Policy and Procedure AD-103 will be submitted to DHCS for review and approval. DHCS may request additional changes and if this occurs, the policy will also be brought back to the RHA Commission for approval.	*Rose Mary Rahn asked if there is a system for assuring equitable distribution between the three service counties.* *Jeffrey Nkansah responded that the State will determine how much the Plan should invest, the Plan with then work through the distribution.* *Soyla Griffin asked if there is a minimum for the reinvestment.* *Jeffrey Nkansah stated there is a minimum. The State will use the Plan's net income, and the methodology stated in DHCS All Plan Letter 25-004 to determine the Plan's investment requirements. The State*	***Motion**: Approve Community Support & Community Reinvestment* *10 – 0 – 0 – 7* *(Frye / Griffin)* *A roll call was taken.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		will provide that number to the Plan. Within the policy letter it is estimated they will not provide the number until Q2 2026. The CFO and team has come up with an estimate of what they believe to be the community investment number, estimated conservatively, at $2.7-$2.8M.	
#9 Annual Delegation Oversight of Health Net Action J. Nkansah, CEO	The 2024 Annual Delegation Oversight and Monitoring Report of Health Net was presented to the Commission. The following areas were reviewed: Quality Assurance, Performance Standards, Reporting Completeness, Timeliness & Accuracy, and Oversight Audits. For 2024, Health Net has met the requirements and their obligations with a Passing score in three of the 4 areas: Quality Assurance, Performance Standards, and Reporting Completeness, Timeliness, & Accuracy. Health Net did not Pass in Oversight Audits as 9 of the 16 audits required CAPs. Additional conversations will occur with Health Net surrounding this area, however, as those conversations continue, it was recommended to approve Health Net to continue their delegated functions for another year.		***Motion**: **Motion**: Approve Annual Delegation Oversight of HN and for them to continue their delegated functions for another year.* *10 – 0 – 0 – 7* *(Neves / Rogers)* *A roll call was taken.*
#10 New Ad-Hoc Committee re: Conference Report Involving Trade Secret Action J. Nkansah, CEO	As a result of two Closed Sessions, May 2024 and January 2025, it is recommended to establish an Ad-Hoc Committee appointed by the RHA Commission. The Ad-Hoc Committee will include a minimum of three Commissioners, the CEO, and the CFO. This Committee will review, evaluate, and make recommendations to Commission for action. In addition, the Plan is requesting the Commission grant authority for CalViva CEO to contract an organization/individual who can assist in navigating the California political and policy making environment.		***Motion**: **Motion**: Approve new Ad-Hoc Committee & contract an organization/individual who can assist in navigating the political and policy making environment.* *10 – 0 – 0 – 7*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The three Commissioners recommended for the Committee include Paulo Soares, Rose Mary Rahn, and David Luchini. In addition, Dr. Hodge requested to be added to the Committee.		*(Neves / Frye)*
#11 2024 Annual Quality Improvement & Health Education Work Plan Evaluation Action P. Marabella, MD, CMO	Dr. Marabella presented the 2024 Annual Quality Improvement and Health Education Work Plan Evaluation. The Quality Improvement (QI) & Health Education (HEd) Program Evaluation 2024 Year-End includes: 1. Summary of Overall effectiveness of QI Program 2. Goals and Quality Indicators 3. Overall Effectiveness of QI & HEd Work Plan Initiatives 4. QI & HEd Reporting 5. Summary of Key Accomplishments 6. Annual QI & HEd Program Changes The QI 2024 Work Plan includes the following categories: 1. Behavioral Health 2. Chronic Conditions/ Chronic Disease 3. Hospital Quality/Patient Safety 4. Member Engagement & Experience 5. Pediatric/Children's Health 6. Perinatal Health/ Reproductive Health 7. Pharmacy 8. Preventative Health/ Cancer Prevention 9. Provider Engagement 10. Continuity/Coordination of Care (Non-BH/BH) 11. Access, Availability and Service and Satisfaction 12. Health Education Overall, there were 78 objectives, of which 49 were met: 61.53%. Some are ongoing activities that were not expected to meet goal this year. Rate of objectives met:		***Motion**: See item #13 for motion*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	1. Behavioral Health – 0 out 6; 0% 2. Chronic Conditions – 6 out of 6; 100% 3. Hospital Quality / Patient Safety – 9 out of 11; 81.82% 4. Member Engagement and Experience – 0 out of 1; 0% 5. Pediatric/Perinatal/Dental – 15 out of 30; 50% 6. Pharmacy (Asthma)– 1 out of 3; 33.33% 7. Preventive Health – 12 out of 12; 100% 8. Provider Communication/Engagement – 5 out of 9; 55.56% For Behavioral Health, the focus is on improving follow up after E.D. visit for substance use or mental health disorder measured by the HEDIS® metric FUA-7/30 and FUM-7/30. Overall, CalViva did not meet the 50th Percentile Quality Compass performance goal. Kings County did meet the MPL for both measures in MY2022 therefore, excluded from improvement activities in 2024. • Non-clinical PIP to focus on Fresno and Madera Counties. • Project is ongoing through end of 2026. For Chronic Conditions & Pharmacy, the goal is to Implement strategies to improve performance in Asthma Medication Ratio (AMR), Blood Pressure Control (CBP), Diabetes (CDC >9). For Hospital Quality / Patient Safety, CVH has five (5) facilities total. The activities are focused on ensuring hospitals are providing appropriate, safe care to patients that avoids preventable harm, and provide guidance to members about informed choice when selecting a site. C-section performance improved in 3/5 hospitals meeting the target rate of 23.5% (or lower) compared to improvement in just one hospital last year. Member Engagement and Experience: CAHPS Survey – 3 out of 8 measures met the Outcome Quality Compass (QC) 25th percentile goal. Outcomes not met were 1) Getting Needed Care, and 2) How Well Doctors Communicate. For Pediatric / Children's Health Program, the Plan initiated a Performance Improvement Project (PIP) for Well-Child Visits for Black/African American members in the first 30 Months of Life (W30-6+).		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	For Perinatal/Reproductive Health, all CalViva Health Counties are exceeding the 50th percentile for timely prenatal care, postpartum care, and Chlamydia screening. Kings County exceeded the 90th percentile for PPC-post. Fresno and Madera Counties exceeded the 75th percentile for PPC-pre. For Preventive Health/Cancer Prevention, the focus is Breast Cancer, Cervical Cancer & Chlamydia Screening. Sixteen (16) Alinea (vendor) mobile mammography events were completed for CalViva in 2024. Member outreach scheduled appointments also completed. Opportunity in 2025 to form direct partnership with radiology facilities, collaborate with CBO to deliver equitable and culturally sensitive care. For Provider Engagement, Quality Evaluating Data to Generate Excellence (EDGE) with special focus to align with the DHCS goal to achieve 50th percentile for all pediatric MCAS measures in 2025. Full implementation of standardized data reconciliation process to address challenges with data workflow, provider use of codes, and other systems issues that impact receipt of evidence of member care will take place in 2025. For Continuity / Coordination of Care, CalViva utilizes NCQA as a roadmap for improvement on how an organization can deliver high-quality care. For non-medical, during 2024 CalViva monitored several aspects of COC such as Timeliness of Perinatal Care- Postpartum Care (PPC) and Eye Exams for Patients with Diabetes. For behavioral, throughout 2024 the focus was on E.D. visits for behavioral health and substance use coordination of care and follow up. For Access, Availability, and Service and Satisfaction, Provider Access, Availability, Satisfaction Survey Measures met the following goals: • 50.82% of PAAS measures for Providers • 100% of PAAS (DMHC) - Access to Ancillary measures. • 66.67% of Provider After-Hours Survey measures. • 64% of Provider Satisfaction Survey (PSS) measures and 50% of BH PSS measures.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• 100% of Behavioral Health PAAS by Risk Rating measures. For Health Education, programs were aimed at increasing participation in Well Care Visit, Breast Cancer Screening, Cervical Cancer Screening, Childhood Immunizations and Well Child Visits. For HEDIS®, RY 2024, overall, CalViva achieved 59% of MCAS measures above the MPL for MY 2023.		
#12 2024 Annual Utilization Management Case Management Workplan Evaluation **2025 Utilization management Program Description & Change Summary** **2025 Utilization Management Case Management Work Plan** Action P. Marabella, MD, CMO	Dr. Marabella presented the 2024 Annual Utilization Management Case Management Workplan Evaluation Executive Summary and Year End Evaluation; the 2025 Utilization Management Program Description & Change Summary; and the 2025 Utilization Management Case Management Work Plan. All Accreditation & Regulatory Requirements: Objectives Met Except for Separation of Medical Decisions from Fiscal Considerations (Affirmative Statements) and Periodic Audits for Compliance with Regulatory Standards (Post Stabilization). Monitoring the UM Process: TAT was met with 95% or better threshold in all areas and in all quarters. Monitoring Utilization metrics: Objectives met except for Improve Medi-Cal shared risk and FFS UM acute in-patient performance, and PPG Profile Actions. Monitoring Coordination with Other Programs and Vendor Oversight: All activities related to monitoring coordination with other programs and vendor oversight met objectives for this end of year evaluation. All monitoring activities for Special Populations met goals. This includes CCS Tracking, SPD Tracking, CBAS Tracking, and Mental Health Tracking. The Adequacy of UMCM Program Resources met goal. Utilization metrics met the goal of a 2% decrease or greater in bed days, acute admissions, and length of stay.		***Motion**: See item #13 for motion*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Readmissions 8-30 did not meet goal (-1.4%) but source of issues were process based, not resource. Satisfaction data reports noted consistent results with previous years with some improvements and some opportunities for MY2023. MY2024 results pending. Will be reported Q1 2025. Improvement in timeliness of referrals was identified as an opportunity and BH referrals increased with data from ADT reports. Increase in perinatal referrals noted compared to prior year. Program Scope, Processes, Information Sources: The Annual DHCS survey (2023) had only one deficiency identified. Ongoing out-reach and monitoring to continue. And criteria used for decision-making updated and approved in November 2024. For Practitioner Participation and Leadership Involvement in the UM Program: contracted network providers participated in the QI/UM Committee and Credentialing and Peer Review Sub-Committees. Weekly multi-disciplinary care rounds were conducted. Leadership and staff provided reports, participated in improvement activities, and attended monthly meetings. <u>2025 Utilization Management Program Description</u> The highlights of changes for 2025 include: • Distinguished medical and behavioral health. • Updated goals and objectives to include “mental health parity”. • Moved auth exclusion references to Preauthorization/ Prior authorization. • Removed clinical onsite staff, LCD, and NCD references from Inpatient Facility Concurrent Review. • Added non-specialty mental health services and APL references and removed LCD/NCD from behavioral health care services. • Added description of Pharmacy advisory committee role. • Updated Health Promotion Programs (weight management, pregnancy, diabetes prevention, health promotion incentive, community health) removed Health Hearths. • Updated types of methods for over and under utilization.		

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	• Added SB844 to utilization decision criteria. • Revised consistency of application of Utilization decision criteria. • Removed reference to separate behavioral health committees. • Delegation section revised to better describe activities. <u>2024 Utilization Management Case Management Work Plan</u> The five areas of focus consist of: 1. Compliance with Regulatory & Accreditation Requirements 2. Monitoring the UM Process 3. Monitoring Utilization Metrics 4. Monitoring Coordination with Other Programs and Vendor Oversight 5. Monitoring Activities for Special Populations The UMCM Work Plan changes include: • Five Sections remain the same for the 2025 Work Plan with minor edits and updates throughout. • Updates were focused on streamlining documentation to ensure ongoing and consistent evidence of compliance with NCQA accreditation standards. • Updating Section 3.2 Over/Under Utilization – to clarify and update metrics and reporting. • Section 4.4 Captures Chronic Condition Management required reporting.		
#13 Care Management 2025 Program Description & Change Summary Action P. Marabella, MD, CMO	2025 Care Management Program Description. Highlights of Changes for 2025 include: • Added in CalViva QI/UM info and organization, updated HealthNet job titles (removed VP PHCO and added CM Director, VPMM changed to CMO), removed Member Connections. • Update to team staffing, changed average active caseload to up to 75 for PH/BH, and 150 for CalViva Pregnancy Program CM. • Updated Transitions of Care program section to reflect requirements for 2025. • Added CalViva Pregnancy Program to Special Program section.		***Motion:*** *Approve 2024 Annual Quality Improvement & Health Education Work Plan Evaluation, 2024 Annual Utilization Management Case Management Workplan Evaluation, 2025 Utilization Management Program Description & Change Summary, 2025 Utilization Management*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
			Case Management Work Plan, and Care Management 2025 Program Description & Change Summary *10 – 0 – 0 – 7* *(Naz / Neves)*
#14 Compliance • *2024 Annual Compliance Program Evaluation* • *2025 Compliance Program Description* • *2025 Fraud Prevention Program* • *2025 Privacy and Security Plan* • *2025 Emergency Preparedness Crisis Response Plan* **Action** M.L. Leone, CCO	Mary Lourdes Leone presented the Compliance Program documents including the 2024 Annual Compliance Program Evaluation, 2025 Compliance Program Description change summary, 2025 Fraud Prevention Program change summary, and the 2025 Privacy & Security Plan change summary, and the 2025 Emergency Preparedness Crisis Response Plan. The key 2024 Compliance Program Initiatives: • Achieving National Committee for Quality Assurance (NCQA) Accreditation. • 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). In 2024, the Compliance Program was supported by all Plan Departments by:		***Motion**: Approve 2024 Annual Compliance Program Evaluation, 2025 Compliance Program Description, 2025 Fraud Prevention Program, 2025 Privacy and Security Plan* *10 – 0 – 0 – 7* *(Neves / Frye)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Developing and revising several policies and procedures in accordance with new Contractual requirements, DMHC/DHCS regulations and NCQA Standards. • Participating in and responding to DMHC/DHCS Audits and corrective actions. • Ensuring network adequacy, access standards and performance metrics are met. • Ensuring responses to Member grievances and Provider payments are timely and appropriate. Regulatory Affairs: Administrative and Operational Regulatory Reporting: Over 400 regulatory filings* were made to DMHC and DHCS, not including periodic monthly/quarterly program data reports or the Operational Readiness submissions. Summary of State Audits, Corrective Actions, and Medi-Cal Contract Amendments: Department of Health Care Services (DHCS): • 2023 DHCS Focused Audit - 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 - There were two findings: The Plan did not ensure written PA extension notices specified the information requested and did not receive from the provider; 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 – There were two recommendations that focused on the following: working to resolve the findings from the DHCS 2022 annual DHCS audit and improving MY2022 HEDIS measures; The Plan submitted its response to how it would address the recommendations on August 2, 2024.		

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	• DHCS 2024 Encounter Data Validation (EDV) Study –Overall, the Plan did not meet Encounter Data Completeness standard (i.e., <10%) in two categories, and did not meet the Encounter Data Accuracy standard (>90%) in the three categories. The Plan is working with Health Net on strategies to improve standards in 2025.
	• DHCS RY 2023 Subnetwork Certification (SNC) – For RY 2023 SNC, the Plan issued five PPGs CAPs for not meeting time and distance standards. The Plan submitted quarterly updates to DHCS and on 12/10/24 DHCS approved the Plan's SNC.
	• 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), conducted 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 accepted.
	• DHCS Contract Amendments - DHCS Medi-Cal contract amendments were executed between DHCS and CalViva Health in 2024:
	  • Contract 23-30220 A02- 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- Extended the contract to December 31, 2025.
	
	Department of Managed Health Care (DMHC):
	• Compliance with Timely Access and Network Reporting Statutes - The Plan successfully submitted and received approval for compliance with the new Timely Access Regulations.
	• Measurement Year (MY) 2022 Timely Access Report (TAR) – On May 6, 2024, DMHC issued a Network Findings Report with two findings related to		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Geographic Access and Data Accuracy. The Plan submitted a response on August 1, 2024. • Measurement Year (MY) 2023 Timely Access Report (TAR) - 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. All CAPs have been closed. • Compliance with Timely Access and Network Reporting Statutes - The Plan successfully submitted and received approval for compliance with the new Timely Access Regulations. • 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) - 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. All CAPs have been closed. • 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. DHCS Fraud, Waste and Abuse Required Reporting: • Plan filed 24 MC609s with DHCS for Suspected FWA		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Privacy and Security Incident Reporting: • Plan filed 32 privacy and security incidents with DHCS New/Expanded DHCS Benefits, and New Plan Coverage Requirements: • Enhanced Care Management (ECM) - 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 and is expected to complete contracts with all remaining providers by July 2025. • Community Supports (CS) – The following CS services went live 7/1/24: Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties); and Recuperative Care (Madera County]. Additionally, 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). • Long-Term Care Phase II Carve-In – The Plan completed the network readiness and policy deliverables on July 7, 2024 for ensuring coverage for ICF/DD and Subacute Care Facilities (Adult and Pediatric). • Adult Expansion - Effective 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 member's PCP assignment Plan Compliance with 2024 DHCS Contract Requirements: • Hired a Health Equity Officer • Submitted the annual Population Health Management Strategy • Developed a Diversity, Equity, and Inclusion (DEI) training program • Achieved full NCQA Health Plan Accreditation • Carved-in coverage for ICF/DD and Subacute Care facilities • Submitted updated fully executed MOUs with third-party entities 2024 Program Document Approvals: • Compliance Program Description • Code of Conduct		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Privacy and Security Plan • Anti-Fraud Plan • Compliance Committee Charter • Emergency Preparedness and Crisis Response Plan Oversight and Monitoring of Delegated Activities: 2024 Delegation Oversight Audits and CAPS: • Appeals & Grievances – CAP required • Claims – CAP required • Fraud Wast & Abuse • Credentialing – CAP required • Provider Disputes – CAP required • Pharmacy • Health Education • Utilization Management – CAP required • Provider Network – CAP required • Privacy & Security – CAP required • Emergency Room – CAP required • Quality Improvement – CAP required • Behavioral Health • Marketing • Health Equity • Member Rights 2024 Periodic Monitoring of Health Net • Monthly Management Oversight (MOM) meetings • Review monthly/quarterly performance metrics & key indicator data • Joint Workgroups - Access & Availability, Encounter Data Integrity, Grievances & Appeals, QI/UM/Credentialing • On-going oversight of PPGs, specialty plans and vendors through quarterly report dashboards 2024 CalViva Internal Audit:		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Internal audit of Employee, Commission and Committee Member files. All were compliant and no CAP was issued. CalViva Health Staff Trainings: • One new employee successfully completed training • All staff members successfully completed annual training Provider Communications: • 305 Provider Updates • 22 Informational Letters • 22 Forms Member Communications: • 47 Member Informing • 12 Provider Directories • 1 Newsletter • 1 2025 EOC Provider Engagement: • 6000 interactions - operational, quality improvement and training issues 2024 Appeal and Grievance (A&G) Resolution Summary: With reference to Expedited Grievances, Standard Grievances, Expedited appeals, and Standard Appeals: • There was a total of 2,599 cases received. • There was a total of 2,589 cases resolved. With reference to SPD Appeals & Grievances: • There were 766 cases received. • There were 754 cases resolved. With reference to Exempt Grievances: • There were 2,201 cases received. • There were 2,201 cases resolved.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	2024 Independent Medical Reviews (IMRs) and State Hearings: • There were 51 DMHC Cases received. • There were 42 DHCS State Hearings. • 100% of cases were submitted within the turn-around-time. 2025 Key Areas of Focus: • 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. • 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. Program Description Change Summaries: 2025 Compliance Program Change Summary: • Inserted year 2025 • Change “Anti-Fraud Plan” to “Fraud Prevention Program” • Updated Table 2 to include Emergency Preparedness and Crisis Response Plan • Added Call Center, ER, Privacy and Security and Transportation • Updated Table 4 to include Emergency Preparedness and Crisis Response Plan; Clarified language related to external distribution of Compliance Program documents. 2025 Fraud Prevention Program Change Summary: • Inserted year 2025 • Added language regarding the corresponding P&P “CO-005 Fraud and Abuse Prevention and Detection Investigation”		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Corrected name for Fraud Prevention Program. Added reference to P&P "CO-005 Fraud and Abuse Prevention and Detection Investigation" • Added #10 to specify that the CCO will "Submit reports of suspected fraud, waste and abuse to the RHA Commission" • Added "clinicians" to team members • Added reference to P&P "CO-005 Fraud and Abuse Prevention and Detection Investigation". Updated language regarding Preliminary Report. • Minor grammatical edits 2025 Privacy & Security Plan Change Summary: • Clarifies CCO serves as Privacy and Security Officer. • Replaced CVH's Contingency Plan with Business Continuity and Disaster Recovery Controls. • Added text regarding permissible disclosures per AB 352, Civil Code Section 56.110(a). • Replaced CVH's Contingency Plan with Business Continuity and Disaster Recovery Controls. 2025 Emergency Preparedness and Crisis Response Plan Change Summary: • Inserted year 2025 • Updated to include members in LTC facilities • Updated with more precise language applicable to each function. • Listed applicable CalViva Health policies • Minor edits to grammar		
#15 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of December 31, 2024</u> As of December 2024, total current assets recorded were approximately $580.8M; total current liabilities were approximately $418.9M. Current ratio is approximately 1.39. Total net equity as of the end of December 2024 was approximately $171.7M, which is approximately 614% above the minimum DMHC required TNE amount.		***Motion**: Standing Reports Approved* *9 – 0 – 0 – 8* *(Frye / Neves)* *A roll call was taken.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	For the first six months of FY 2025, interest income actual recorded was approximately $5.8M, which is approximately $3.6M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately $996.4M which is approximately $77.6M more than budgeted due to enrollment and rates being higher than projected. Total Cost of Medical Care expense actual recorded was approximately $674.7M which is approximately $74.8M more than budgeted due to enrollment and rates being higher than projected. License expense actual recorded was approximately $744K, which is approximately $31K more than budgeted due to the actual fee being higher than projected as DMHC has indicated higher labor costs as a reason for higher DMHC license fees. Telephone expense actual recorded was approximately $28K, which is approximately $6.6K more than budgeted due to the Plan's previous phone service provider increasing the rates stating the Plan was on a legacy platform. In response to that increase, the Plan obtained bids from other phone service providers and has now transitioned to a different phone service provider at a much lower cost. By the end of the year, the Plan should be close to budgeted amounts. Total net income for the first six months of FY 2025 actual recorded was approximately $10.1M, which is approximately $6M more than budgeted primarily due to interest income being approximately $3.6M higher than projected, and rates and enrollment being higher than projected. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through year end 2024. • The total number of grievances through Q4 2024 increased slightly when compared to previous YTD. The Quality-of-Service category represents the highest volume of total grievances.		*Dr. Naz left meeting at 3:09 pm, not included in vote.*

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	• For the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Administrative and Balance Billing. Transportation Access has improved. • The volume of Quality of Care (QOC) cases decreased when compared to previous YTD. • The volume of Exempt Grievances increased when compared to previous YTD. • Total Appeals volume increased when compared to previous YTD due to new services (CalAIM-Medically tailored meals). The majority being Consultation, DME, 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 year end 2024. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through year end 2024. • TANF and SPD populations are experiencing lower hospitalization rates and shorter stays, which may be driven by better preventive care, alternative treatment options, or system-wide efforts to reduce inpatient admissions. • The decline in SPD bed days suggests significant changes in the management of high-needs patients, which could be due to policy adjustments or improvements in outpatient and community care. • These trends highlight a potential shift toward more efficient inpatient utilization and a growing emphasis on outpatient and community-based care models. • The downward trend in ALOS for MCE and SPD populations suggests improved hospital efficiency, better discharge coordination, and potential shifts toward alternative treatment pathways. • The TANF population maintaining its ALOS at the goal level indicates a stable care approach with no significant shifts in inpatient care management.		

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• **Equity Report** S. Xiong-Lopez, EqO	• Shorter hospital stays for MCE and SPD could result in cost savings and increased hospital capacity. After further analysis of our data this does not lead to higher readmission rates. • MCE and TANF populations demonstrated improved readmission rates, suggesting effective discharge planning and post-hospitalization care. • SPD's increase in readmissions, despite shorter hospital stays, warrants closer monitoring to ensure that reductions in ALOS and inpatient utilization do not compromise care quality. • To improve care management and prevent unnecessary hospitalizations, Clinical Concurrent Review (CCR) implemented a mandatory Medical Director Review for these conditions as of August 1, 2024. • CCR cases are now regularly reviewed during rounds, ensuring care teams can intervene early to optimize treatment and reduce unnecessary inpatient days. • Care Management (CM) and Enhanced Care Management (ECM) referrals are completed as needed, providing members with follow-up support post-discharge to prevent readmissions. Care Management (CM) engagement rates are up, and all areas continue to improve. **Health Equity** <u>Equity Report</u> <u>Health Equity Oversight & Monitoring Activities</u> Mental Health and Substance Abuse training: Working with Health Net 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. Transgender, Gender Diverse or Intersex cultural Competency training: The TGI training is based on the requirement of the DHCS APL 24-017, required by Senate Bill (SB) 923. OutCare was identified as the CBO that will be delivering the training curriculum.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	<u>Current Health Equity Project(s) and Initiative(s)</u> Network Improvement Community Schools with Fresno County Super Intendant Schools: 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 address SoDH, improve health, wellness and academics outcomes. 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. 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): 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: Met with DHCS to review current State Data, Assessments; Set Pilot goals and development implementation plan; 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: • 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• 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. Topics 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: 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: 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: • 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) • 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.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	**Executive Report** <u>Executive Dashboard</u> Enrollment as of December 2024 is 432,709. Market Share is currently approximately 66.86%. Enrollment is expected to continue its decline. Regarding Information Technology Communications & Systems, no significant issues or concerns at this time. 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. The Plan is currently monitoring Federal activities with regard to immigration, Medicaid, and DEI. The Annual Report 2024 was provided to all Commission members.		
#16 Final Comments from Commission Members & Staff	None.		
#17 Announcements	None.		
#18 Public Comment	None.		
#19 Adjourn	The meeting adjourned at 3:22 pm. The next Commission meeting is scheduled for March 20, 2025, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

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

November 21, 2024

Finance Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Director, HR/Office
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
	Paulo Soares		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 October 17, 2024, Finance meeting were approved as read.		Motion: *Minutes were approved* *4 – 0 – 0 – 3* *(Neves / Rahn)*
#3 Financials – as of September 30, 2024 Action D. Maychen, Chair	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.		Motion: *Financials as September 30, 2024, were approved* *4 – 0 – 0 – 3* *(Neves / Rahn)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	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. Admin service agreement fees expense actual recorded was approximately $14.4M, which is approximately $678K 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. 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.		
#4 Draft CY 2025 Rates Information D. Maychen, Chair	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 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 FY 2025. The Plan is requesting 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		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	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. In addition, DHCS made a substantial change in how they pay the long term care (LTC) and SPD rates. Previously Plans were paid two separate rates, and now DHCS is combining it into one. The issue with this is the rate difference, or the cost difference, in the LTC vs SPD rate noting approximately a 900% difference. If DHCS, in their assumption, are off even a minimal amount of how many LTC members are in that combined rate, it could have a material impact. Plans are asking 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. It was noted that numerous other Plans are seeing the same issues and are also considering filing a Notice of Dispute. The last time the Plan filed a Notice of Dispute was over ten (10) years ago and was for the SPD rates, which took approximately two (2) years to resolve. As a result, DHCS settled and increased the rates retroactively. Last week Plan CEOs, and Plan CFOs met with DHCS leadership to communicate concerns, and it appeared that DHCS was receptive and stated that the rates are draft rates, and the final would possibly be different, and they would take all concerns into consideration including reviewing more current utilization.		
#5 Announcements	Daniel thanked his Finance team for the work performed on the audit that will officially begin in 2025.		
#6 Adjourn	Meeting was adjourned at 11:49 am		

Submitted by: Cheryl Hurley
Cheryl Hurley, Clerk to the Commission
Dated: 2.20.25

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson
Dated: 2/20/25

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
November 21st, 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 Senior 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 10:05 am. A quorum was present. Dr. Marabella introduced Dr. Hodge, RHA Commission Chair and QIUM Committee alternate to the CalViva staff and members of the QIUM Committee.	
#2 **Approve Consent Agenda** Committee Minutes: October 17,	The October 17th, 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
2024 - Standing Referrals Report (Q3 2024) - California Children's Services Report (Q3 2024) - Concurrent Review IRR Report (Q3 2024) - Evolent (NIA) (Q3 2024) - A&G Inter-Rater Reliability Report (Q3 2024) - Quarterly A&G Member Letter Monitoring Report (Q3 2024) - A&G Validation Audit Summary (Q2 2024) - Customer Contact Center DMHC Expedited Grievance Report (Q3 2024) - Potential Quality Issues (PH & BH) (Q3 2024) - Provider Preventable Conditions (Q3 2024) - Lead Screening Quarterly Report (Q2 2024) - Initial Health Appointment Quarterly Audit (Q2 2024) - County Relations Quarterly Report (Q3 2024) - Pharmacy Provider Updates (Q2 2024) - Compliance Regulatory Report (Attachments A-P)	for further discussion at the request of any committee member. A link for Medi-Cal Rx Contract Drug List was available for reference.	(Cardona/Hodge) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair		
#3 **QI Business** - A&G Dashboard and Turnaround Time Report (September 2024) - A&G Executive Summary (Q3 2024) - A&G Quarterly Member Report (Q3 2024) (Attachments Q-S) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard and Turnaround Time Report** through September 2024 were presented. Dr. Marabella explained the process in which members and providers submit grievances via phone, fax, email, or online, and how each of these grievances are categorized and reported on the dashboard, with supportive narratives in the separate quarterly reports. Monthly Excel files include the logs identifying each member who submitted a grievance during the reporting period (monthly) with a narrative description of the grievance and including the resolution. A total of 1,620 grievances were received during the current quarter (YTD Q3 2024), and the total received for Q3 2023 was 1,887. For Q3 2024, 484 grievances were categorized as Quality of Service (QOS) especially around prior authorizations and network access, with 1,368 related to service quality issues. • Administrative issues have increased, largely due to changes in PPG contracting and network access issues. • Balanced Billing has shown some improvement this quarter, however, we will continue to monitor for sustained improvement. • Interpersonal grievances have decreased slightly but remain a concern, with efforts to improve customer service. • Transportation Access, like no-shows, has been halved compared to last year, but some grievances still exist due to concerns about quality of service. There were 210 YTD 2024 Quality of Care (QOC) grievances. A projected increase compared to 361 for 2023. • PCP Care/Delay QOC grievances remain a concern but have improved. Exempt Grievances are a separate category from QOS and QOC and are resolved over the phone within one business day. The volumes for this category increased to 626 in Q3 2024. • Behavioral health grievances have increased, reflecting changes in how grievances are captured since the MHN transition. • The Attitude/Service Provider category has increased from 43 in 2023 to 146 YTD in 2024 through Q3.	**Motion**: *Approve* - A&G Dashboard and Turnaround Time Report (September 2024) - A&G Executive Summary (Q3 2024) - A&G Quarterly Member Report (Q3 2024) (Cardona/Hodge) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• ID cards and balance billing issues still cause grievances, though improvements are being made in addressing these. • Issues with out-of-network consultations, DME (Durable Medical Equipment), and advanced imaging have seen an increase, especially related to pediatric care and the need for specialized equipment. • Cardiology imaging has also risen, partly due to new providers' unfamiliarity with submission rules. The **Appeals & Grievances Executive Summary Q3 2024 and Appeals & Grievances Quarterly Member Report Q3 2024** were presented. Trends were noted as above with the following additional issues identified: • Comparing Q3 2023 to Q3 2024: Total Appeals have increased from 86 to 136 compared to last year, and Total Grievances have risen from 535 to 557. The number of exempt grievances is also up, from 430 to 607. Specific areas of increase include issues with PCP assignment, health plan materials, attitude and service, and member billing. Transportation grievances have decreased with 23 formal and 28 exempt grievances for Q3 2024. • Top Access to Care Grievances include prior authorization delays, PCP referrals, appointment availability, and missed appointments. There were 23 formal transportation grievances in Q3 2024, and issues related to access and other administrative concerns, like balance billing, were common. There were no Continuity of Care cases in Q3 2024. o Challenges were noted in accessing specialists in fields such as neurology, rheumatology, orthopedics, OBGYNs, Cardiology, and otolaryngology (ENT), particularly in Fresno County. • Top Appeal categories include MRIs, CAT scans, and medically administered self-injectables, with several overturned decisions. Fresno County has the highest number of grievances, primarily about balance billing and prior authorization delays. • The top Quality of Care Grievances are Delays in referrals by PCPs and Prior Authorizations. • Top Quality of Service Grievances continue to be Balanced Billing and Access to Care-Prior Authorization Delays. A trend for PCP referral was identified and addressed with different locations of UPN/UHC sites. • Nine behavioral health grievances were recorded, mostly related to difficulty finding providers.	

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	• The turnaround times for Acknowledgement letters across all categories met the standard at 100%, except for Grievance Acknowledgment Letters at 99.6%. Resolution Letters met all timeliness standards at 100%. • The A&G Inter-rater Reliability audit results for Q3 2024 increased slightly to 98%. *Discussion:* *Dr. Cardona asked if there were specific specialties that had access to care issues.* *Dr. Marabella stated that the Plan tracks all grievances, and access issues and reports these findings in the Specialty Referral Report included in today's packet. Member access is routinely discussed at our monthly Management Oversight Meetings (MOM). Some specialty providers do not take Medi-Cal patients which restricts access to care.* *Dr. Cardona asked if there were other reasons besides money that providers do not take MediCal.* *Dr. Marabella said the primary reason was financial, but sometimes it is medically based as it is harder to treat the indigent population. Some providers allow a small volume of their assigned patients to have Medi-Cal coverage.*	

#3 **QI Business**
- A&G Classification Audit Report (Q3 2024)
 	
(Attachment T)
 	
Action
Patrick Marabella, M.D Chair
	The **Appeals & Grievances Classification Audit Report Q3 2024** is a review of a random sample of grievance logs and grievance classification while the case is still open to ensure appropriate disposition of grievances.
	• Out of 298 cases reviewed by A&G Clinical staff this quarter, 278 cases were classified correctly, yielding a 93% accuracy rate.
	• Out of 20 misclassified cases:
	  • Fourteen (14) were classified as QOS instead of QOC.
	  • Three (3) cases were duplicate complaints.
	  • Two (2) members did not want to file a formal complaint for QOS.
	  • One (1) was identified as a carveout benefit (Medi-Cal RX) for QOS.
	Audits were completed on approximately 53% of the Q3 grievance universe. All case classifications were corrected prior to case closure.
		Motion: *Approve*
		- A&G Classification Audit Report (Q3 2024)
		
		(Cardona/Hodge)
		4-0-0-4

#3 **QI Business** - Call Center Inquiry Audit Report (Q3 2024)	The **Call Center Inquiry Audit Report Q3 2024** report is conducted to ensure all member expressions of dissatisfaction are properly identified and processed as grievances and ensures the proper handling and/or routing of grievances to the Appeals and Grievances department where	**Motion**: *Approve* - Call Center Inquiry Audit Report (Q3

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(Attachment U) **Action** Patrick Marabella, M.D Chair	the Oversight team will implement a quarterly internal audit. A monthly audit of a randomized sample of ten (10) inquiry call audio files are evaluated against established criteria. If an individual audio file is not auditable or is otherwise unavailable, a replacement file is selected for the audit. Both English and Spanish calls are evaluated. • During Q3 2024, a total of 33 cases were audited with three cases deemed not auditable due to the absence of recordings. Overall, the remaining cases were found to be 100% compliant.	2024) (Cardona/Hodge) 4-0-0-4
#3 **QI Business** - Preventive Health Guidelines (2024) (Attachment V) **Action** Patrick Marabella, M.D Chair	**CalViva Health's Preventive Screening Guidelines 2024*** were presented and reviewed. • The screening guidelines list the schedule of immunizations for children aged 0 through 18 years and adults aged 19-65+ • The screening guidelines listed the schedule of recommended screenings for the following categories of members: o Children aged 0 to 18 o Adults aged 19 to 65+ o Women aged 19 to 65+ o Men aged 19 to 65+ *Based on National Guidelines *Discussion:* *Dr. Cardona asked if there were any changes to the Guidelines.* *Dr. Marabella indicated there was a change to the recommended age to begin mammography screenings to 35 years.*	**Motion**: *Approve* - Preventive Health Guidelines (2024) (Cardona/Waugh) 4-0-0-4
#4 **Key Presentations** - Quarterly CAHPS Root Cause Analysis Report (Q3 2024) **Action** Patrick Marabella, M.D Chair	The **Quarterly CAHPS Root Cause Analysis Report Q3 2024** was presented and reviewed. NCQA requires Health Plans: Evaluate member satisfaction for physical health at least annually. (Quantitative and qualitative analysis of CAHPS Survey.) Evaluate member satisfaction for behavioral health at least annually. (Experience of Care and Health Outcomes ECHO® Survey) Aggregate all complaints* and appeals** into the following required categories: Quality of Care, Access, Attitude and Service, Billing and Financial Issues, and Quality of Practitioner Office Site. Annually opportunities for improvement should be identified, priorities set, and decisions made regarding which opportunities to pursue based upon analysis of the following information: • Member complaint and appeal data (Separately PH & BH) (At least one opportunity for each PH/BH from this data). • CAHPS/ECHO survey results (Separately PH & BH) (At least one opportunity for each PH/BH from this data).	**Motion**: *Approve* - Quarterly CAHPS Root Cause Analysis Report (Q3 2024) (Cardona/Waugh) 4-0-0-4

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	Implement actions to improve member satisfaction and address issues based on these identified opportunities. Assess the effectiveness of the actions and modify the plan. *As defined by NCQA, a * "Grievance" is 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.* ***An "Appeal" is a request for your health plan to review a decision that denies a benefit or payment.* The current process for CAHPS Improvement includes: • The CAHPS Team conducts root cause analysis (RCA) to highlight member pain points. • RCA is based on resolved cases. • Conducted quarterly. • Better understanding of CAHPS results, rate movement, and areas for improvement. Year Over Year Comparison - Q3 Appeals & Grievances Volume by County: There was an increase in the appeals volume for Fresno (45.6%), Kings (100%), and Madera (200%) counties, which resulted in a higher PTMPY rate compared to 2023 Q3. There was a slight increase in the volume of grievances of 12.2% in Fresno County. Kings and Madera counties showed a decrease of 28.3% and 36.9% respectively compared to Q3 2023. 2024 Q1-Q3 Trends - Appeals & Grievances Volume Comparison by County: 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 2024. Overall, grievances volume for Q3 2024 showed a slight decrease compared to Q2 2024 in Fresno (1.64%) and Madera (28%) counties. Kings County stayed the same as Q2 2024. Year-Over-Year Comparison - Q3 Top Appeals & Grievances Trend by Classification Codes: In 2024 Q3, there was a 60.2% increase in appeals for the Not Medically Necessary classification code compared to 2023 Q3. For grievances, there was a decrease in three of the top five grievances: 5.4% in Access to Care, 30.1% in Balanced Billing, and 22% in Quality of Care – PCP compared to Q3 2023. Administrative Issues and transportation grievances had an increase of 85% and 17.2% respectively compared to last year, in the same quarter. Quarter over Quarter - Top Appeals & Grievances Trends by Classification Codes: In 2024 Q3, there was a 19.8% increase in appeals for the Not Medically Necessary classification code compared to 2024 Q2. For grievances, an increase was noted in three of the top five grievances in volume,	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	11.4% in Access to Care, 2.7% in Administrative Issues, 36% in 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 Q3 2024 compared to Q2 2024. Trending Appeals (volume) by Category: In 2024 Q3, appeals appear steady compared to last year, at the same time, in two out of the four categories. Diagnostic –CAT Scan had an increase of 166.6% compared to Q3 2023. 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 Q2 2024 with an increase of 180% and 175% compared to 2024. *Discussion:* *Dr. Cardona asked why the PCP Referral for Services grievances had increased.* *Dr. Marabella indicated that the grievances for PCP Referral were primarily due to members not being able to see a specialist.* 2023 & 2024 Q3 Trending Grievances (volume) by Category: Most of the trending grievances had a decrease in Q3 2024 compared to Q3 2023. Prior Authorization Delay (13.7%), Transportation Missed Appointment (70.2%), and Inappropriate Payment Demand (par) (30.6%) had a decrease in volume compared to Q3 2023. The trending grievances that had a noted increase are PCP Referral for Services of 200% and Health Plan of 420% compared to Q3 2023. 2024 Q1 - Q3 Trending Grievances (volume) by Category: Similar trend where most of the grievances had a decrease in Q3 2024 compared to Q1 and Q2 2024. Prior Authorization Delay and Inappropriate Payment Demand (in-network providers) volume showed an improvement of 15.3%, Referral Process of 57.1%, and Inappropriate Payment Demand (in-network providers) of 27.1% in Q3 2024 compared to Q2 2024. There was an increase in grievance volume in PCP Referral for Services of 114.2% and a Delay in Referral by PCP of 116.6% from the previous quarter. Actions & Next Steps: • Live and Recorded Provider Training Webinars • Started in July 2024 with topics on how to be compliant related to Prior Authorizations and use of e-consults. • Best Practices Tip Sheets were released in September 2024. Guidelines developed for Prior Authorizations on how to avoid processing delays and improve member satisfaction. • Corrective Action Plans (CAPs) Improvement plans were required from PPGs with low scores in the Access and Availability	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	results (PAAS and PAHAS surveys). • Isolated Appeals Cases Plan leadership to discuss issues and opportunities to improve members' experience with PPG leaders. • Future Activities CalViva A & G Work Group will work with A & G Team and Data Analysts to analyze CAHPS results and A & G Quarterly Data to identify priority opportunities and establish interventions to address identified issues and improve member satisfaction. *Discussion:* *Dr. Marabella framed the opportunity for discussion using prompting questions related to oversight responsibilities.* *Dr. Cardona mentioned that HN should call out providers who do not meet requirements.* *Dr. Marabella mentioned that HN could enforce compliance with Letters of Agreement. Dr. Marabella added that there is a shortage of Specialty providers, and they don't always take Medi-Cal patients. It is an issue that is not easily solved. One action would be to set up a satellite office where specialties could rotate in to see patients on a specific day of the week.* *Dr. Cardona mentioned another issue is dual payment models. More revenue is generated through surgeries than seeing patients in the clinic.* *Dr. Marabella stated that since Madera doesn't currently have a hospital in the county Camarena is trying to set up its own specialty group.*	
#4 **Key Presentations** - SB 1019 Non-Specialty Mental Health Services Outreach and Education Plan **Action** Patrick Marabella, M.D Chair	The **SB 1019 Non-Specialty Mental Health Services Outreach and Education Plan** was presented and reviewed. SB 1019 and APL 24-012 require Managed Care Plans to: Develop and implement an Annual Outreach and Education Plan for Members and PCPs regarding covered Non-Specialty Mental Health Services (NSMHS) by January 1, 2025. Managed Care Plans (MCPs) are required to provide the following NSMHS for Members of any age with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders; five or with potential mental health disorders not yet diagnosed: • Mental health evaluation and treatment, including individual, group, and family psychotherapy. • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental	**Motion**: *Approve* - SB 1019 Non-Specialty Mental Health Services Outreach and Education Plan (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	health condition. • Outpatient services for purposes of monitoring drug therapy. • Psychiatric consultation. • Outpatient laboratory, drugs, supplies, and supplements. **Objectives:** 1. To address the historic underutilization of Non-Specialty Mental Health Services (NSMHS) by ensuring Members and PCPs are aware of all covered NSMHS. 2. To address gaps in utilization by focusing on culturally and linguistically appropriate outreach and education materials. **The Outreach and Education Plans will be reviewed to ensure:** • Alignment with culturally and linguistically appropriate standards (CLAS). • Use of best practices in stigma reduction. • Provide multiple points of contact for Members to access Mental Health benefits. No Wrong Door Policy. **Factors We Will Consider:** • Population Needs Assessment (DHCS) or Population Health Assessment (NCQA) • NSMHS Utilization Assessment (Current rates) • County Mental Health Plan to coordinate with. • The Public Policy Committee (PPC) and Quality Improvement Committee (QI/UM) must be consulted to provide recommendations for the Outreach and Education Plan. • Consider other organizations such as tribal liaisons, CBOs, navigators, CHWs, promotores, etc. • Member Experience Assessment of NSMHS (CAHPS & ECHO results). **We are seeking your suggestions and recommendations to inform our communication strategies:** • Preferred method of outreach or availability of education materials for both Members and Providers • What should the Plan avoid? • What are the barriers the plan should be aware of when accessing NSMHS? • Keywords to include or exclude in the messaging to Members and Providers? • Suggestions to reduce stigma in outreach and education or materials the Plan provides? *Discussion:* *Dr. Marabella framed the opportunity for discussion using prompting questions on suggestions for*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	outreach to our members. *Mary Lourdes Leone suggested a texting campaign.* *Dr. Cardona asked whether we have a closed-loop system that tracks prescribed medication linked to mental health such as antidepressants which triggers a follow-up with a mental health professional for counseling support or other strategies to encourage medication adherence, etc.* *Dr. Marabella stated that our system does track the use of antidepressants relating to HEDIS® scores. Additionally, we're doing a HEDIS® project on follow-up out of the ED for FUM/FUA.* *Dr. Waugh suggested increased BH integration with primary care, not only educating members with materials provided by their primary care physicians but also having them facilitate a warm handoff to onsite BH specialists from their trusted provider. Having onsite BH specialists discuss what therapy options look like can help reduce negative stigmas and on a general level might make it seem a little less threatening.*	
#4 **Key Presentations** - CalViva Operations Guide Annual Review (Attachment W) **Action** Patrick Marabella, M.D Chair	The **CalViva Operations Guide Annual Review** was presented and reviewed. In 2024 all Medi-Cal Managed Care Plans signed a new contract with the Department of Health Care Services (DHCS). Article A, Section III,3.2.4 Requires that a Provider Manual is issued to network providers, subcontractors, and downstream subcontractors regarding covered services and responsibilities. <u>DHCS Contract</u> The Provider Manual must be updated at least annually and include information on: Basic Population Health Management Care Coordination for Non-Covered Services Policies and Procedures Quality Improvement & Monitoring UM & Prior Authorization clinical protocols Timeliness Standards & Telephone Access Credentialing Appeals and Grievances & State Fair Hearings* Other regulations and reporting requirements *The contract includes specific requirements regarding A & G-related information to be addressed. <u>New in 2024</u> Must solicit feedback from the Community Advisory Committee (CalViva's Public Policy Committee) and Quality Improvement Committee.	**Motion**: *Approve* - CalViva Operations Guide Annual Review (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The Purpose of this activity is to: Obtain information regarding the development of future Provider Manuals. Clarify New and Revised Policies and Procedures. Most Recent Redline Changes were reviewed as examples of the topics covered and the kinds of edits generally made to include: Pg 59 Minor's consent (16 yrs) for MAT/ MH Pg 78 Subacute Care Facilities Pg 90 Palliative Care as a Benefit Pg 98 Revised Education Programs Pg 107 Peer to Peer Review Requests Discussion & Recommendations Review of Chapters Who to Contact Enrollment & Disenrollment Access to Care Medical Standards Sensitive and Referral Services Public Health Carve-out Services Public Health Waiver Programs Health Care Management Claim Billing and Encounter Information Grievance and Appeal Procedures *Committee members had no specific recommendations for improvement at this time. Dr. Cardona indicated that now they are aware of this requirement they will observe for future opportunities and notify the Plan.*	
#5 **UM/CM Business** - Key Indicator Report & Turnaround Time Report (September 2024) - UM Concurrent Review Report (Q3 2024) - Specialty Referrals Report – HN	The **Key Indicator Report & Turnaround Time Report** through September 2024 were presented. • Utilization for Acute Admissions, Bed Days, Acute Length of Stay, and Readmissions (all adjusted PTMPY), for TANF, MCE, and SPDs show a steady decline in recent months. o The decline could be attributed to an increase in the 30-day Transition of Care services to all members with an emphasis on connecting them to community services or telehealth post-discharge. • Behavioral Health Care Management referrals and engagement rate have improved for Q3	Motion: *Approve* - Key Indicator Report & Turnaround Time Report (September 2024) - UM Concurrent Review Report (Q3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Q3 2024) - PA Member Letter Monitoring Report (Q3 2024) (Attachments X - AA) **Action** Patrick Marabella, M.D Chair	2024. • Perinatal Care Management referrals have fluctuated but have rebounded with a 70% engagement rate. • Physical Health Care Management referrals follow a similar pattern to Perinatal. • Transitional Care Services' (TCS) engagement rate is back up to 65%. Referral numbers have steadily increased from the beginning of the year to 1,746 for Q3 2024. TCS receives all the Care Management cases initially and then refers to the different programs accordingly. • First Year of Life engagement rate remains high for Q3 2024. • One Deferral letter failed the Turnaround Time for September. The **Utilization Management Concurrent Review (CCR) Report** presents inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning, and medical appropriateness during Q3 2024. • Sepsis, Pneumonia, and UTI were identified as diagnoses over-utilized in Q3 2024. Clinical Concurrent Review (CCR) has implemented a mandatory Medical Director Review for those diagnoses as of 8/1/24. • The CM department, Saint Agnes Medical Center and Transitional Care Clinical and Outreach teams is now communicating with inpatient members with status updates, discharges, and care coordination. • The CCR team will continue validating the correct diagnoses utilized by hospitals and review cases completed by nurses in admissions with mandatory diagnosis, identifying trends to provide appropriate coaching to the staff. The **Specialty Referral Report Q3 2024** provides a quarterly summary of CalViva member referrals requiring prior authorization, with a breakdown of SPD and Non-SPD member Specialty Referral Requests in the three-county area (Fresno, Kings, and Madera) with a specific focus on in-network and out-of-network cases. • Referral statistics include: o Overall, 119 cases with a 10% denial rate. o Denial rates for out-of-network cases are higher than for in-network cases. o The most common specialty referrals are neurology, surgery, and dermatology.	2024) - Specialty Referrals Report – HN (Q3 2024) - PA Member Letter Monitoring Report (Q3 2024) (Hodge/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Nephrology is now the leading specialty for out-of-network referrals, surpassing otolaryngology. Further investigation into nephrology and neurology referrals is planned, especially regarding why nephrology is increasingly out of network. ○ A notable concern is providers switching from contracted in-network status to out-of-network, contributing to denials. ○ Specific surgical referrals include treatments for cancer, organ transplants, and pain management. The **PA Member Letter Monitoring Report Q3 2024** monitors Notice of Action (NOA) letters including Prior Authorizations, Concurrent, and Post Service denials. Findings are discussed with the entire UM Management Directors monthly. All metrics are expected to meet the standard of 100% compliance. The Medical Management Monitoring and Reporting Team collects CAP information on metrics that fall below the 100% threshold. • There was a total of 47- decision letters and six unique deferral letters impacted by letter opportunities. • Of the 40 letters that were not deemed clear and concise (LTR Code 48), 27 were CalAim services that included unexplained abbreviations and 13 lacked clarity. • Denial and Deferral LTR Codes 48, 49, & 60 will continue to be monitored. In follow-up, Medical Management implemented staff/physician coaching focused on the use of clear and concise language and no medical jargon.	
#5 **UM/CM Business** - Care Management & CCM Report (Q3 2024) (Attachment BB) **Action** Patrick Marabella, M.D Chair	The **Care Management and CCM Report Q3 2024** was presented to provide an overview of Physical Health Care Management (PH CM), Transitional Care Services (TCS), Behavioral Health Care Management (BH CM), Perinatal (PCM), and First Year of Life activities. This includes referral volume, member engagement, and an evaluation of Program effectiveness. • PCP visits within thirty (30) days of referral decreased 3% from Q2 to Q3 2024. • When a member is in care management, readmission rates, ED visits, and costs decrease while positive outcomes increase. ED claims per 1,000 members per year decreased by 480 (22%) for Q2 2024). There was a 4.3% decrease in readmission rate 90 days following CM enrollment from BH and PH. • Perinatal Outcomes demonstrated increases in compliance rates for prenatal and postpartum visits and decreased pre-term deliveries for high-risk members.	Motion: *Approve* - Care Management & CCM Report (Q3 2024) (Cardona/Hodge) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Forty-five members completed a Member Satisfaction Survey, with 93% being satisfied with the Care Management program. • There was one member complaint regarding CM in Q3 2024. • Next steps to improve CM include: o Managers will attend JOMs with Providers and PPGs to provide CM overview, build partnerships, and encourage referrals into CM teams. o Continue to look for and evaluate additional phone options for CM staff (to increase member engagement). o Support of CalAIM activities.	
#5 **UM/CM Business** - Medical Policies (October & September 2024) (Attachment CC) **Action** Patrick Marabella, M.D Chair	The **Medical Policies (September & October)** 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. 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 September & October 2024 include but are not limited to: • CP.MP.108 – Allogeneic Hematopoietic Cell Transplant for Sickle Cell Disease • CP.MP.180 – Implantable Hypoglossal Nerve Stimulation • CP.MP.202 – Orthognathic Surgery • CP.MP.12 – Vagus Nerve Stimulation The following retired policies include but are not limited to: • CP.MP.53 - Ferriscan R2-MRI • HNCA.CP.MP.456 - Ultrafiltration for Heart Failure	Motion: *Approve* - Medical Policies (October & September 2024) (Waugh/Cardona) 4-0-0-4
#6 **Pharmacy Business** - Pharmacy Executive Summary (Q3 2024) - Pharmacy Operations Metrics (Q3 2024) - Pharmacy Top 25 Prior Authorizations (Q3 2024) - Quality Assurance Reliability	The **Pharmacy Executive Summary Q3 2024** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q3 2024. o Overall, TAT for Q3 2024 was 97.8%.	Motion: *Approve* - Pharmacy Executive Summary (Q3 2024) - Pharmacy Operations Metrics (Q3 2024) - Pharmacy Top 25 Prior Authorizations

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Results (IRR) for Pharmacy (Q3 2024) (Attachments DD-GG) **Action** Patrick Marabella, M.D Chair	○ PA volume was slightly lower in Q3 2024 compared to Q2 2024 and there were some drug-specific differences. PA approval rate was slightly lower in August compared to July and September of 2024. The **Pharmacy Operations Metrics Q3 2024** provides key indicators measuring the performance of the PA Department in service to CalViva Health members. The turnaround time (TAT) expectation is 100% with a threshold for action of 95%. • The average Turnaround time met the standard with 97.8%. The **Pharmacy Top 25 Prior Authorizations Q3 2024** identifies the most requested medications to the PA Department for CVH members and assesses potential barriers to accessing medications through the PA process. The top ten denials of the quarter by percentage and total number are consistent with recent quarters except for a few placement variations. Non-preferred IV Iron requests were higher than expected in Q3 2024, however the total number is lower than seen in Q1 and Q2 2024. Testosterone authorizations continue to drive PA volume despite a high approval rate and limited requirements for PA. The **Quality Assurance Reliability Results (IRR) for Pharmacy Q3 2024** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of ten prior authorizations (four approvals and six denials) from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold for action of 90%. • The 90% threshold was met. The 95% goal was not met. The overall score was 93.33%.	(Q3 2024) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q3 2024) (Cardona/ Hodge) 4-0-0-4
#7 **Policy & Procedure Business** - UMCM Annual Policy & Procedure Review (Attachments HH) Action Patrick Marabella, M.D Chair	The **UMCM Annual Policy & Procedure Review** was presented to the committee. The following policies were presented for annual review with **no changes made:** UM-001 Post-Stabilization Inpatient Care Requested by Contracted/Non-Contracted Hospitals UM-002 Pre-Certification and Prior Authorization UM-003 Standing Referral to Specialty Care UM-010 Second Opinion UM-030 Potential Over and Under Utilization UM-050 Communications and Accessibility to UM	Motion: *Approve* - UMCM Annual Policy & Procedure Review (Hodge/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	UM-065 Skilled Nursing Facilities UM-100 Emergency Care and Services UM-111 Identification and Referral of CCS Members UM-118 Separation of Medical Management from Administrative and Financial Management UM-119 Concurrent Review UM-120 Hospice Care Services UM-121 Dental Services and IV Sedation and General Anesthesia UM-208 Appropriate Professionals and Use of Board-certified Physicians in UM decision making UM-210 Referrals to Non-Participating Practitioners/Providers CMP-040 HIV/AIDS Coordination with HCBS Waiver Program CMP-050 Developmental Disability and Community Resources Linkage CMP-051 Coordination of Care for Children in Foster Care CMP-102 WIC Coordination CMP-107 Care Coordination/Case Management Services CMP-108 Referrals to Specialty Mental Health, Alcohol and Substance Abuse Treatment Services CMP-109 Transitional Care Management CMP-110 Targeted Case Management CMP-112 Medi-Cal Disease Management Programs CMP-125 Case Management and Members Under 21 Receiving Private Duty Nursing Services CMP-401 Advance Directives CMP-500 Enhanced Care Management Program Overview and Requirements CMP-501 Administration of CalAIM Community Supports **The following policies were presented for annual review and were approved with minor edits:** UM-012 Discharge Planning UM-013 Provision of Enteral Nutritional Supplements/Replacements CMP-123 Case Management Program Effectiveness CMP-400 Palliative Care Program UM-060 UM Decisions and Timely Access to Care **The following policies were presented for annual review and were approved with updated definitions section:** UM-004 Delegation Evaluation and Determination of UM UM-005 Specialty Referral System	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	UM-007 Major Organ Transplant UM-103 Continuity of Care UM-113 Criteria for Utilization Management Care Management Decisions *(full policy included in meeting materials)*. This policy provides for clearly written, reasonable, and approved criteria that are based on evidence-based medical literature to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying, or denying requests for UM/Care Management Determinations. It was pointed out that state policy and national medical necessity criteria are used to determine benefit coverage and medical necessity. Where national or state guidelines do not exist, CalViva allows Health Net to develop medical guidelines, using physician experts, medical literature, and usual standards of practice. Such medical policies developed through Health Net's Medical Advisory Council (MAC Policies) will be presented to the CalViva CMO (Chief Medical Officer) and CalViva's QI/UM committee for review and adoption. It was also pointed out that the Plan also uses Inter-Qual® Care Planning Criteria along with other company-wide evidence-based medical policies which are approved and updated by the Plan's Medical Advisory Council. Committee members were in agreement with the policy as stated and voiced no questions or concerns. UM-211 Experimental and Investigational Services UM-212 Transgender Services UM-300 CBAS Authorization Process CMP-015 Seniors and Persons with Disabilities (SPDs) Health Risk Stratification and Assessment **The following policies were presented for annual review and were approved with the following changes:** UM-011 Long Term Care: Added reference to regulations guiding appropriate care level assessment. UM-014 Long-Term Care Transition to Managed Care: Updated to address APL-009/APL-010/APL-011 to include the Claims section. UM-015 Management of Enrollees in Subacute Long-Term Care: Updated to include appropriate clinical timeframes and access to dental services, specialty referral, behavioral health, standing referral, and arranging appointments with provider shortage. Updated to address APL-009/APL-010/APL-011 to include Claims section. UM-016 Intermediate Care Facilities for Members with Developmental Disabilities: Updated to include appropriate clinical timeframes and access to dental services, specialty referral, behavioral	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	health, standing referral, and arranging appointments with provider shortage. Updated to address APL-009/APL-010/APL-011 to include Claims section. UM-116 Clinical Criteria for Medical Management Decisions: Full policy attached for criteria review and approval. UM-117 Clinical Practice Guideline Development: Updated Regulation SB855 and removed reference to MHN. CMP-030 Tuberculosis Services and the Local Health Department (LHD) Direct Observed Therapy (DOT): Updated TBCB contact link. CMP-124 CalViva Pregnancy Program (CVPP) Case Management Services: Updated maternal health program goals. **The following is a new policy that was approved:** UM-040 System Controls Policy & Procedure: The full policy was included in the packet. The policy focuses on ensuring secure handling of data, control of member PHI and monitoring who has access to appeal decision data. The annual UM System Controls reports to monitor compliance with this policy are included on the QI/UM Committee reporting matrix and will be reported at a subsequent meeting in 2025. *Committee members were in agreement with the new policy as stated and voiced no questions or concerns.*	
#8 **Credentialing & Peer Review Subcommittee Business** - Credentialing Subcommittee Report (Q4 2024) (Attachments II) Action Patrick Marabella, M.D Chair	The **Credentialing Sub-Committee Quarterly Report Q4 2024** was presented. The Credentialing Sub-Committee met on October 17, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. The 2025 Credentialing Sub-Committee meeting dates were presented and approved. Reports covering Q2 2024 were reviewed for delegated entities and for Q3 2024 for Health Net (HN) and HN Behavioral Health (BH). A summary of Q2 2024 data was presented. • The **Credentialing Adverse Actions** report for Q3 2024 for CalViva from the HealthNet Credentialing Committee was presented. o There were two (2) cases presented for discussion for July, August, and September for CalViva Health. o One (1) case was placed on pending status awaiting the Medical Board of California's decision. o One (1) case was placed on annual monitoring for compliance with the Medical Board of California's orders.	Motion: *Approve* - Credentialing Subcommittee Report (Q4 2024) (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The **Adverse Events Q3 2024** report was presented. o One (1) case was identified in Q3 2024 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no (0) reconsiderations or fair hearings during Q3 2024. o There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of appointment availability. o There were no (0) cases identified outside of the ongoing monitoring process this quarter. (NCQA CR.5.A.4) • The **Access & Availability Substantial Harm Report Q3 2024** was presented and reviewed. This report aims 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 Issues (PQIs) related to identified appointment availability and are ranked by severity level. o After a thorough review of all Q3 2024 PQI/QOC cases, the Credentialing Department identified zero new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1).	
#8 **Credentialing & Peer Review Subcommittee Business** - Peer Review Subcommittee Report Q4 2024 (Attachment JJ) Action Patrick Marabella, M.D Chair	**Peer Review Sub-Committee Quarterly Report Q4 2024** was presented. The Peer Review Sub-Committee met on October 17, 2024. • The county-specific **Peer Review Sub-Committee Summary Reports for Q3 2024** were reviewed for approval. No significant cases to report. The 2025 Peer Review Sub-Committee meeting dates were presented and approved. • The **Q3 2024 Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs), and Credentialing Adverse Action (AA) cases identified during the reporting period. o Six (6) cases involved a practitioner, and three (3) cases involved organizational providers (facilities). o Of the nine (9) cases, three 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. o Five (5) cases involved seniors and persons with disabilities (SPDs). o Zero (0) cases involved behavioral health. o There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q3 2024.	Motion: Approve - Peer Review Subcommittee Report Q4 2024 (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ No (0) cases met the Peer Review trended criteria for escalation. ○ No (0) cases were 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 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. This report aims 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 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 without appointment availability issues. No (0) cases 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. • The **Q3 2024 Peer Count Report** was presented and discussed with the committee. There was a total of 18 cases reviewed. Eleven (11) cases were closed and cleared. Three (3) cases were tabled for further information. Two (2) cases were pending closure for CAP compliance and one (1) case was deferred. No (0) cases were closed/terminated. One (1) case had a Corrective Action Plan (CAP) outstanding/continued monitoring.	
#9 **Access Business** - Provider Office Wait Time Report (Q3 2024) (Attachment KK) **Action**	The **Provider Office Wait Time Report Q3 2024** was presented and reviewed. Health plans are required to monitor waiting times in providers' offices to validate timely access to care and services. This report provides a summary that focuses on Q3 2024 monitoring for Fresno, Kings, and Madera Counties. All counties are within the 30-minute office waiting time threshold for both mean and median metrics. • The combined number of providers per county who submitted data in Q3 2024 is Fresno (93), Kings (15), and Madera (6) for a total of 114 providers and 2,911 patients monitored.	Motion: *Approve* - Provider Office Wait Time Report (Q3 2024) (Hodge/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	• The average wait times by County for Q3 2024 are as follows: Fresno at 9 minutes, Kings at 12 minutes, and Madera at 17 minutes. • To encourage complete reporting data requirements, individual provider performance reports for Q3 2024 will be modified to visually demonstrate where data was missing if applicable. This change will graphically differentiate between a low average wait time and missing data. • Supplemental educational materials are in development to support providers in their office wait time improvement efforts. Materials will be distributed as soon as they become available. • Monitoring of wait times beyond two (2) hours and maintaining consistent contact with office staff via monthly reminders (emails and telephone calls) to sustain submission rates are ongoing.	
#9 **Access Business** - Access Workgroup Quarterly Report (November 2024) (Attachment LL) **Action** Patrick Marabella, M.D Chair	The **Access Work Group Quarterly Report November 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 9/24/24, the following Standing Reports were approved: Consent Items: • Appeals & Grievances Executive Report (Full & Executive Summary) – Q2 2024 • Provider Satisfaction Survey with Access Medical Providers and C&L - 2022 • Specialty Referrals Report (HN) – Q1 2024 • Telehealth Program and eConsult Report (September) • Provider Office Wait Times Report – Q2 2024 • 274 Monthly Provider Data Quality Check – July and August 2024 • Transportation Oversight Report – Q2 2024 Standing Reports: • MY 2023 Access & After-Hours CAP & Evaluation • Network Adequacy Report – Q2 2024 • Transportation Oversight Report – Q2 2024 • HNBH Services Triage and Screening Report – Q2 2024 • RY 2024 Practitioner Availability Report (incl. Behavioral Health) • Open Practice Report – Q2 2024 • Provider Over Capacity Grievance Report – Q2 2024	Motion: *Approve* - Access Workgroup Quarterly Report (November 2024) (Cardona/Waugh) 4-0-0-4

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Triage and Screening Report – Q2 2024 • PPG Dashboard & Access Narrative (incl. Access & Network Adequacy) – Q2 2024 • BH Network Adequacy, Availability and Open Practice Report – Q1 2024 & Q2 2024 • Behavioral Health Performance Indicator -Q2 2024 • Long-Term Support Services (LTSS) – Q2 2024 • BH Triage and Screening Report – Q2 2024 The following are some of the key standing reports/matters approved and discussed: • **Network Adequacy Report (Q2 2024)** - This report is a quarterly analysis measuring compliance with geographic distribution standards for member distance and drive times to Primary Care Providers (PCPs) and Specialists within Fresno, Kings, and Madera Counties. DMHC PCP reviews are done to the standard of 10 miles **or** 30 minutes, and Specialist reviews are done to the standard of 45 miles **or** 75 minutes. DHCS PCP reviews are done to the standard of 10 miles **or** 30 minutes, and Specialist reviews are done to the standard of 45 miles **or** 75 minutes. **DMHC Analysis:** o PCP: The DMHC PCP standard was met for Kings County. Fresno (99.2%) and Madera (99.7%) Counties do not meet the standard, access percentages remain the same from Q1 2024 to Q2 2024. The Standard was met through an approved Alternative Access Standard. o Specialties by Combined Counties: All specialties in all counties met the internal standard of 90% or higher. o Specialties by County: All specialties in Fresno and Madera Counties met the internal standard. Anesthesiology, Cardiovascular Surgery, Geneticists, HIV/AIDS, Maternal/Fetal Medicine, and Neonatology specialties are below standard in Kings County. Two of the six specialties above that did not meet the 90% standard had minor percentage increases. Cardiovascular Surgery went from 80.8% to 80.9%. Geneticists went from 89.3% to 89.4%. **DHCS Analysis:** Primary Care Physicians: The access percentages for PCPs in Fresno, Kings, and Madera County remained the same from Q1 2024 to Q2 2024. o Adult PCP: The DHCS standard was not met in Fresno (98.6%) and Madera (99.7%)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Counties. Kings County met the standard at 100%. o Pediatric PCP: The DHCS standard was not met in Fresno (98.6%) and Madera (99.7%) Counties. Kings County met standards at 100%. Adult Specialties and OB/GYN: o Fresno: One adult specialty of Psychiatry met standards. Sixteen adult specialties do not meet the standards. Access percentages ranged from 99% to 95%. o Kings: Fifteen adult specialties met standard. Two adult specialties of HIV/AIDS Spec/Infectious Disease (96.4%) and Ophthalmology (98.2%) do not meet the standards. o Madera: All adult specialties except for Psychiatry and Dermatology in Madera County met standards. Psychiatry remains at 99.9%. Dermatology remains the same from Q1 2024 to Q2 2024 at 99.9%. Pediatric Specialties: o Fresno: All pediatric specialties do not meet access standards. Access percentages range from 99% to 94%. o Kings: Fourteen pediatric specialties met the standard. Two pediatric specialties of HIV/AIDS Spec/Infectious Disease (92.8%) and Ophthalmology (98.2%) do not meet the standard. o Madera: All pediatric specialties except for Psychiatry (98.7%) and Physical Medicine and Rehab (99.2%) in Madera County met standards. Both specialties remain at the same percentages from Q1 2024 to Q2 2024. • **MY2023 Access & After-Hours Evaluation** The following provider types did not meet the DMHC appointment time standards: o Five (5) Tier 1 PPGs and six (6) Direct Network providers received Corrective Action Plans (CAPs). o Nine (9) Tier 2 PPGs and four (4) Direct Network providers received Educational Packets (Ed. Packets). • **Call Center Exempt Grievance/Access to Care Report – Q2 2024** Exempt, or informal, grievances that are related to access to care are tracked and monitored, to assess access to care issues and identify opportunities for improvement. In Q2 2024, there was a total of 28 access-related Exempt Grievances. The top three types of access grievances were:	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Availability of Appointment with PCP -14 ○ Panel disruption -6 ○ Wait Time too long on the phone - 5	
#10 **Old Business**	None.	
#11 **Announcements**	The next meeting is February 20th, 2025.	
#12 **Public Comment**	None.	
#13 **Adjourn**	The meeting adjourned at 11:47 p.m.	

NEXT MEETING: February 20th, 2025

Submitted this Day: February 20th, 2025

Submitted by: Amy B Schneider RN

Amy Schneider, RN, Senior Director Medical Management

Acknowledgment of Committee Approval:

X Peter B Marabella

Patrick Marabella, MD Committee Chair

Public Policy Committee
Meeting Minutes
December 4, 2024

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

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

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:31 am. Roll call was taken to establish a quorum.		
#2 Meeting Minutes from September 4, 2024 **Action** Joe Neves, Chair	The September 4, 2024, meeting minutes were reviewed and approved.		**Motion:** Approve June 4, 2024, Minutes 7-0-0-2 (R. Garcia / D. Phillips)

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#3 Enrollment Dashboard **Information** Mary Lourdes Leone, CCO	Mary Lourdes Leone presented the enrollment dashboard through September 2024. Membership as of September 30, 2024, was 435,615. CalViva Health maintains a 66.92% market share.		**No Motion**
#4 Health Education 2024 Work Plan Mid-Year Evaluation **Information** Steven Si	Steven Si presented the 2024 work Plan Mid-Year Evaluation. A total of 3,810 CalViva Health members participated in four-member incentive programs during Q1-Q2 2024. In total, $95,250 worth of gift cards were distributed to members as awards. Out of the recipients, 52% were from Fresno County, 39% were from Madera, and 9% were from Kings. There was a 134% increase in the total member incentive awards given during Q1-Q2 2024. A total of 1,757 pieces of member materials have been ordered for CalViva members. The pieces of member materials with the most orders were lead poisoning with 135 pieces, 212 pieces for diabetes, 167 pieces for nutrition, and 167 pieces for exercise. Providers are able to order materials using the online Health Education Material Order Form. A total of nine calls have been made to the Health Education Information Line. One call inquired about the weight loss program for families and kids. Two calls inquired about diabetic services, and six calls inquired about the health risk assessment form. Major health education initiatives for Q3-Q4 2024 include: • The Member Incentive strategy will remain in effect for the rest of the year 2024. • The Plan will continue to promote digital resources which include QR codes and links to health education resources for members. • The Plan will continue to work with the Member Services Department to inform members of available health education materials and programs available to CalViva members. • Complete the emergency room visit analysis for the 2023 Central California Asthma Collaborative (CCAC) asthma project. • Continue partnership and promotion of BCS and CCS screenings via Every Woman Counts. • Continue promotion of Kick It California tobacco cessation program.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Awaiting Plan partner to obtain DHCS approval of new Diabetes Prevention Program (DPP) with new DPP provider.		
#5 Health Equity • 2024 Executive Summary and Work Plan Mid-Year Evaluation • 2024 Summary and Language Assistance program Mid-Year Report • CalViva Community Connect • 2024 Meaningful Stakeholder Engagement **Information** Sia Xiong-Lopez Pao Houa Lee	As of June 30, all activities are on target to be completed by the end of the year with some already completed Highlights include: • One hundred and forty-five staff completed their bilingual assessment/re-assessment. • Responded to 20 cultural and linguistic related grievances and 4 interpreter complaints. • LAP resources are made available in provider's library • Completed key informant interviews and a focus group for W30-6+ and MH/SUD PIP projects. • Collaborated with Fresno Superintendent Schools and Cradle to Career in Fresno Network Improvement Committee to improve reading levels for children grades Pre-K to 3rd. 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 and providers can utilize Community Connect to refer members to various social service resources and programs.		
#6 Medical Management Quality Improvement & HEDIS® Update MY 2023 **Information** Dr. Marabella, CMO	Dr. Marabella presented the Quality Improvement and HEDIS® update for Measurement Year 2023. The four categories of the Managed Care Accountability Set Measures include: • Child & Adolescent Health • Reproductive Health & Cancer Prevention • Behavioral Health • Chronic Disease Fresno County: • Did not meet Child & Adolescent Domain		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Did not meet Behavioral Health Domain Kings County: • Did not meet Child & Adolescent Domain • Did not meet Behavioral Health Domain Madera County: • Did not meet Behavioral Health Domain CalViva collaborates with high volume, low performing clinics to improve our HEDIS results. The Plan also works with Community Based Organizations on these projects. CalViva follows PDSA/Rapid Cycle Improvement for All Projects, which stands for Plan, Do, Study, Act. Performance Improvement Projects (PIPs) consist of: 1) Improve is Well Child Visits (WCV) for AA/Black Children 0 to 15 months in Fresno County. The two interventions are: a) Referring all caregivers/mothers of Black/AA children to Black Infant Health to encourage and facilitate WCV. (Incentives & Partnership Webinar) b) CDC Milestones Tracker App. 2) The second PIP Improve is Follow up with Provider after ED Visit for Behavioral Health/Substance Use in Fresno and Madera Counties which include working with Acute Care hospitals in Fresno County. The two interventions are: a) Coding of BH/SUD Services Training for Hospital staff (SUNs, CHWs, LCSWs, etc.). b) Cultural Training to Improve Treatment Compliance for Hispanic population. 3) Lean Health Equity Quality Improvement Projects in Kings and Madera Counties. a) Madera County (Behavioral Health Domain) Focusing on the Hispanic population to improve follow up care after ED Visit for BH/SUD. b) Kings County (Childhood Domain) Develop and share data reconciliation policy and tool to close care gaps. Focus on Hispanic population to address identified disparity in Kings County. 4) Comprehensive Health Equity Quality Improvement Project in Fresno County. a) Increase member access to evidence-based health education resources on well-child visits, screenings and immunizations through provider offices using QR codes.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	b) Develop and test an internal step-by-step process for an e-campaign that communicates with providers on how to reconcile their data for pediatric well-care measures and ensure all completed services and encounters are received by CalViva Health. 5) Institute for Healthcare Improvement (IHI) Collaborative Projects to Improve Well Child Visits for Hispanic Children 0-15 months in Fresno County. a) Working with Clinica Sierra Vista Elm Street clinics b) Five Interventions April 2024 to March 2025: i) Equity & Transparent, Stratified and Actionable Data ii) Understanding the Provider and Patient/Caregiver Experience iii) Reliable & Equitable Scheduling Process* iv) Asset Mapping and Community Partnerships v) Partnering for Effective Education and Communication The Medical Management Team reinitiated annual Clinic Visits in November. The visited two providers, United Health Centers Fresno County, and Adventist Health in Kings County to share their recent HEDIS® results and discuss opportunities for improvement. Additional Clinic Visits will be conducted in Q1 2025. For 2024 HEDIS® rates, the measures are consistent with MY 2023. The Plan will continue its efforts and address Childhood Domain, and Behavioral Health Domain.		
#7 Appeals, Grievances and Complaints **Information** Mary Lourdes Leone, CCO Dr. Marabella, CMO	For Q3 2024 there were nine (9) Coverage Disputes (Appeals), 131 Disputes Involving Medical Necessity (Appeals), 81 Quality of Care, 167 Access to Care, and 324 Quality of Service, for a total of 712 appeals and grievances for Q3. The majority of which are from Fresno County. There were 120 appeal cases for Fresno County, 4 for Kings County, and 16 for Madera County, for a total of 140 for Q3 2024. There were 487 grievances cases for Fresno County, 38 for Kings County, and 47 for Madera County for a total of 572 for Q3 2024. The turn-around time compliance for resolving appeal and grievance cases was met at 100% for all categories. There was a total of 626 Exempt Grievances received in Q3 2024.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	Of the total grievances and appeals received in Q3, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 178 • Appeals: 40 • Exempt: 77 The majority of appeals and grievances were from members in Fresno County (largest CalViva Health enrollment). The majority of quality of service (QOS) grievance cases resolved were categorized as Access-Other, Administrative, and Balance Billing. The majority of quality of care (QOC) cases were categorized as PCP Delay, PCP Care, and Specialist Care, and Other. The top categories of appeal cases resolved were related to Advanced Imaging, Other, and DME. The top categories for exempt grievances were Attitude Service Provider, PCP Assignment/Transfer HealthPlan Assignment Change Request, and Health Plan Materials-ID Cards not received. Dr. Marabella presented the Appeals & Grievances Dashboard for Q3 2024. The total of grievances for Q3, as stated, was 579 which is an increase from last year. The majority of grievances are Quality of Service, having to do with Access-Other, Administrative, Balance Billing, Interpersonal, Other, and Transportation. Quality of Care grievances remain consist with prior year. Exempt grievances remain about the same as last with the exception of Access-Panel Disruption, Attitude/Service-Health Plan, Attitude/Service-Provider, Attitude/Service-Vendor, Health Plan Materials-ID Cards Not Received, Transportation-Access-Provider No Show, and Claims Complaint-Balance Billing from Provider. Appeals for Q3 2024 have increased when compared to previous year. The majority of appeals were pre-service with		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	Consultation, DME, Advanced Imaging and Other being the highest categories, and consistent with previous year.		
#8 Annual Review of the Provider Operations Guide **Information** Mary Lourdes Leone, CCO	Mary Lourdes presented the CalViva Health Operations Guide review. In 2024 all Medi-Cal Managed Care Plans signed a new contract with the Department of Health Care Services (DHCS). Within the contract is the requirement that a Provider Manual is issued to network providers, subcontractors, and downstream subcontractors regarding covered services and responsibilities. The Provider Manual (aka Operations Guide) must be updated at least annually and include information on a broad set of topics including but not limited to: • Member Enrollment and Disenrollment • Access to Care • Sensitive and Referral Services • Public Health Carve Out Services • UM & Prior Authorization clinical protocols • Health Care Management • Appeals and Grievances & State Fair Hearings • Other regulations and reporting requirements Plans must solicit feedback from Public Policy Committee and the Quality Improvement Committee. The Purpose of this activity is to obtain information regarding the development of future Provider Manuals, and to clarify new and revised Policies and Procedures. The PPC was informed to review and are welcome to provide feedback after their review.		**No Motion**
#9 2023 DHCS Focused Audit – CAP Update **Information** Mary Lourdes Leone	The Plan has provided initial responses to the State, and they have in turn provided additional comments on the information provided to them. CalViva has to respond to those additional comments by 12/10/24. Updates will be provided until DHCS closes the CAP.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#10 2024 DHCS Audit – CAP Update **Information** Mary Lourdes Leone	The Plan submitted the update for November to the State the week of 11/25/24. Currently pending comments from DHCS.		**No Motion**
#11 2025 DMHC Follow-Up Audit **Information** Mary Lourdes Leone, CCO	DMHC will be conducting the 2025 Follow-up audit in May 2025. They will be looking to make sure the Plan has corrected any deficiencies that were found during the previous audit.		
#12 Teladoc Mental Health (Digital Program) **Information** Mary Lourdes Leone, CCO	Mary Lourdes reminded the PPC that the Plan now provides Teledoc, telehealth services. For mental health Teledoc services, members must be 18+ years or older. This service provides access to doctors from wherever the member may be via telephone. Information is located on the website and the CalViva Facebook page.		
#13 Final Comments from Committee Members and Staff	Norma Mendoza thank CVH for sponsoring the promotores to attend the conference in L.A. She also shared that since September 2024 they have been helping Madera County with health for seniors. Four promotores are taking CHW training online. QPR training was taken in Madera. They have been taking FindHelp training to help members. Maria Areola shared seven promotores are taking CPR certification training. Promotores are also supporting the Thanksgiving health fairs. Sylvia Garcia shared that ModivCare for Fresno County has significantly improved, and members have been using the app. Roberto Garcia shared Self Help Enterprises continues to assist with housing from Kern County to Modesto. They are currently finishing construction in Reedley and Oakhurst. David Phillips shared there is a grand opening for the UHC site located on First & Gettysburg on Friday, December20th. Another site to be open January 6th on Jensen & Cedar, in Calwa, with the grand opening being January 17th. UHC is partnering with the Cutler-Orosi school district to open a behavioral health clinic in the school. UHC is starting an enhanced learning program to		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	work with patients on the difficulties they have with getting to appointments, largely unhoused patients. By the end of 2025 UHC will have a PACE program in downtown Fresno.		
#14 Announcements	Courtney Shapiro shared highlights of project CVH funded: • The Plan partnered with a med-student to pay for CPR and First Aid training for 40 students at Riverdale High School. • The Plan sponsored a luncheon for Veterans for the holidays. • Presents on Patrol in Lemoore. • CVH was honored at Association for Fundraising Professionals (AFP) for outstanding foundation.		
#15 Public Comment	None.		
#16 Adjourn	Meeting adjourned at 1:22 pm.		

NEXT MEETING March 5, 2025, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: March 5, 2025,

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

Approval Date: March 5, 2025

Approved By: _____
Joe Neves, Chairman

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2025 YTD Total
# of DHCS Filings													
Administrative/ Operational	35	23	10										68
Member Materials Filed for Approval;	5	2	3										10
Provider Materials Reviewed & Distributed	11	13	1										25
# of DMHC Filings	6	9	4										19

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

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	5	4	2										11
High-Risk	0	1	0										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	0	0										1
# of Cases Open for Investigation (Active Number)	29	28	28										

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 2/20/2025 Compliance Regulatory Report to the Commission, there were no new MC609 filings.

Report Date 3/20/2025

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, Call Center, Claims/PDR, and Quality Improvement The following annual audits have been completed since the last Commission report: Pharmacy (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 to complete its stated corrective actions and will provide its next monthly update on 4/10/25.
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 4/1/25.
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. Awaiting a response from DMHC.

Department of Health Care Services ("DHCS") 2025 Medical Audit	The 2025 DHCS Audit will be conducted virtually from 6/2/2025-6/13/2025. The Entrance Conference will begin on 6/2/25 @ 10:00am. All Pre-Audit document requests are due to DHCS by 3/17/2025.
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 MOUs, which have been posted to CalViva's website: • Madera County MHP MOU • Amendment No. 1 to Fresno County MHP-DMC-ODS MOU
Annual Network Certifications	➢ 2024 Subnetwork Certification (SNC) Landscape Analysis – 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. ➢ 2024 Annual Network Certification (ANC) - The Plan is on track to submit all required documents by the 3/17/2025 due date
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. Plans are required to submit evidence of training along with the curriculum. The Plan has been 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. On 2/28/2025, the Plan submitted P&Ps to DHCS, along with required attestation regarding the provider directory. The TGI curriculum and various other documents are due to DHCS and DMHC by 3/14/2025.
(RY)2025 (MY)2024 Timely Access and Annual Network Submission (TAR)	➢ On March 11, 2025, the Plan convened its "Kick-Off" meeting for the MY2024/RY2025 Timely Access Report ("TAR") filing which must be filed with DMHC by 5/1/2025.
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 Public Policy Committee met on March 5, 2025. The following reports were presented: • Q4 2024 Appeal and Grievance Report • A&G Dashboard review by Dr. Marabella • CalViva Health Annual Report • Semi-Annual Member Incentives

	• 2024 Annual Compliance Report The next PPC meeting will be held on June 4,2025, 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

Item #5

Attachment 5.A

Population Health Management Program Strategy Description 2025 & Change Summary

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Tarjani Padmani, Manager, Clinical Pharmacy Services

COMMITTEE DATE: February 20, 2025

SUBJECT: PHM Strategy Description Change Summary

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Updated CalViva Health logo.
Throughout	Multiple	Updated year from 2024 to 2025.
Throughout	Multiple	Made grammatical and punctuational changes.
Throughout	Multiple	Updated footer to reflect updated revision date.
1	Table of Contents	Updated Table of Contents to reflect updated page numbers.
12	Basic Population Health Management (BPHM)	Updated establishment of collaborative partnership with Fresno, Madera, and Kings counties' LHJs/LHDs to present state.
12	Transitional Care Services	Removed "with an identified care manager as the single point of contact for all transitional care services".
12	Transitional Care Services	Removed "Communication of care management assignment and Care Manager Responsibilities (including: Information sharing, Discharge risk assessment, Discharge planning documentation, Medication reconciliation, Referrals) are addressed when updated Transitional Care Services policy and procedures".
12	Transitional Care Services	Changed "TCS Program strives" to "Care Manager works".
12, 13	Transitional Care Services	Changed "patient" to "Member".
13	Transitional Care Services	Changed "The program" to "TCS".
13	Transitional Care Services	Removed, added, and updated TCS interventions.
13	Transitional Care Services	Removed "Members receive TCS for a minimum of 30 days. Staff may refer members to additional services, such as ECM and Community Supports, at any time during program as appropriate".
13	Transitional Care Services	Changed "the best" to "effective".
13	Transitional Care Services	Changed "Staff will refer members on to complex care management if they need continued support in their health care goals" to "Members are referred to Care Management, Complex Care Management programs, or ECM as appropriate for ongoing/longer term support".
14	PHM Programs and Services: Transitional Care Services	Changed "Transitional Care Management" to "Transitional Care Services".
13, 15	PHM Programs and Services: Improve Preventative Health: Flu Vaccinations	Updated eligibility age from 6 months to 18 years and older.
15	PHM Programs and Services: Improve Preventative Health: Flu Vaccinations	Fixed ASI-Flu to correct spelling (AIS-E) and explained acronym (Adult Immunization Status)

14	PHM Programs and Services: Chronic Condition Disease Management	Removed “Heart Failure” and added “Sickle Cell Disease”.
14	PHM Programs and Services: Diabetes Prevention Program	Added additional details to eligibility criteria, including BMI, HbA1c, Fasting plasma Glucose, and 2-hour plasma glucose levels.
14	PHM Programs and Services: Cardiac + Diabetes	Removed “(formerly Cardio Protective Bundle Project – SHAPE)”.
14	PHM Programs and Services: Fit Families for Life – Home Edition	Removed program.
14	PHM Programs and Services: Initial Health Appointment	Updated “Health Risk Questionnaire” to “Initial Health Appointment” and updated eligibility to all members.
15	PHM Programs and Services: Teladoc Mental Health Digital Platform (formerly myStrength)	Updated Program name from “Digital Behavioral Health Platform (MyStrength)” to “Teladoc Mental Health Digital Platform (formerly myStrength)”.
15	PHM Programs and Services: Emergency Room Diversion Program	Updated eligibility from “Members visiting the ER for avoidable chief complaints” to “High-frequency emergency department utilizers”.
15	PHM Programs and Services: Chronic Condition: Oncology	Updated cancer types by adding “or other cancers” and added “IP” visits to eligibility criteria.
15	PHM Programs and Services: Telemedicine	Removed duplicate program.
15	PHM Programs and Services Focus Areas: Improve Preventative Health: Flu Vaccinations	Updated Program goal to “Medicaid 25% MPL for ASI-Flu measure”.
15	PHM Programs and Services Focus Areas: Improve Preventative Health: Flu Vaccinations	Updated Program services by adding “Interactive Voicemail Response (IVR) messaging”, removed “Boosted Facebook posts”, and updating flyer to “Provider Flu Flyer”.
16	PHM Programs and Services Focus Areas: Tobacco Cessation	Updated Program services by removing offering of “90 day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization”, adding “without prior authorization” to current services information, and adding reference to Medi-Cal RX contract drug list for individual products and any restrictions to coverage.
16	PHM Programs and Services Focus Areas: Tobacco Cessation	Updated Relevance section with most up-to-date statistics and information.
17	PHM Programs and Services Focus Areas: Improve Preventative Health: Breast Cancer Screening	Updated eligibility criteria to “40-74” from “50-74”.
17	PHM Programs and Services Focus Areas: Improve Preventative Health: Breast Cancer Screening	Updated Program services by removing “Social media to provide member education and increase the awareness regarding the importance of regular screening” and adding “Identify opportunities to collaborate with community based organizations” and “Host office

		hours for internal Provider-Facing teams to provide measure specific education on updated recommendations, guidelines, and best practices".
18	PHM Programs and Services Focus Areas: Diabetes Management Program	Updated, added, and removed multiple Program services.
18	PHM Programs and Services Focus Areas: Diabetes Management Program	Updated Relevance section with most up-to-date statistics and information.
19	PHM Programs and Services Focus Areas: CalViva Pregnancy Program (CPP)/ High-Risk Obstetrics (OB) CM	Updated Program goal numbers from "5" to "8"% and from "5" to "10"%.
22	PHM Programs and Services Focus Areas: Care Management	Updated Program goal numbers from "3" to "10"% and "3" and "5"%.
25	External Partnerships	Removed entities: Local Continuums of Care (COCs), Area Agencies on Aging, Local Caregiver Resource Centers (CRCs), and Local Home and Community Based Services (HCBS) Waiver Agencies.
27	Delivery System Supports: Data and information sharing with practitioners	Fixed capitalization of "Cal AIM" and changed "can create" to "are creating".
27,28	Delivery System Supports: Data and information sharing with practitioners	Added information regarding Closed-Loop Referral (CLR).
29	Delivery System Supports: Coordination of Member programs	Removed "Transition Care Management" on #2 and changed "Palliative Care, CPP" to "Transitional Care Services, First Year of Life" to #5.
30	Delivery System Supports: Coordination of Member programs	Updated "Health Risk Questionnaire" to "Initial Health Appointment".

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Population Health Management Strategy Program Description

HEALTH NET – CALVIVA HEALTH

2025

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Introduction

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

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

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for population health management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Population Needs Assessment (PNA)

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

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

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

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- Annually, a cohort of Members with disabilities are identified and assessed for needs to determine the appropriateness and adequacy of available clinical programs. A disabled Member is defined as needing assistance with Activities of Daily Living (ADL).
- Identification criteria example: Members with one or more of the following: 1) Power Wheelchair 2) Home Hospital Bed 3) Hoyer Lift 4) In Home Supportive Services.
- Analysis of this cohort consists of diagnostic categories and utilization trends for acute inpatient admits, readmits, and emergency department utilization.

- Evaluation of the needs of Member with Severe and Persistent Mental Illness:
  - Annually, a cohort of Members with severe and persistent mental illness are identified and assessed for needs to determine the appropriateness and adequacy of the available clinical programs. Severe and persistent mental illnesses are defined as diagnosis such as schizophrenia, psychosis, and bipolar disorder.
  - Identification criteria example: Members prescribed one or more of the medications on the Health Effectiveness Data and Information Set (HEDIS) schizophrenia, schizoaffective disorder (SSD) National Drug Code (NDC) list (See attachment in "Appendix A").
  - Analysis of this cohort consists of diagnostic categories and rates of acute inpatient readmits, emergency department utilization, and those receiving at least 2 outpatient medication management visits in 12 months.

PNA Activities

When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources to meet the unique needs of our population and offer timely services and supports. In addition, there is an evaluation of the extent to which PHM programs facilitate access and connection to community resources that address Member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

Stakeholder Engagement

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

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

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

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

- Public Policy Committee (PPC): CalViva Health maintains a Public Policy Committee as one way for members to participate in establishing the public policy of the plan, to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care, and to establish and maintain

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community linkages. The Public Policy Committee meets four times a year. The PPC empowers members to ensure the Plan is actively driving interventions and solutions to build more equitable care. The Plan will ensure that PPC meetings are accessible to PPC members and that PPC feedback is meaningfully incorporated in the Plan's operations and governance. Information provided by the PPC members is included in the development of Health Equity Department materials, health education materials and programs, and Quality Improvement Projects. The Committee includes a culturally diverse group including CalViva Health members, member advocates (supporters), Commissioner of CalViva Health's governing board, the Fresno-Kings-Madera Regional Health Authority (RHA) Commission, and health care providers. We incorporate county or region-specific Population Needs Assessment per PHM Policy Guide to build community partnerships and improve Member participation to fully understand the barriers preventing all populations from receiving care and preventive services as well as social drivers of health.

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

Population Stratification

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

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

- Screening or assessment data
    - Screenings and assessments data is captured by our Health Information Form and additional screening conducted by the Plan including SDoH survey, CalViva Pregnancy Program (perinatal/postpartum program including maternal risk: history, age, or SUD) screening data etc. The inputs from the form are incorporated into member level data to assign members based on RSST model as well as at an aggregate population health level data set.
- Claims and Encounter data, including Fee-For-Service data
    - Claims and encounter data, including Fee-For-Service data is captured by various sources of data and based on member's utilization pattern (High Utilizer, Prospective High Utilizer) members are assigned into appropriate category and that flows into our RSST model.

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- **Available social needs data**
    - CalFresh, WIC, CalWORKs, In Home Services, Z-Codes and Supports (IHSS), Safety risk factors (e.g., available caregiver support and environment) are captured from various sources of data and incorporated into our RSST model.
- **Electronic health records**
    - Electronic Health Record (EHR) data is captured by EHR integration as well as other data feeds and using that information members are assigned to appropriate category; this data feeds into and informs our RSST model.
- **Referral data**
    - Referral data is captured by Find Help/Community Connect, customer contact center data, provider portal, authorization data, and other sources. Referral data is being used for identifying individuals who are at higher risk for adverse health outcomes or high healthcare costs. Using referral data, the model identifies members who have been referred to specialists or specialty services for high-risk conditions such as cancer, heart disease, or chronic illnesses. Subsequently, based on frequency and intensity of healthcare services need, the members are assigned to certain category including members who require more coordinated and managed care of PHM model. Referral data combined with other member data, such as demographics, claims history, and clinical data is being used for risk stratification.
- **Behavioral Health data (including SBIRT and other SUD data)**
    - Behavioral Health data is captured by data exchange agreement to establish secure data exchange with all contracted counties to obtain Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health Services (SMHS) data available through the Short-Doyle/Medi-Cal claims system by use of HIE, secure file transfer protocol (SFTP), or other means to then be incorporated into RSST. We are also capturing Behavioral Claims from our Behavioral Health administrator to capture mental health needs of our members and assigning members to a PHM category based on their need.
- **Pharmacy data**
    - Pharmacy data is captured via data feed from Magellan/Okta portal. Pharmacy data helps to determine a member's adherence to prescribed medications. Poor medication adherence is associated with adverse health outcomes. Using pharmacy data, we identify individuals who are non-adherent to their medications, which may indicate a higher risk for future health complications or hospitalizations and this information is being used for the RSST model. In addition to medication adherence data, pharmacy data is also being used to identify members with chronic diseases who are prescribed specific medications for disease management. By analyzing medication usage patterns, we are identifying individuals with suboptimal disease control, escalating medication needs, or frequent medication changes. These members may require additional support and care management to optimize their disease management and reduce the risk of complications. This information is also being used in the RSST model.
- **Utilization data**
    - Utilization data is captured via claims and encounters data. Utilization data helps to identify individuals with frequent or intensive healthcare service utilization. This includes emergency department visits, hospital admissions, and outpatient utilization. Members with high utilization patterns are often at a higher risk of future

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healthcare utilization or adverse health events. Utilization data provides us insights into the level of care coordination and management required for individuals.

Utilization data highlight the extent to which individuals engage in preventive services such as vaccinations, screenings, or wellness visits. Low utilization of preventive services may indicate an increased risk of undiagnosed or unmanaged health conditions. Targeting interventions towards individuals with low preventive service utilization helps us identify and address potential health risks earlier. Utilization data helps to identify individuals who utilize high-cost healthcare services, such as expensive procedures, specialty medications, or complex surgeries. Individuals with high-cost service utilization are more likely to have higher healthcare costs and may require targeted interventions to manage costs and improve outcomes.

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

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

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

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

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

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programs. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information.

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

We conduct continuous improvement evaluation and the incorporation of inputs that explicitly aim to reduce bias or existing disparities that may exist in basic cost or utilization data (e.g., care gaps, ambulatory care sensitive conditions, underutilization of primary care). We have found and rectified biases in utilization data, for example: prioritization based solely on high utilization, access to care by zip code, or homeless members with no utilization.

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

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

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

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

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

- Admit/K,
- Emergency room (ER)/K,

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

Along with that we also use SdoH dashboard to track and trend Member SdoH needs and we align our health equity goals with DHCS' Health Equity Framework within the Comprehensive Quality Strategy (CQS) Report, and stratify DHCS selected MCAS measures by demographics.

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

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

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

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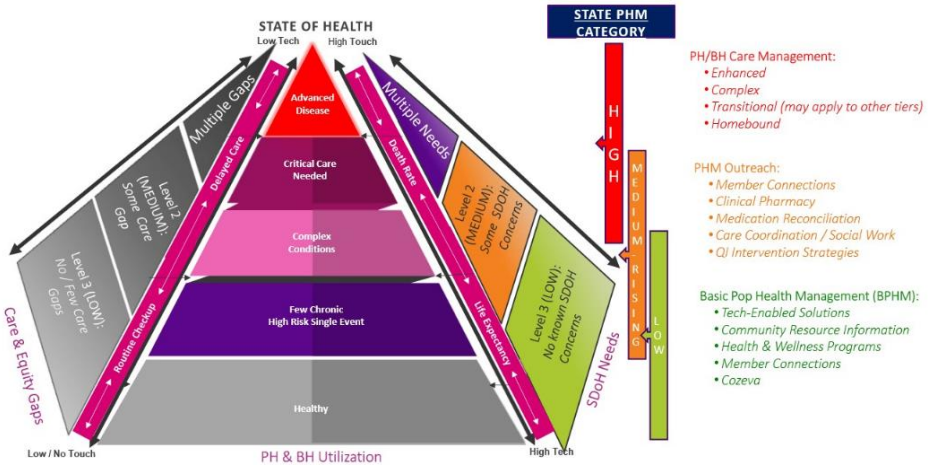
Once the statewide RSST and risk tiers are available through the PHM Service, at a minimum Members who are identified as high-risk through the PHM Service will be assessed.

ImpactPro Population Health Categories* consist of the following:

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

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



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

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PHM Programs and Services Overview

Basic Population Health Management (BPHM)

Health equity is a guiding principle. Population Health Management (PHM) is the framework to achieve health and wellness for all, free from barriers, using the Health Equity (HE) Improvement Model to identify and design community-anchored interventions. We offer BPHM services that promote health equity and aligns with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A multi-pronged, non-delegated, empanelment approach is used for BPHM which directly facilitates connections to primary care. New Member welcome packets are sent to ask Members to schedule their initial health appointment (IHA), and conduct new Member outreach to facilitate appointment scheduling, and survey Members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new Member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who don't select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible Members are not required to select a PCP).

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

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

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

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Key aspects of member navigation support include:

- Establishing a relationship with a usual source of care through their PCP that meets Member's geographic, clinical, and cultural needs.
- Ensuring PCPs have successfully engaged Members in ongoing care and are familiar with the holistic needs of the Member, through systematic monitoring of the initial health appointment, ambulatory or preventive visits every 12 months, vaccinations and immunizations (e.g., COVID-19, Flu, Pneumococcal), care gaps, and sharing insights with PCPs. Our provider engagement teams, who perform onsite and virtual meetings with providers, regularly encourage providers to leverage engagement strategies, provide them disengaged Member lists with contact information, engage ability scores, and provide routine progress on how well engaged their Member are with required care. Providers can request funding to address specific barriers to engaging Members.
    - As part of the implementation of the Community Health Worker (CHW) benefit, providers are encouraged to leverage new ways to support Members who have significant clinical needs, health equity or SDoH barriers, or are lost to follow up
    - Members and their family are supported with community resources and carved-out services
- The Quality Improvement Team supports systematic evaluations to assess why Members are not engaged with their PCP or other healthcare needs and provide findings to the engagement team and providers for intervention. Providers are not delegated responsibilities, however, are provided with incentive and support tools to engage and outreach to Members.
- We use a quality and health equity framework to ensure all Members under age 21 receive all screening, preventive and medically necessary diagnostic treatment services and immunizations required by early periodic screening, diagnosis and treatment (EPSDT), American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and the ACIP Childhood Immunization Schedule. Our strategy includes 1) service tracking and early identification, 2) connecting to services, and 3) meaningful innovation to continuously improve outcomes with a focus on the life course perspective. To achieve this, we:
    - Invest in preventive programs, coordinate/collaborate with Local Health Departments (LHDs), Local Government Agencies (LGAs), and local organizations to address SDoH and identified health disparities.
    - Support Members with culturally relevant health education, Member incentives; reminder outreach programs; and community engagement to promote prevention, screening, remove SDoH barriers.
    - Activate our plan CHW model to work with families with historical gaps in screenings to proactively outreach and remove barriers.
    - Prioritize partnerships with Providers to support our effective EPSDT program. Our pediatric Providers receive training and support tools to help identify care gaps timely and are audited for adherence to medical record requirements including EPSDT services. We incentivize providers for quality care and provision of preventive services, including EPSDT.
    - Track and report EPSDT screenings, AAP Bright Futures and ACIP Childhood Immunization periodicity adherence and monitor follow-up service needs. Tracking and stratification are at the population, community, subpopulation, and individual Member level. KPIs include annual and monthly HEDIS metrics (e.g., W30 (Well-Child Visits in the First 30 Months of Life), WCV (Child and Adolescent Well-Care Visits), CIS (Childhood Immunization Status), IMA (Immunizations for Adolescents), AAP (Adults' Access to Preventive/Ambulatory Health Services), IHA). Additional claims/encounters codes are evaluated for specific assessments and screenings (e.g., Oral Evaluation, Dental Services (OED), topical fluoride for children (TFC)).

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

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

In 2024, CalViva Health representatives established a collaborative partnership with Fresno, Madera, and Kings counties' LHJs/LHDs to begin "meaningful participation" in their current or future CHA/CHIP cycles. Plan will work with LHJs to determine what combination of funding and/or in-kind staffing the plan will contribute to the LHJ CHA/CHIP process, which includes attending CHA/CHIP meetings and serving on the CHA/CHIP governance structure. CalViva Health representatives are also engaging with these LHJs to co-develop joint SMART goals. This collaborative work includes CalViva Health/Health Net partnering and aligning with the other Managed Care Plans (Anthem and Kaiser) providing Medi-Cal services in these three counties.

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

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

Transitional Care Services

The purpose of the Transitional Care Services (TCS) program 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

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- Initiating Community Support referrals as appropriate
- Focus on 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 of how to respond
- Preparation for discussions with other health care professionals and use of a personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care
- Supporting the 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

During the post discharge period, staff evaluates 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.

PHM Programs and Services

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

Program Name	Eligible Population
Improve Preventive Health: Flu Vaccinations	Members 18 years and older, especially high-risk populations
Improve Preventive Health: Breast Cancer Screening	Women ages 50-74 years
Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
CalViva Pregnancy Program	Pregnant Members at risk for complications of pregnancy as determined by having an NOP score >34 and/or provider determination
Care Management	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health.
Transitional Care Services	Members with high complexity profile: Member is inpatient with anticipated discharge or recently discharged, hospital readmissions risk, 2 or more admissions within the past 6 months, 3+ emergency department visits within the past 6 months, multiple medications/high cost medications/high-risk medications, recent catastrophic event or

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Program Name	Eligible Population
	illness, unmanaged/poorly managed chronic or behavioral health issues, psychosocial issues/barriers impacting access to care and/or services, history of non-compliance and/or complexity of anticipated discharge
Chronic Condition Disease Management	Members with Asthma, COPD, Diabetes, Cardiovascular Conditions, and Sickle Cell Disease
Chronic Condition Management: Substance Use Disorder-Opioid (SUD-O) Program	SUD-O program timely/effective care in collaboration with providers for members on dangerous combinations (benzodiazepines, opioids, muscle relaxants, other), high doses and prolonged use.
Tobacco Cessation – Kick It California	Members 13 years and older
Diabetes Prevention Program	Members 18 years and older with BMI > 25 (BMI >23 if Asian) and have one of the following within 12 months: HbA1c between 5.7% and 6.4%, Fasting plasma Glucose 100-125 mg/dL. 2-hour plasma glucose of 140-199 mg/dL
Diabetes Management Program	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Cardiac + Diabetes	Members that have diabetes with hypertension and/or cardiovascular disease
Health Information Form	All Members
Initial Health Appointment	All Members
Teladoc Mental Health Digital Platform (formerly myStrength)	Ages 13 years and above - Mental health and substance use (behavioral health) educational support for depression, anxiety, substance use, pain management, and insomnia/sleep health
Behavioral Health Care Management	All members
Chronic Condition: Respiratory Conditions (Chronic Obstructive Pulmonary Disease (COPD) and Asthma)	Members with Chronic Obstructive Pulmonary Disease or Asthma diagnosis with pharmacy claims who are either not adherent to their medications, have ER visits in the last 12 months, or both
Emergency Room Diversion Program	High-frequency emergency department utilizers
Chronic Condition: Oncology	Members with diagnosis of breast, prostate, colon cancer, or other cancers with pharmacy claims who are either not adherent to their medications, have ER/IP visits in the last 12 months, or both
Telemedicine	All Members

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Focus Areas

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

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Improve Preventive Health: Flu Vaccinations	
Eligible population:	Members 18 years and older, especially high-risk populations
Focus area:	Keeping Members healthy
Program goal(s):	Reach or maintain Medicaid 25% MPL for AIS-E (Adult Immunization Status) measure
Program services:	Member education promoting flu vaccination through: ○ Emails ○ Proactive Outreach Manager (POM) messaging ○ Interactive Voicemail Response (IVR) messaging ○ ProviderFlu Flyer ○ Web landing page and web pop-up/notification banner
Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations, enrollment data
Relevance	The flu vaccine can prevent contracting the flu and other illness and can decrease health care utilization by reducing risk of going to the doctor or hospital, and keeping the community healthy. It is an important preventative tool for people with chronic health conditions. The ability to get the flu shot can also be an indicator of any health plan/network access barriers.

Tobacco Cessation	
Eligible population:	Members 13 years and older
Focus area:	Keeping Members Healthy
Program goal(s):	Increase member participation in smoking cessation programs by 5% from prior year.
Program services:	CalViva Health will cover a minimum of two separate quit attempts per year without prior authorization, with no mandatory break between quit attempts. Please refer to the Medi-Cal RX contract drug list for individual products and any restrictions to coverage. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_OTC_FINAL.pdf. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless of if they opt to use tobacco cessation medications. Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include: • tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), • a texting program in English or Spanish, • a website chat function, and • mobile apps on smoking and vaping.

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Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations using ICD-10 identifiers. Program is opt-in. Members can also be referred by their PCP, or Care Management.
Relevance	Tobacco use is the leading cause of preventable death and disease in the U.S., making it critically important that prevention and cessation programs are available to help people break their tobacco addiction for good. In 2021, an estimated 1.8 million adults reported current cigarette smoking in California and 1.2 million reported current vape use. The cost of smoking in California totaled $43.54 billion in health care costs and lost productivity from illness and premature death. Tobacco cessation is critical to improve members' health outcomes and reduce health care costs by decreasing the rate of tobacco users among CVH membership. Source: CDPH Tobacco Facts and Figures 2022

Improve Preventive Health: Breast Cancer Screening	
Eligible population:	Women ages 40-74 years
Focus area:	Managing Members with Emerging Risk
Program goal(s):	Meet/exceed the Quality Compass national 50th percentile for reporting year (RY)
Program services:	Member education promoting breast cancer screenings through: • Mobile mammography events • Multi-gap call outreach to members • Identify opportunities to collaborate with community based organizations Provider education and partnership to promote breast cancer screenings through: • Tipsheets on the Breast Cancer Screening HEDIS measure • Provide Breast Cancer Screening HEDIS measure specific best practices, coding practices, and clinic processes practices in the Provider Best Practices guide • Collaboration with priority Providers to identify opportunities to improve breast cancer screening utilization rates • Host office hours for internal Provider-Facing teams to provide measure specific education on updated recommendations, guidelines, and best practices
Methods and data sources used to identify the eligible population	HEDIS care gap reports, enrollment data
Relevance	The American Cancer Society cites breast cancer as the second leading cause of cancer-related deaths and the second most common cancer among women in the US.[2] Regular breast cancer screenings (also known as a mammogram) can help detect the cancer while it is still in early stages, which is also when the cancer treatment is most likely to be successful. Breast cancer screening is an

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	important preventative tool that can help keep members healthy and decrease health care utilization.

Diabetes Management Program	
Eligible population:	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Focus area:	Managing Members with emerging risk
Program goal(s):	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: • Glycemic Status >9
Program services:	Member education on diabetes management: ○ Digital Health Education QR Codes on diabetes-related resources. ○ Access to comprehensive diabetes webpages on member portal site. ○ Targeted Community Health Workers (CHW) outreach to members with SDOH barriers. ○ Pharmacy medication adherence outreach by phone. ○ Availability of A1c home kits and follow-up email and/or follow-up calls to encourage completion. ○ Multi-gap live calls encourage members to complete A1c screening and assist in scheduling appointments with provider; bi-directional texting to accompany live calls for targeted populations to promote trust and improve health outcomes. Provider partnerships on diabetes management: ○ Targeted outreach to high-volume, low-performing PPGs/PCPs utilizing root cause analysis for uncontrolled A1c to segment population follow-up. ○ Provider tipsheets on HEDIS Diabetes measures: GSD (Glycemic Status Assessment for Patients with Diabetes), EED (Eye Exam for Patients With Diabetes), BPD (Blood Pressure Control for Patients With Diabetes) and KED (Kidney Health Evaluation for Patients With Diabetes).
Methods and data sources used to identify the eligible population	HEDIS care gap reports, pharmacy claims
Relevance	According to the Centers for Disease Control and Prevention (CDC), 38.4 million people have diabetes (11.6% of the US population), and 1 in 5 individuals have undiagnosed diabetes.[3] Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities such as blindness, amputation, kidney failure, heart disease, stroke, and early mortality. Diabetes is the eighth leading cause of death in the United States. Disadvantaged and underserved communities experience higher disease rates

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	and worse health outcomes. In 2023, African American adults were 1.4 times more likely than white adults to be diagnosed with diabetes, and more likely admitted to the hospital for uncontrolled diabetes. Early detection and comprehensive management of diabetes can significantly prevent, reduce, and delay complications of the disease, ultimately improving patient health outcomes, while greatly reducing costs. Diabetes control is achieved through effective whole-person approach to care and management, addressing SDOH barriers and clinical preventive care practices that achieve optimal rates for the HEDIS diabetes-related measures, specifically blood sugar control, retinal eye exam, and kidney health evaluation.

CalViva Pregnancy Program (CPP) / High-Risk Obstetrics (OB) CM	
Eligible population:	Pregnant Members at risk for complications of pregnancy as determined by having a notification of pregnancy (NOP) score >34 and/or provider determination
Focus area:	Patient safety or outcomes across settings
Program goal(s):	- Members managed in OB program have 8% greater completion of the 1st pre-natal visit within the 1st trimester or 42 days of enrollment than pregnant Members not managed. - Members managed in OB program have 10% greater completion of the post-natal visit between 7-84 days post-delivery than pregnant Members not managed. - High-risk Members managed have 2% lower rate of pre-term delivery than high-risk Members not managed. - Member experience survey – each question and overall >90%
Program services:	Care manager completes the CPP OB CM Assessment, Edinburgh Depression Screen, Post-Partum Assessment with Member. - Education Materials are sent to Member - Members who received a medium or high score receive outreach to be enrolled in High-Risk OB Program - The OB Care manager coordinates care with the BH Care manager for Members with behavioral health needs.
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims
Relevance	Pregnancy complications can be harmful for mom and baby. Early and regular prenatal care helps identify conditions and behaviors that can result in preterm and low weight births. Early identification of pregnant women and their risk factors is an important factor in improving birth outcomes. Interventions are aimed at increasing pre-natal visits thereby improving health outcomes and resulting in reducing utilization costs.

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	Pregnancy complications can be harmful for mom and baby. Post-natal care is important in preventing and addressing the health of mom and baby after pregnancy. Interventions are aimed at improving health outcomes and resulting in reduced utilization costs. Pregnancy complications can be harmful for mom and baby. Preterm birth is the leading cause of US infant morbidity and mortality and low birth weight can cause serious and long-term health problems. Interventions are aimed at reducing pre-term deliveries thereby improving health outcomes and resulting in reduced utilization cost. Measuring member experience evaluated the effectiveness of the services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement.

Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	
Eligible population:	Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
Focus area:	Patient safety or outcomes across settings
Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Program services:	Behavioral Health clinical staff live calls to members with a very recent ED visit for Mental illness or Intentional self-harm to conduct assessments and support timely follow-up to outpatient care for members in Fresno, Kings and Madera counties. Clinical staff are able to identify depressive symptoms and provide additional counseling and resources to assist with stress management and avoidance of at-risk alcohol and substance use.
Methods and data sources used to identify the eligible population	Hospital admissions, discharges, and transfers (ADT), claims or encounter, and membership data
Relevance	Major depression is one of the most prevalent and treatable mental health disorders. Although antidepressants are considered effective treatment, non-adherence to antidepressants significantly hinders successful treatment of depression. Symptoms associated with major depression can last for years and has been linked to poor treatment outcomes (e.g., relapse occurrence) if left untreated. Conversely, many can improve through treatment with appropriate medications. Measuring antidepressant medication adherence for 84 days (12 weeks) among individuals diagnosed with depression evaluates the impact of the recommended treatment monitoring during the acute phase, during which remission (reduction of depressive symptoms) is induced. This measure ensures patients successfully adhere to treatment plans.

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	Successful treatment of patients with major depressive disorder is promoted when patients adhere to the treatment plan through the continuation phase of treatment (six months), the period in which remission is preserved. Ultimately, adherence through the continuation and maintenance phase protects the patient against the recurrence of a subsequent major depressive episode.

Cardiac + Diabetes (formerly Cardio-Protective Bundle Project – SHAPE)	
Eligible population:	Members that have diabetes with hypertension and/or cardiovascular disease.
Focus area:	Managing multiple chronic illnesses
Program goal(s):	Improve cardio-protective bundle medication adherence by performing successful outreach to high risk members who were flagged for non-adherence, utilization (ER/IP), or both and provide education/counseling to encourage compliance
Program services:	Member education and outreach through - ○ A "live call" by health care coaches to engage the Member and help ensure that they are compliant with their medications. The health care coaches, consisting of pharmacists, diabetes educators, nutritionists, or dieticians, can conduct follow-up visits as needed to address Members' chronic conditions and healthy weight (BMI) maintenance, encouraging physical activity and healthy eating ○ Multimodal communications: online newsletters and mailings. ○ Connecting Members with care management and disease management.
Methods and data sources used to identify the eligible population	Medical claims, encounter data, pharmacy claims
Relevance	Diabetes was the eighth leading cause of death in the United States in 2021.[5] If not properly managed, it can lead to renal, vision, hearing impairment and cardiovascular disease. If complicated with other chronic comorbid conditions like hypertension and CAD, the utilization is very high affecting the quality of life and the challenges to navigate through the healthcare system. In 2022, the total cost of diagnosed diabetes in the United States was $412.9 billion.[5] The utilization is primarily around pharmacy, inpatient and emergency room costs. Timely intervention, focus on prevention and developing wellness into the lifestyles, and implementation of evidence-based strategies to incorporate best practices are the goals of the initiative.

Care Management	
Eligible population:	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health. A predictive modeling tool, reports and health risk screening are used to identify Members who have higher risk and more complex health needs. Members may self-refer and/or be referred to the program by other internal and external entities. The person-centered approach allows us to link Members to a tailored variety of Complex Care Management (CCM) programs and interventions

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	(inclusive of BPHM) to address Members' unique needs. Types of interventions and conditions the Program addresses include: health promotion, disease management, maternal and child health, Behavioral Health (BH), telehealth, transitional care services, palliative care, oncology, nursing facilities, and ED diversion. Depending on the Member's preferences, the CCM program uses a variety of communication modalities to initiate and sustain Member support (e.g., in-person contacts, face-to-face virtually, calls, texts, email).
Focus area:	Managing multiple chronic illnesses
Program goal(s):	• Member experience survey – each question and overall > 90% • Reduce Non-Emergent ER Visits > 10% annual • Reduce Readmissions > 5%
Program services:	**Care coordination:** Typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to Member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of care management is used for continuity of care transitions and supplemental support for Members managed by the county. **Care management (CM):** Services included at this level of care management include the level of coordination along with identification of Member agreed upon goals and progress towards meeting those goals. If the CM program is delegated to the Participating Physician Group (PPG) and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up. **Complex Care management:** Services at this level of complex care management include all coordination and care management services from above, along with a more frequent outreach to the Member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor Members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence. If the CM program is delegated to the PPG and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims, focused Population Health Management reports, referrals

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

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Care Coordination

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

- Mental Health Plans (or specialty mental health system): We coordinate care through interdisciplinary care team (ICT) discussions with MH resources and with the county Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) to address the holistic needs of members including transitioning between SMHS and NSMHS. CM provides education on and referrals to SMHS and NSMHS. For members who are medically and BH complex, we perform an ICT round, and work with the county to coordinate care. We monitor individual cases, and we also have enhanced and global reporting on trends across cases for provision to providers. We can now track how many members have been linked to BH Therapist and/or Psychiatrist, as well as how many members we facilitated ICT meetings with county Mental Health Providers for SMI services.

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

External partnerships

Entity	Description:
Departments of Social Services and In-Home Supportive Services (IHSS)	CalViva Health will maintain MOUs with Local Departments of Social Services and In-Home Supportive Services (IHSS) programs in all services areas and will meet with these departments/programs quarterly at minimum, as is required under the new State contract.
Departments of Behavioral Health and Substance Use Disorder Services (SUDs)	CalViva Health will maintain MOUs with Local Departments of Behavioral Health and Substance Use Disorder Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Regional Centers	CalViva Health will maintain MOUs with the Regional Center(s) for all services areas and will meet with the Regional Center(s) quarterly at minimum, as is required under the new State contract.
Local Health Departments	CalViva Health will maintain MOUs with Local Health Departments (LHDs) in all services areas and will meet with LHDs quarterly at minimum, as is required under the new State contract. Example of how Plan and LHDs work together include but are not limited to:

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	Collaborating to ensure COVID-19 vaccinations were/are available to homebound members; Collaborating to deliver provider trainings (e.g., CPSP); Collaborating to deliver certain member-facing events (e.g., breastfeeding mom's lunch and learn).
Departments of Child Welfare Services	CalViva Health will maintain MOUs with Local Departments of Child Welfare Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Women, Infants and Children (WIC) Supplemental Nutrition Programs	CalViva Health has an MOU in place with Fresno Economic Opportunity Commission (EOC) concerning the arrangement and coordination of Women, Infant, and Children Supplemental Nutrition Program (WIC) services to CalViva members who are enrolled in Fresno County. CalViva Health will also maintain MOUs with the local WIC programs in all services areas and will meet with the WIC programs quarterly at minimum, as is required under the new State contract.
County Targeted Case Management Programs	CalViva Health will maintain MOUs with Local County Targeted Case Management (TCM) programs *(where applicable)* in all services areas and will meet with the TCM programs quarterly at minimum, as is required under the new State contract.
First Five programs and providers	CalViva Health will maintain MOUs with the local First Five programs in all services areas and will meet with these programs quarterly at minimum, as is required under the new State contract. We participate in coalitions and help establish processes for local programs. We provide First Five with sponsorships as needed or requested.
Justice Departments & Correctional Facility Partners and Programs	CalViva Health will maintain MOUs with the local Justice Departments/Correctional Facility partners and program in all services areas and will meet with the JI/CI partners quarterly at minimum, or as directed by DHCS, as is required under the new State contract.
Schools and Local Education Agencies	CalViva Health has agreements in place with three Local Education Agencies (LEAs), Fresno County Office of Education (FCOE), Fresno Unified School District (FUSD) and Clovis Unified School District (CUSD). We will be working to execute memorandum of understandings (MOUs) with LEAs in all service areas under the new State contract requirements. We meet regularly with FCOE, FUSD and CUSD, and will maintain, at minimum, quarterly engagement with LEA partners in all service areas under the new State contract requirements as well. CalViva Health partnership activities with schools and LEAs include, but are not limited to, participation in on-site health fairs, support for back-to-school events and trainings, etc. We also provide grant support to schools and LEAs for workforce training and development, as well as infrastructure and support for the expansion of telehealth services in schools. We do not currently participate on any School or LEA boards, but this is something in which will look to more involved in the future.

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Early Start	Plan works with Early Start through local health departments. We participate in coalitions and help establish processes for local programs. We meet on an as-needed basis. We provide Early Start with sponsorships as needed or requested.
California Work Opportunity and Responsibility to Kids (CalWorks)	Plan provides warm-handoffs and referrals to support our members who can benefit from CalWorks services. Example of warm-handoff: While speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalWorks program, we will 3-way call the CalWorks Customer Service number (California Department of Social Services) and connect our members to a CalWorks representative to ensure our member is connected to CalWorks benefits.
CalFresh	Plan provides warm-handoffs when possible and referrals to support our members who can benefit from CalFresh services. Example of warm-handoff: While we are speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalFresh program, we will 3-way call the California Department of Social Services and connect our member to a CalFresh representative to ensure our member is connected to CalFresh benefits.
Supplemental Security Income (SSI)	Plan provides warm-handoffs and referrals to support our members who can benefit from SSI services. Warm hand-off Example: While we are speaking to a member on the phone, and we identify through listening to our member that they might be eligible for SSI, we will 3-way call the Social Security Administration and make an appointment for our member to apply for SSI. 2. We do not provide financial support or investments to SSI. 3. We do not have involvement with SSI boards or governance structures.

Activities Which Support PHM Programs and Services

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

Delivery System Supports

Data and information sharing with practitioners

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

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We implemented additional bidirectional data exchange processes with other CoCs as well as exchanging Behavioral Health data with various counties across California.

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

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

A Closed-Loop Referral (CLR) is a referral initiated on behalf of a member that is tracked, supported, monitored and results in a known closure. A known closure occurs when a member's initial referral loop is completed with a known closure reason such as the member receiving services. The goal of CLRs is to increase members successful connection to the services they need by identifying and addressing gaps in referral practices and service availability. The Plan is taking steps to collect and report CLR data for ECM and Community Supports by 7/1/2025 to ensure more members are connected to needed services.

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

Value-based payment arrangements

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

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Incentive Payments

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

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

Incentive Program Components

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

Ability to view evidence-based practice guidelines on demand

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

Providing practice transformation support

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

Coordination of Member programs

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

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

- Defining a program hierarchy so Members don't receive outreach from multiple programs. The following hierarchy is used to determine which entity will be the primary point of contact, unless Member specific evaluation demonstrates otherwise:

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1. Delegated Participating Physician Group (PPG) Concurrent Review and Care Management
    a. Example: To avoid duplicative outbound calls, a data analyst reviews potential care management list in Impact Pro and excludes Members who are assigned to a Delegated PPG as well as those already enrolled and engaged with Care Management
2. Health Plan Concurrent Review (e.g., Inpatient Concurrent Review)
3. Plan Complex Care Management
4. Plan Care Management
5. Special or Disease Specific Clinical Programs (e.g., Transitional Care Services, First Year of Life)
6. Disease Management
7. Auxiliary services may run concurrently as coordinated and requested by the primary Care Manager with the consent of the Member.
    a. Examples: Wellness Coaching (smoking cessation, weight management), Life Solutions evaluation for home safety, field-based Member Connection outreach for difficult to engage Members, Licensed Clinical Social Worker (LCSW) assessments, special PPG programs, ECM providers, Doulas and CHWs, etc.

EXAMPLE OF HIERARCHY IMPLEMENTATION:

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

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

  EXAMPLES:
  - Alerts placed Member record in the Medical Management System are visible to staff when the Member record is accessed.
  - Tasks generated within the system from one process to another informing the recipient of activity to complete.
  - Inbound and outbound calls related to CM programs, tasks, notes, assessments, and correspondence are captured and dated within the medical management system and are visible to associates with access to the Member record.
- Assigning a single care coordinator and/or Co-Management to address all of the Member's needs:
  - Integrated Care Management: Integrated Care involves managing the Member's physical, behavioral, and psychosocial needs (including SDoH needs) with the care manager as the primary point of contact for the Member. This holistic approach lessens the complexity for our Members and aligns with our overall population health program.
  - Behavioral Health (BH) and Physical Health (PH) Care Management Coordination: for new BH CM referrals of Members enrolled in open PH CM, the PH Care manager coordinates with

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the referring party and BH CM to determine which CM staff will be the primary Care manager. Co-management may occur between BH and PH during CM rounds, and by documentation in a common platform. With Member's express permission, both BH and PH CM may work with Member, but always coordinating outreach and discussing during rounds.
    - The BH CM coordinates with Regional Centers to coordinate services falling within their domain.
    - The Care Manager coordinates with county programs and other external entities to facilitate services and programs available to the Member.

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

- Interdisciplinary/Integrated Care Management Team Rounds:
    - Care Management rounds are routinely conducted with a team-based approach, using Care Managers, Social Workers, Registered Dietitian, Pharmacists, Behavioral Health, and Medical Directors to coordinate between departments for specific Members, and develop and/or support a comprehensive care plan. Reports are shared with key internal stakeholders for care coordination.
    - On an annual basis, we report on population health metrics including a population health summary and risk factor analysis based on a Initial Health Appointment.

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

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

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

- Standardized Protocols for Unable to Reach Members: Each clinical program follows a standard protocol for the number and frequency of outbound attempts to reach Member to avoid multiple or intrusive calls to Members. All outreach is documented in the common platform.

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- Integrated Care Management: A standard number of outbound call attempts are followed by a letter.
- Disease Management: Establishes a set number of call attempts for Members with a valid phone number, then sends an outreach letter.
- Disengaged/housing insecure or homeless member support: Street Medicine providers support in reaching the most difficult to reach populations and provide basic care coordination and connection to PCP.

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

Informing Members about Available PHM Programs

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

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

Informing Members about PHM Programs – Interactive Contact

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

Key Program Attributes Communication Check list

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

Key Modes of Communicating Program Information

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

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Appendix A

This table contains guidance to determine specific HEDIS SSD NDC list

HEDIS SSD NDC list	HEDIS SSD NDC List.xlsx

Appendix B

This table contains guidance to PHM Level and KPI tools Overview

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

Appendix C

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

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

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

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

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

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

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

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

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

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

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

References

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

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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

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Item #6

Quality Improvement & Health Education

6.A 2025 Program Description & Change Summary

6.B 2025 Work Plan

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Amy Wittig, Director, Quality Improvement

COMMITTEE DATE: March 20, 2025

SUBJECT: Quality Improvement Program Description Change Summary 2025

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Updated year from 2024 to 2025.
Throughout	Multiple	Removed references to the annual Access Survey under the following sections: Satisfaction, Access and Availability, QI Process, and QI Projects, Surveys and Audits. The Access Survey is no longer needed since the CAHPS surveys are conducted
Throughout	Multiple	Updated Director of Medical Management to Senior Director of Medical Management
Throughout	Multiple	Updated ECHO Survey to behavioral health member experience survey due to survey changing.
Throughout	Multiple	Removed references of population needs assessment from the Health Education Program.
2-3	Table of Contents	Page numbering and section titles updated.
10	Clinical Practice Guidelines (CPGs)	Updated provider communication fax to include provider updates.
11-13	Health Education Programs	Revised the Health Promotion Programs title to Health Education Programs. Updated the Health Education Information Line to Member Services phone number. Updated Weight Management Resources: removed Health Education resources such as Staywell, Fit Families for Life Home Edition, and Healthy Habits for Health People; added Krames Library. Revised the Diabetes Prevention Program description details to include the program length of 12 months. Removed Healthy Hearts, Healthy Lives program. Added Teladoc Mental Health digital program as part of the Behavioral Health Programs. Revised the Health Program Incentive Programs to include both QI/Health Education Department.
14	MemberConnections Program	Added Post Partum Assessment / Edinburgh Postnatal Depression Scale, Notification of Pregnancy as part of the assessments the MemberConnections representatives conducts.
16-17	Transition of Care Services	Updated Transitional Care Services to include details on program activities to members post discharge. Scope includes completing risk assessments for members, conducting health status evaluations, medication reconciliation, post discharge care coordination and follow-up, and discussing referral options, health goals, and treatments with members. Removed section on Member Impact of TCS.

19	Health Plan Performance	Added Health Plan accredited information for CalViva.
24-26	Health Equity and Cultural and Linguistic Needs	Added information on the Diversity, Equity, and Inclusion Training Program. Updated non-discrimination statement to include language.
26	Satisfaction	Added information on HSAG CAHPS survey. Updated Population Needs Assessment to Population Analysis Report. Updated Provider Relations team to Provider Engagement under scope of CAHPS improvement collaboration efforts.
28	Telehealth Services	Added Member to Provider telehealth description. CalViva now provides this telehealth service to members.
38	Supervisory (Regional) Medical Director	Added “Supervisory” to Regional Medical Director title.
39	Health Education	Revised description to include Health Education resources and framework.
40	QI Team	The CalViva QI Team org chart was updated to revise from Director to Senior Director Medical Management Services.
41	Provider Network Management	Clarified that contractual issues that PNM resolves with providers are related to terms and conditions and payments rates for services.
42	Program Accreditation	Added additional scope of Program Accreditation team’s role on Provider Edge efforts.
47	Provider Communication	Updated description to include specifics on Provider Communication resources and channels.

CalViva Health
Quality Improvement and Health Education Program Description

2025

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I. Introduction and Background

A. *Health Plan Services and Membership*

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

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

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

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

CalViva works with stakeholders in each county to develop unique programs tailored to the county's needs and continues to interact with the families, health care providers and county

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administrators to ensure the programs achieve their goal of providing access to needed health care services.

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B. *Information Systems and Analysis*

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

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

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

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II. Purpose and Goals

A. *Mission*

The CalViva mission is:

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

The mission of the CalViva QIHEd Program is:

To help CalViva members stay healthy, secure and comfortable by providing access to quality care and services and information to make better decisions about their healthcare choices.
The vision of CalViva QIHEd Program is to:

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

B. *Purpose*

Quality Improvement Purpose

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

Health Education Purpose

The CalViva Health Education Department (HEd) provides accessible, no-cost health education programs, services, and resources based on the community health, cultural and linguistic needs of CalViva members and contractually required program scope. The CalViva HEd also monitors the quality and accessibility of health promotion and education resources made available by CalViva primary care physicians (PCPs) to CalViva members.

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C. *Goals*

Quality Improvement Goals

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

Health Education Goals

- To provide culturally and linguistically appropriate health education programs and resources at no cost to:
  - Support members and the community to achieve optimal physical and mental health.
  - Promote health equity.
  - Improve CalViva's quality performance.
  - Enhance member satisfaction and retention.
  - To engage communities, stakeholders, and partners.

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III. Scope

D. *Overview of QIHEd Program*

The QIHEd Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. The Population Health Management (PHM) strategy provides a unifying framework to support the QIHEd Program in delivering a whole-person approach to caring for CalViva members.

Health education interventions are based on community health and cultural and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health and dental care services, and to follow self-care regimens and treatment therapies. Health education services include individual, group or community-level education and are supported by trained health educators and public health professionals to encourage immediate positive knowledge gain and healthy behavioral intentions. Health Education Programs include individual, community or population-based initiatives designed to encourage long-term behavioral changes for positive health outcomes. Provision of health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations, website articles, and social media resources. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

The QIHEd Program impacts the following:

- **CalViva Members** in all demographic groups and in service areas for which CalViva is licensed.
- **Network Providers** including practitioners, facilities, hospitals, ancillary providers, and any other contracted or subcontracted provider types.
- **Aspects of Care** including level of care, health promotion, wellness, chronic conditions management, care management, continuity of care, appropriateness, timeliness, and clinical effectiveness of care and services covered by CalViva.
- **Health Disparities** by supporting activities and initiatives that improve the delivery of health care services, patient outcomes, and reduce health inequities.
- **Health Education** by providing accessible no cost health education programs, services and resources based on the community health, cultural and linguistic needs of members and contractually required program scope and by monitoring the quality and accessibility of health promotion and education resources made available to members by Health Net's subcontracting/delegated vendors, Participating Provider Groups (PPG), and Primary Care Physicians (PCPs).
- **Communication** to meet the cultural and linguistic needs of CalViva members.
- **Behavioral Health Aspects of Care** integration by monitoring and evaluating the care and service provided to improve behavioral health care in coordination with other medical conditions.
- **Practitioner/Provider Performance** relating to professional licensing, accessibility and availability of care, quality and safety of care and service, including practitioner and

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office associate behavior, medical record keeping practices, environmental safety and health, and health promotion.

- **Services Covered by CalViva** including preventive care, primary care, specialty care, telehealth, ancillary care, emergency services, behavioral health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, Health Homes Program (HHP), long term care (LTC), Long Term Services and Supports (LTSS): Community Based Adult Services (CBAS), and CalAIM benefits that meet the special, cultural and linguistic, complex or chronic needs of all members.
- **Internal Administrative Processes** which are related to service and quality of care, including customer services, enrollment services, provider relations, practitioner and provider qualifications and selection, confidential handling of medical records and information, care management services, utilization review activities, preventive services, health education, information services and quality improvement.

Health Net and CalViva collaboratively and continually strive to incorporate a culture of quality across their organizations and conduct operations to improve service and satisfaction for CalViva members. This philosophy also extends across the provider network to improve provider quality outcomes, as evidenced by the plan's Healthcare Effectiveness Data and Information Set (HEDIS®); provider access, availability, and satisfaction surveys; 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.

The QIHEd Program is prepared annually by the CalViva Health Senior Director of Medical Management and Chief Medical Officer for presentation to the CalViva QI/UM Committee during the first quarter of each year. The CalViva committee structure ensures that contracted network providers with various specialties participate in the oversight, monitoring, evaluation, and improvement of the QIHEd Program. Six practicing providers participate 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 chairs the committees and invites the contracted network practitioners to participate. Health Net Medical Directors are involved in designing the program, establishing monitoring metrics, analyzing data, and assessing program outcomes in order to make recommendations for improvement including behavioral health components of the program. The QI/UM Committee, approves or modifies the QIHEd Program annually, based on goals and initiatives for the year, taking into consideration new legislation, regulation and needs of the membership and provider community.

Once approved, the CalViva Chief Medical Officer presents the finalized QIHEd Program to the RHA Commission for its approval at its next scheduled RHA Commission meeting. After the RHA Commission has approved the QIHEd Program, the CalViva Chief Medical Officer, as a licensed physician and the QI/UM Committee Chair collaborates with the QI/UM Committee to monitor the full scope of clinical services rendered on a scheduled basis, including a full review at mid-year. During the first quarter of the next year, annual reviews of the QIHEd and UM Work Plan progress and completion are conducted by the CalViva Chief Medical Officer and QI/UM Committee following the completion of a calendar year.

Each CalViva delegate has established and implemented policies and procedures regarding approval, modification, delay or denial of services as well as the timeliness of those decisions consistent with CalViva policies/standards. As part of the pre-delegation audit and annual audit, CalViva verifies that each delegate has policies and procedures regarding authorization,

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modification, denial or delay of services, as well as policies regarding the timelines of those decisions.

E. *Provider Network*

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

F. *Preventive Screening Guidelines (PSGs)*

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

Preventive services that are relevant to CalViva's membership are monitored through participation in National Committee for Quality Assurance's (NCAQ) Healthcare Effectiveness Data Information Set (HEDIS) and other programs as specified in the QIHEd Work Plan. In collaboration with HNCS, physicians and providers, CalViva encourages members to utilize health promotion and preventive care services.

G. *Clinical Practice Guidelines*

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

CalViva adopts guidelines from recognized organizations that develop or disseminate evidence-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Directors, (through the Health Net Medical Advisory Council), and CalViva's CMO and the QI/UM

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Committee. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

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

H. *New Technologies*

CalViva has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the HAYES Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as American Hospital Formulary Service-Drug Information (AHFS DI®), Facts & Comparisons®, Clinical Pharmacology®, DRUGDEX®, Lexi-Drugs®, 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 these primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by CalViva members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

I. *Health Education Programs*

CalViva provides health education programs, services and resources to Medi-Cal members to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. A whole person approach is used with a focus on removing barriers to care and providing health education and guidance. Interventions are tailored to meet the member's clinical, cultural and linguistic needs.

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers may obtain more information by contacting the toll-free Member Services Line at (888) 893-1569. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website based services are available 24/7. The Plan sends member informing health education

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materials to members in their preferred threshold language or alternative format. Content will also be promoted using QR codes to improve accessibility to information.

- Weight Management Resources: Members have access to weight management resources through our Krames Library.
- 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.
- 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, 9am-5pm (excluding holidays) by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.
- Diabetes Prevention Program – 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.
- The Teladoc Mental Health (Digital Program) offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic condition, pain management and many other conditions. This program is available for members ages 13 and older.
- Health Promotion Incentive Programs - The Quality Improvement/Health Education Department develops, implements and evaluates incentive programs to encourage members to receive health education and 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 for members and the community. Classes are

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The Fit Families for Life-Home Edition is a five-week self-paced home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. Materials include a program booklet, cookbook, and exercise stretch band. Exercise videos are available online. Providers may complete and fax or email a copy of the Fit Families for Life Program Referral Form to the CalViva Health Education Department to refer members to the Home Edition program.¶
The Healthy Habits for Healthy People weight management educational resource is for older adults and seniors. Program materials also include a program booklet, cookbook, and exercise stretch band. Exercise videos are available online.¶

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Commented [ML9R7]: @Tuyen T. Pham The Teladoc Mental Health Digital Program is for members ages 13 a ...

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available in various languages. Topics vary and are determined by the community's needs and topic availability.
- Community Health Fairs - The HEd partners with Community Engagement to participate in health fairs and community events to promote health awareness to members and the community.

The following resources are also available to members:

- Health Education Resources - Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, weight control, diabetes, immunizations, dental care, breastfeeding, breast cancer, cervical cancer, exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at www.calvivahealth.org.
- Health Education Programs and Services Flyer - This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines - The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages. They are mailed to new members and are also available on www.CalvivaHealth.org. These are available in English, Spanish and Hmong.
- Member Newsletter - CalViva Whole You newsletter is mailed to head-of-household members once a year to notify members of: NCQA, health equity, and other regulatory articles; promotion of health education resources and wellness programs; and quality improvement interventions.

J. *MemberConnections® Program*

MemberConnections is an educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections representatives (MCRs) extend the reach of member engagement and Population Health Team efforts by making telephonic and home visits and providing personalized service to members. MCRs are highly trained, specialized non-clinical members of our integrated care teams. MCRs serve as a liaison/link/intermediary between the health plan and providers and members.

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the Health Risk Screening, Post Partum Assessment / Edinburgh Postnatal Depression Scale, Notification of Pregnancy and SDoH needs.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect and reconnect members to clinical pharmacy, care management and chronic condition management to better manage their chronic and/or complex health conditions.
- Identify and address SDoH needs by linking members to county, CalAim Programs and community-based organizations.

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- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.
- Support various outreach programs from the Health Plan. These include multiple Plan, Do, Study, Act and Performance Improvement Projects.
- Schedule and complete home visits for noncompliance members. Having “eyes on the member” to do visual assessments while in the member’s home.
- Follow-up and monitor the status of high-risk member referrals.
- Help with utilizing telehealth services.
- Completing emergency outreach during natural disasters.
- Engage members based on Population Health Prioritization Reporting and HEDIS Care Gap Reports to connect members to PCP and to refer into clinical pharmacy and care management.

K. *Health Management Programs*

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

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

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

The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in members’ health status or level of care and in this way, members are monitored to ensure appropriate re-stratification and connection to chronic disease management, care management, enhanced care management (ECM), complex care management (CCM), community supports (CS) and other programs. Outcomes data is stratified by race, ethnicity, language, and age on a plan-level including emergency room (ER)/inpatient (IP) utilization, ambulatory and preventative visits within a 12 month period, enrollment into CCM, and transitions for high-risk member having connection with their assigned care manager.

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The PHM operations team is a cross-unit operations team composed of talent from multiple departments and is led by a core team of a Medical Director and a Pharmacist.

Basic Population Health Management
CalViva's Basic Population Health Management (BPHM) services support the ongoing, seasonal, episodic, and occasional needs of our members to ensure appropriate care. Using a multi-pronged, non-delegated, empanelment approach to BPHM, we directly facilitate connections to primary care. New member welcome packets are sent to ask members to schedule their initial health appointment (IHA), and conduct new member outreach to facilitate appointment scheduling, and survey members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who don't select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible members are not required to select a Medi-Cal PCP).

The Plan proactively outreaches to members without a PCP visit in the past year to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach members, including those with unstable housing or no phone, are assigned to the Plan's MemberConnections Field Team for telephonic and in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant).

Chronic Condition Management
CalViva's chronic condition management programs increase awareness of self-care strategies and empower participants to better manage their disease. The program targets high-risk members identified with chronic conditions including, but not limited to asthma, diabetes and heart failure and encourages them to participate in the program. This program includes a population-based identification process, interventions based on clinical need, patient self-management and disease education. Multi-disciplinary teams participate in the development of these efforts. Additional referrals to chronic condition management programs are multichannel and come through provider, Care Management and member self-referrals.

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

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

Adult Weight Management
Members ages 18 and older with a BMI of 25 or greater are eligible for the adult weight management program. Individualized care plans are developed based on the member's current health status, presence of co-morbidities, dietary intake, and physical activity limitations. Registered Dietitians (RDs) and exercise physiologists serve as program coaches. Themes

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introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, and tips for eating out. Members are offered unlimited inbound calls to program coaches and appropriate educational resources.

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

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

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

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

L. *Transitional Care Services*

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 are focused on coaching the member and the member's support system during an inpatient stay and the post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external resources and processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.

The 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 evidence-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 Supports 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.

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- 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 mmember in medication reconciliation including how to respond to medication discrepancies.

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.

M. *Care Management (CM) Program*

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

The goals of the CM program are:

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

This program seeks to identify and intervene with members:

- Who are at risk of re-admission to hospitals
- With declining health status

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¶
The focus of this model is based on a coaching intervention rather than a care management intervention. Under this model, the Care Transition nurse helps members and/or their primary caregiver, to support a safe discharge by: ¶
¶
Outreach to members in the hospital to enroll in TCS program and complete an inpatient discharge risk assessment and assist with scheduling post-acute follow up appts.¶
Conducting a post-acute follow-up call within 24-72 hours of discharge that actively engages the member in medication reconciliation, how to respond to medication discrepancies, ensure any post-acute services are being received, and how to utilize a personal health record (PHR), and¶
Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.¶
¶
A minimum of two follow-up calls are made to the member within 15 days of discharge which focus on:¶
¶
Reviewing progress toward established goals¶
Discussing encounters with other health care professionals¶
Reinforcement of the importance of maintaining and sharing the PHR¶
Supporting the member's self-management role¶
Medication reconciliation with access to pharmacist, and¶
Educating the member to follow up with the PCP, and/or specialist within 30 days of discharge¶
¶
After the post discharge period, the TCS staff assess member needs for ECM referral or CCM referral and perform a warm hand off for continued care management needs as necessary. All assessment documents are transferred to the assuming care manager along with ...

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- Whose profiles resemble other members with prior poor outcomes
- Who are most likely to engage with care managers (demographics)
- With extensive coordination of care needs, such as members receiving transgender services

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

- Health information forms
- Any of the chronic condition management programs
- The concurrent review and discharge planning process
- A member/caregiver request for care management
- A practitioner request for care management

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

Once members are identified for potential inclusion in the Care Management Program, outreach to the member is completed to assess the care need. The member is then invited to participate in care management if they meet established screening criteria. The member is assigned to the appropriate program and acuity level to address their care needs. Acuity levels vary from complex to low. Members are also afforded the opportunity to opt out of the program. The Care Management staff also identify members for ECM programs as appropriate and make those referrals and warm handoffs.

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

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

N. *Behavioral Health Services*

CalViva delivers covered mental health services to its members through Health Net. Health Net contracts directly with psychiatrists as well as non-MD behavioral health specialists and is delegated to perform certain functions (e.g., credentialing, claims, utilization management, etc.).

CalViva and HNCS are taking a collaborative approach to educate providers and members on the importance of:

- Coordination of care and exchange of information between medical and behavioral health providers and county mental health plans

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

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

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

O. *Operations and Service*

The scope of CalViva's delegated entity's (Health Net Community Solutions) operational oversight is broad and is a collaborative effort among several departments that support the QIHEd Program, including but not limited to: Population Health and Clinical Operations, Pharmacy, Health Equity, Appeals and Grievances, Customer Contact Center, Credentialing, Provider Network Management, Provider Engagement, Provider Performance & Analytics, Claims, Compliance, Privacy, Program Accreditation, Sales and Marketing.

CalViva's delegated entity monitors and evaluates the effectiveness of functional areas and processes that enable the availability, timeliness, and quality of health care services. Additionally, it assesses member and provider satisfaction with several aspects of the care delivery system. In many areas, effectiveness is measured against standards established by regulatory agencies and accrediting bodies.

The program data and outcomes of these activities are routinely reported and reviewed at various internal work groups, committee and management oversight meetings that identify issues and implement opportunities for quality improvement.

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P. *Health Plan Performance*

CalViva conducts ongoing monitoring of health plan performance by participating in annual HEDIS measurement, member experience and practitioner satisfaction assessments, monitoring of appeals and grievances, and evaluating the accessibility and availability of medical services.

CalViva Health ("CalViva") annually assesses the overall effectiveness of its Quality Improvement and Health Education (QIHEd) Program at improving network-wide clinical and service practices. 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, CalViva became "NCQA accredited" for HPA in 2024 and plans to obtain HEA accreditation by January 1, 2026.

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CalViva's QI Program also has established metrics for key operational processes, such as Claims and Customer Service, and monitoring for service improvement opportunities.

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

CalViva monitors HEDIS rates, access and availability standards, quality of care incidents, and CAHPS/BH member experience survey results to assess practitioner and provider adherence to best practices and prioritize health plan outreach activities and campaigns. CalViva emphasizes the importance of technology/Electronic Health Records (EHRs) enabling providers to track and remind patients about regular health screenings. Multiple activities may be in place to improve outcomes, promote safety, increase screening and improve performance metrics. Examples are included in the following list (refer to the QI and HEd Annual Work Plan section for more details):

- Practitioner and provider outreach to improve exchange of quality performance data.
- Member and provider outreach to share quality performance ratings.
- Development of tools to assist practitioners and providers to improve performance.
- Hospital quality monitoring for hospital acquired conditions.

Q. *Credentialing / Recredentialing*

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

Compliance issues are reported to CalViva's Chief Medical Officer. CalViva's Credentialling Committee addresses such compliance issues.

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

R. *Continuity and Coordination of Care*

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

- Across medical care settings that include (but are not limited to) inpatient, residential, ambulatory and other locations where care may be rendered
- Continuity and coordination between medical care locations and public health agencies, medical care providers, behavioral health care providers and county mental health plans

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- Transition of care when benefits end or practitioners leave the network, between practitioners or changes in setting

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

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

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

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

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

S. *Delegation*

CalViva Health has an Administrative Services Agreement ("ASA") with HNCS to provide certain administrative services on CalViva's behalf (e.g., utilization management, appeals and grievances, claims, credentialing, etc.). CalViva also has a Capitated Provider Services Agreement ("CPSA") with HNCS for the provision of health care services to CalViva members through HNCS' network of contracted providers (e.g., primary care providers, specialists, behavioral health providers, ancillary providers, etc.).

CalViva has delegated QI functions to HNCS and other entities, including QI program structure and operations (including behavioral health aspects), health services contracting for practitioners and providers, continuity and coordination of medical care and continuity and coordination between medical care and behavioral healthcare.

CalViva oversees activities performed by Health Net and its subdelegates through a variety of mechanisms including review of monthly, quarterly, semi-annual and annual data or summary

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activity reports, and through monthly management oversight meetings between CalViva and Health Net management staff, ongoing joint workgroups or other focused joint ad-hoc work groups when needed, oversight assessments / audits, re-assessment / re-audits and periodic focus audits as needed. Formal audits include desktop reviews of documents reports, case files, and on-site operations reviews when necessary. Through these mechanisms, HNCS must demonstrate the capability, proficiency and experience to manage the delegated responsibilities. Results and performance of delegated QI activities (Credentialing/ Recredentialing, and Peer Review) are reported at least semi-annually to the CalViva QI/UM Committee. CalViva will institute corrective action and/or may revoke delegation when it determines that HNCS or its subdelegates are unable or unwilling to carry out the delegated responsibilities.

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

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

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

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

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T. *Safety*

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

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

Mechanisms for communication may include:

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

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U. *Health Equity and Cultural and Linguistic Needs*

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

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

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

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

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

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provided to network practitioners and internal department associates periodically. Cultural competency training addresses the delivery of services in a culturally competent manner to all members, including prohibiting discrimination based on national origin, race, color, ancestry, ethnic group identification, sex, sexual orientation, marital status, gender, gender identity, age, physical disability, mental disability, religion, language, medical condition, or genetic information

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

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

- Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services.
- Utilizes and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities.
- Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities.
- Collects, analyzes and reports membership language, race and ethnicity data in reports such as the Population Needs Assessment (PNA).
- Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually.
- Obtains feedback and guidance from the Public Policy Committee (PPC) in the delivery of culturally and linguistically appropriate health care services, member health education needs, and input on the Population Needs Assessment (PNA).
- Informs contracted providers annually of the C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources.
- Engage community-based organizations, coalitions, and collaboratives in counties where CalViva members reside and be a resource for them on C&L issues.
- Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (HICE) and America's Health Insurance Plans (AHIP).
- Provide health equity and C&L services that support member satisfaction, retention, and growth.
- Conducts English material reviews through the EMR database. EMRs are conducted on all member informing materials to ensure that the information received by members is culturally and linguistically appropriate. Readability levels are assessed on the original document and revised accordingly to ensure they comply with the required readability levels mandated by regulatory agencies.

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

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

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Commented [PM11R10]: Needs to be reviewed and corrected if so...

Commented [TP12R10]: @Louba Aaronson @Amy M. Wittig @Anabel Jayme Please advise.

Commented [TP13R10]: @Dao M. Fang @Louba Aaronson @Amy M. Wittig @Anabel Jayme Do you have any feedback? Need this updated asap.

Commented [AW14R10]: Removed. The Pop Health documents cover this.

Commented [DF15R10]: @Tuyen T. Pham agree with Amy, you can remove this.

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

V. *Satisfaction*

For 2025, the health plan will be conducting the Regulatory CAHPS survey. HSAG will stop conducting the DHCS CAHPS survey after this year and the health plan will be required to administer its own annual Regulatory CAHPS survey moving forward. CalViva continuously monitors member experience throughout the year by monitoring member pain points (resolved member appeals and grievances). Results from the CAHPS surveys conducted by DHCS (HSAG) are also reviewed to track member experience improvement and are included in the Population Analysis Report. CalViva also conducts a member experience survey for Behavioral Health. Results are reviewed to identify any trends or opportunities.

Quarterly Root Cause Analysis Reports on member pain point data are conducted throughout the year to identify improvement opportunities. The annual survey results from CAHPS and the behavioral health member survey, as well as quarterly root cause analysis reports are shared with and analyzed by the A & G Work Group to evaluate the success of interventions and identify new opportunities for improvement. These findings and results are reported to the QI/UM Committee and RHA Commission at least annually. CAHPS and member experience awareness and education are a major focus since there are multiple stakeholder teams that are member-facing and have the potential to impact member experience scores.

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

Member materials are assessed to ensure that prospective member and enrollment information includes details on the benefit plan, obtaining primary and specialty care, and how to voice a

Commented [AS16]: Shouldn't this paragraph start with a sentence about the "Regulatory" CAHPS surveys that we will be conducting annually now? I don't see that here. The DHCS CAHPS will now just be supplemental for us, right?

Commented [PM17R16]: Im not sure on this

Commented [TP18R16]: @Guille V. Toland Can you advise?

Commented [GT19R16]: @Tuyen T. Pham , I added couple of sentences to explain the new role of the health plan to conduct its own regulatory CAHPS survey this year and moving forward. HSAG will not be conducting this survey after this year, so no supplemental data will be available after this year.

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Also, "internal stakeholders" doesn't really work for CVH, should we describe them another way? I do think we should address the A & G Work Group in this process and also reporting to QIUM Committee and the Commission.
Unless we need the last statement for NCQA I might not include it because it doesn't really apply to CVH or modify to clarify this is done at the HN staff level?
Needs some reorganizing.

Commented [PM21R20]: No internal stakeholders Evreything goes to QIUm so do we need to call it out?

Commented [TP22R20]: Removed ECHO since the survey is changing.

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complaint and submit an appeal. In addition, members receive various communications that highlight general medical information and other focused activities.

W. *Access and Availability*

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

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

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

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

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

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- CalViva utilizes a dashboard to address several access reporting metrics at the delegated group level.

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

X. *Telehealth Services*

Member to Provider

CalViva supports members' access to their care through telehealth programs by connecting them to licensed clinicians through leading and global providers of virtual care such as Teladoc Health. Members can schedule general medical and behavioral health virtual visits with various pediatric and adult primary care providers.

Members access mobile apps to connect to providers anytime, anywhere by phone, video, or app. Remote consultations with doctors and mental health care professionals are provided via a secure HIPAA-compliant, videoconferencing and voice over internet protocol (VOIP) software. Medically trained, certified interpreters are available on-demand to limited English proficiency (LEP) membership across high demand and threshold languages including Spanish and American Sign Language.

The goals of the telehealth program are to:

- Enhance member and provider experiences.
- Address critical provider shortages.
- Optimize care coordination.
- Reduce overall health care costs.
- Provide equal health care access to Limited English Proficiency members.
- Provide rapid and convenient access to urgent care after hours and when members assigned PCPs are not available.
- Reduce the incidence of unnecessary emergency room utilization.

Electronic Consultation Services – Provider to Specialist

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

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Y. *Member Rights and Responsibilities*

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

Member rights include the right to:

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

Member responsibilities include:

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

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

Z. *Medical Records*

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

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

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

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

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

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IV. QI Process

AA. *Confidentiality / Conflict of Interest*

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

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

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

CalViva has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the company, and to ensure the appropriate and legitimate use of information. Prior to participation in the QIHEd Program or its non-public committees (Credentialing and Peer Review Subcommittees), participants are educated regarding confidentiality requirements. The CalViva Chief Compliance Officer is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Conflict of Interest

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

BB. *QI Process*

CalViva's quality and performance improvement activities are implemented and documented in accordance with applicable state, federal, and accreditation regulations and standards. CalViva,

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in conjunction with HNCS, identifies opportunities for improvement through continuous monitoring of important aspects of care and service. CalViva's QI process includes the following:

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

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

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

Selection of topics takes into account:

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

Data collected to support the CalViva QI process include:

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- Claims and encounter data
- Membership and Medical Benefit Pharmacy data
- Reports of key performance indicators and sentinel events
- Demographic factors generally associated with risk such as race, ethnicity, language, age, gender identity, sexual orientation or special health care or social needs status
- Cultural and linguistic makeup of membership
- Federal and state-reported quality and administrative data
- Clinical quality data collected by the plan, including recognized quality indicators such as HEDIS and HEDIS-like measures
- CAHPS Survey
- Behavioral health member experience survey
- Medical Record Review
- Member & Practitioner Complaint & Inquiry Reports, and
- Appeals Reports.

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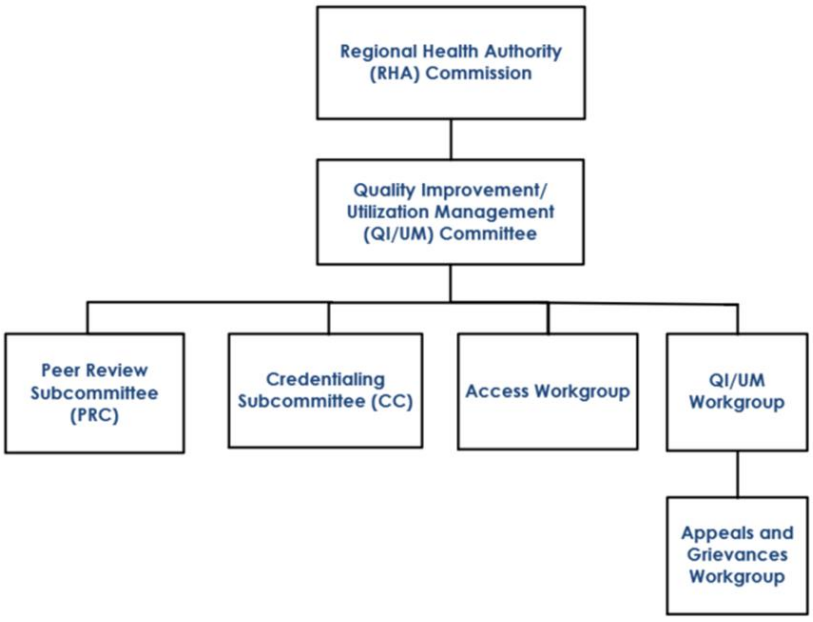
V. Program Structure and Resources

A. QI Committees

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

RHA Commission functions:

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



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CalViva Quality Committees: CalViva Quality Improvement/Utilization Management (QI/UM) Committee and its Peer Review and Credentialing Subcommittees
The CalViva QI/UM Committee is chaired by CalViva's Chief Medical Officer and meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its delegated and non-delegated, and collaborative quality improvement activities.

Quality of care and service is defined as medical care and service which is accessible, meets CalViva standards of performance, is provided in the most timely and appropriate setting, and results in a high level of member satisfaction and improved health outcomes. This Committee identifies opportunities for improvement, recommends and oversees policy decisions and changes, evaluates the results of delegated and non-delegated, and collaborative QI activities, institutes needed actions, and ensures follow up as appropriate.

The Committee also ensures external providers, who are representative of specialties in the network (i.e.; behavioral health, SPD and members with chronic conditions), participate in the planning, design, implementation and review of the CalViva QIHEd Program, and are included as members of the Committee. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis.

Representatives from CalViva and HNCS who report to the QI/UM Committee include the Quality Improvement Department (including behavioral health), Health Equity and CAHPS teams, Pharmacy Department, Provider Network Management, Delegation Oversight, Customer Service Center, Credentialing, Peer Review, Appeals and Grievances, and PHCO. Refer to the CalViva QI/UM Charter for more information on committee members, roles and functions.

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

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Access Workgroup
The CalViva Access Workgroup brings together representatives from CalViva and multiple HNCS departments that have access and network adequacy related functions. The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and evaluate implementation of activities in collaboration with HNCS representatives to improve access to care services. The Workgroup submits quarterly reports to the QI/UM Committee and/or RHA Commission for approval of recommended actions.

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

Refer to the CalViva QI/UM Charter for more information on committee members, roles and functions.

The CalViva QI/UM Committee has the following subcommittees:

Credentialing and Peer Review Subcommittees

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

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

If the Credentialing Subcommittee decides to take disciplinary action against a practitioner that would be reportable to any outside agency, as a result of a practitioner's professional competence and/or conduct not meeting participation criteria or community care standards, all case materials are handled in accordance with CalViva Credentialing policies and procedures.

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

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Peer Review Subcommittee. Membership of the Peer Review Subcommittee includes participating practitioners.

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

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

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B. *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 QIHEd, Health Equity, and PHCO/UM Programs, and assuring that the QIHEd, Health Equity and PHCO Programs are compatible and interface appropriately with the provider network, overseeing compliance with regulatory standards and reporting requirements; and achieving consistency in QI/PHCO 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.

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

Behavioral Health Medical Director
A Behavioral Health Medical Director who is a board certified psychiatrist is involved with the delegated behavioral health care aspects of the QI clinical program for CalViva members, including reviewing all potential quality concerns and functions in an advisory capacity to the QI/UM Committee. He is responsible for ensuring delegated behavioral health clinical services for members are administered in a manner consistent with accepted standards of care and provides direction and oversight for clinical quality improvement activities. Results are reported to CalViva's QI/UM Committee.

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

QI Team
The QI team includes a Chief Medical Officer, Senior Director of Medical Management Services, who is a Registered Nurse, a Manager of Medical Management Services, 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 Quality Program are appropriately trained and experienced in Quality Improvement and Safety, Public Health, Health Administration, and Care Management.

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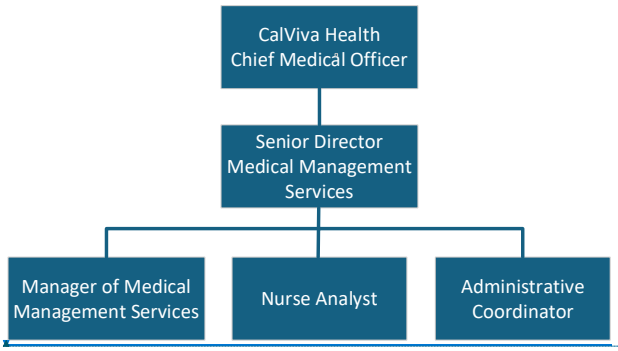

Facility Site Review (FSR)/ Medical Record Review (MRR)/ Physical Accessibility Review Survey (PARS)

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

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

Health Education

CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services. Health education services include individual, group and community-level education, and support by trained health educators. Provision of the health education resources includes culturally and linguistically appropriate brochures, flyers, posters, newsletters, presentations website articles, and social media resources. The framework uses risk stratification data complied from a variety of data sources to help teams target the right members with the right resources to address member health and social drivers of health (SDoH) needs at all stages of life.

Operations

Health Plan Operations works in conjunction with Population Health and Clinical Operations for the monitoring and oversight of clinical performance metrics and operations for programs such as the Nurse Advice Line, SPD HRA, Teladoc virtual general medical and behavioral health

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Commented [AS23]: SS: Similar to my earlier comment on the PNA, I believe this section should be updated as well, since the PNA is now part of the annual PHM strategy.

Commented [PM24R23]: . Why would they write this way if that is so

Commented [TP25R23]: @Anabel Jayme @Amy M. Wittig @Louba Aaronson Can you advise?

Commented [TP26R23]: @Amy M. Wittig @Louba Aaronson @Amy M. Wittig Any updates?

Commented [AW27R23]: removed. @Anabel Jayme please provide any edits here that align with what we state in the health net PD.

Deleted: Under the oversight of CalViva, the Health Education Department, in coordination with the Health Equity and Quality Improvement Departments, conduct a population needs assessment every three years. Assessment results are used to develop health education, culturally and linguistic, and quality improvement priorities and annual work plans.

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services for members, and the specialty UM/prior authorization vendor for musculoskeletal procedures.

Appeals and Grievances
The Appeals and Grievance Department is responsible to conduct full investigation and fair review of all member concerns and/or reconsideration requests. This includes reasonable efforts to gather all information needed to make accurate decisions and provide the member with a resolution in writing within applicable regulatory timeframes. If an appeal has been upheld by the plan, the member is provided their next level of appeal rights which provides the member an independent third-party review and the option to request a State Fair Hearing.

Appeals and grievances are monitored and trended to identify opportunities for improvements in service and quality of care. Appeals and Grievance Department will provide monthly operational and quarterly reporting to CalViva. These reports are to ensure and allow the departments the ability to review, act and follow-up on services, quality events or trends that are significant at the practitioner, provider, or plan level. Initiatives are put in place, as needed to address any identified deficiencies.

Pharmacy Services
CalViva is responsible for managing the pharmaceutical benefits of CalViva. HNCS will assist CalViva in the establishment and maintenance of the Pharmacy Medical Drug Benefit. This includes the implementation of policies and procedures ensuring the safety, quality and appropriate use and delivery of drug products, as well as review of requests for pre-service, pre-authorized urgent and prior authorization of medical benefit drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CalViva members. Pharmaceutical services reports shall be made to the CalViva QI/UM Committee on a quarterly basis.

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

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

Customer Contact Centers
The Customer Contact Centers, operated by HNCS on CalViva's behalf, are responsible for addressing telephone inquiries from members and practitioners. Based on established criteria, the Customer Contact Center refers specific appeals and grievances and expedited requests to appropriate CalViva and HNCS Appeals and Grievances department for focused evaluation and follow-up for any quality of care or service issues. Quarterly reports of trended member/

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practitioner service-related issues are compiled and reviewed for action. The analysis of these reports comprises one of the data sources utilized by CalViva's Chief Medical Officer to directly identify and/or confirm opportunities for improvement.

Provider Network Management
CalViva delegates provider network management to HNCS. HNCS Provider Network Management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CalViva Medi-Cal members. The Provider Network Management staff liaison collaborate with the hospitals, practitioners and other providers for the resolution of contractual issues related to the terms and conditions and/or payment rate(s) for certain services.

Provider Engagement and Provider Performance & Analytics
The Provider Engagement and Provider Performance & Analytics departments provides oversight and capabilities in support of improving and maintaining performance with providers and their membership across all lines of business. Collaboration between the departments involve the Provider Relations, Practice Transformation, Encounters, risk assessment forms (RAF), and Data Analytics and Solutions teams. The Provider Engagement and Provider Performance & Analytics departments' success is dependent on both "internal" and "external" alignment to improve practitioner and provider performance and satisfaction.

Key responsibilities of the Provider Engagement and Provider Performance & Analytics departments include:

- Monitor and maintain and/or improved provider compliance (HEDIS, CAHPS, practitioner/provider satisfaction, UM metrics, RAF and encounter submissions) through provider outreach, training and education.
- Oversee and evaluate provider effectiveness.
- Assure business capabilities meet and support provider and member needs.
- Improve technical support, bi-directional data exchange, and communication channels or methodologies.
- Identify trends, issues, and opportunities to form and adopt best practices and meet or exceed performance targets.
- Engage and collaborate with targeted practitioners and providers through performance improvement projects.
- Collaborate with practitioners, providers and cross-functional departments to build and align incentives based on performance goals.

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

Vendor Management Office (VMO)
The core responsibilities of the VMO are oversight, monitoring, and auditing of vendor delegates. Regular Joint Oversight Committees (JOCs) are led by the VMO in which performance metrics, member experience, complaints and grievances and the status of corrective actions are reviewed. Corrective actions are issued for non-compliance with service

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level requirements or for audit findings and are tracked through remediation.

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

Public Programs
The Public Programs department monitors and acts as a resource for the LTSS {CBAS, MSSP, in-home support services (IHSS), and LTC} services for members. The department is engaged in the following activities:

- Support access to care initiatives through member outreach, coordination of care, and nursing home transitions.
- Early identification and referral to California Children's Services (CCS), and outreach to members aging out of program twelve (12) months before their twenty-first birthday to avoid interruption in care.
- Referral/connection to carved out Medi-Cal benefits and providers.

Program Accreditation
The HNCS Program Accreditation (PA) team supports and promotes activities to assess and monitor CalViva ongoing compliance with requirements of accrediting bodies (NCQA). Responsibilities include managing the accreditation timelines, coordination and submission of documents and implementation of any identified actions based on survey outcomes. PA works with CalViva staff to ensure all aspects of survey submission. The PA team also manages collaboration between Quality, Provider Engagement, and Medical Affairs to increase HEDIS rates as it pertains to Quality Evaluating Data to Generate Excellence (EDGE) efforts.

Additional Resources
Additional resources available to the CalViva QI Program:

- Marketing/Sales
- Compliance
- Privacy
- Legal
- Web Development
- Strategic Sourcing and Procurement
- Claims/Encounters
- Provider Communications, and
- Member Communications.

The **Management Information Systems (MIS)** supporting the CalViva's QI Program allows key personnel the necessary access and ability to manage the data required to support the measurement aspects of the QI activities. Computer systems used by Health Net to support Quality Management includes:

- **Centelligence™**: A comprehensive family of integrated decision support and health care informatics solutions. The Centelligence™ platform integrates data from internal and external sources, producing actionable information: everything from care gap and wellness alerts to key performance indicator (KPI) dashboards, provider clinical profiling

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analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports.

- **Centelligence™ Enterprise Data Warehouse (EDW)**: Supporting both Insight and Foresight, EDW receives, integrates, and continually analyzes an enormous amount of transactional data, such as medical, behavioral, and pharmacy claims, lab test results, health assessments, service authorizations, and enrollee and provider information as required for QI Programs.

  The EDW, powered by Teradata Extreme Data Appliance high performance technology, is the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, and vision); financial information; medical management information (referrals, authorizations, health management); member information (current and historical eligibility and eligibility group, demographics, PCP assignment, member outreach); and provider information (participation status, specialty, demographics) as required by the QI Program. CH&W captures and utilizes data from both internal and subcontractor sources for administration, management and other reporting requirements and can also submit and receive data as well as interface with other systems, as necessary.
- **Statistical Analysis Software**: SAS is an integrated software suite for advanced analytics, business intelligence, data management, and predictive analytics. You can use SAS software through both a graphical interface and the SAS programming language, or Base SAS. R is a programming language and software environment for statistical computing and graphics. Quality improvement uses a combination of SAS and R for all lines of business to extract data, conduct barrier analysis, and conduct statistical analysis (Modeling and statistical testing to assess outcomes).
- **R**: an open-source software environment for statistical computing and graphics. QI utilizes the R-Shiny package within R to build and display interactive dashboards.
- **MicroStrategy**: MicroStrategy is an enterprise business intelligence (BI) application software vendor. The MicroStrategy platform supports interactive dashboards, scorecards, highly formatted reports, ad hoc query, thresholds and alerts, and automated report distribution.
- **Cotiviti** (Verscend): A software system used to monitor, profile and report on the treatment of specific episodes, care quality and care delivery patterns. Cotiviti is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. Enables the Plan to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.
- **Cozeva**: A value-based NCQA-certified care operating system with reporting and analytics functionality, offers up-to-date information on quality and risk measures to plan providers. Cozeva gives providers visibility to provider-level incentives, and supports supplemental data submissions, data integrations with EMRs, and biweekly data syncs to CAIR and various EHR systems. Provider groups have the ability to track and trend performance of their providers to better monitor, understand, and take action on performance gaps through customizable dashboards.
- **Tableau**: Tableau is a data visualization tool which connects easily to several data sources and allows for rapid insight by transforming data into dashboards and are also interactive. Quality uses this software for plotting data on maps and displaying outcomes through dash-boarding.
- **Quest Analytics**: Quest analytics allows geo-mapping to conduct analysis on provider and facility access and compliance for our membership.

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- **TruCare**: Enrollee-centric health management platform for collaborative care coordination, and care, behavioral health, disabling condition, and utilization management. Integrated with Centelligence™ for access to supporting clinical data, TruCare allows Population Health and Clinical Operations staff to capture utilization, care and population-based chronic condition management data; proactively identify, stratify, and monitor high-risk enrollees; consistently determine appropriate levels of care through integration with InterQual Criteria and capture the impact of our programs and interventions.
- **OMNI**: The call center application with guided workflows and business process drivers that allow the business better flexibility and integration with other systems and with changing environments. OMNI application is used to research, record and share information between providers and members.
- **PRIME**: A system application used by employees to handle complaints, grievances and appeals. PRIME includes business process management features that integrate with upstream applications, including Membership, Provider Authorizations and OMNI.

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VI. QI Program Activities

QI Program activities are selected based on their relevance to CalViva's membership, the ability to affect a significant portion of the population or the population at-risk and their potential impact on high-volume, high-risk or high-cost conditions or services. Morbidity, mortality and vulnerable groups with special needs are considered in the selection process as well as race, ethnicity, and language disparities.

CalViva fosters a multi-disciplinary approach to the quality improvement process and involves all functional areas with direct impact on quality and safety of care and service. Activities involve HNCS departments and collaborations with network providers, community entities including public health, quality improvement organization and behavioral health (see QIHEd Work Plan for details of performance improvement goals, objectives, and activities). The QI Program uses PDSA cycles as one method for monitoring quality improvement activities. Progress and results of the following activities are reported up to CalViva through various mechanisms including the CalViva QI/UM Workgroup and QI/UM Committee.

1. **Projects, Surveys and Audits**

   Issues/topics are selected based on identified opportunities for improvement through member and provider input, nationally and regionally identified or mandated projects, HEDIS, CAHPS/behavioral health member experience survey measurement and participation in regional and national coalitions. This includes:

   - Quality Improvement Activities (QIAs), Quality Improvement Projects (QIPs), and Performance Improvement Projects (PIPs) to improve an aspect of clinical care or service. These may include activities to improve HEDIS and/or CAHPS indicators, activities for disease conditions, or other identified areas for improvement by regulators such as CMS, DHCS, and NCQA.
   - Data collection improvement projects: Includes deploying contracts with health information exchanges and vendors that receive or process claims, encounters, member demographics or clinical data to improve efficiency of operations.
   - Behavioral health projects to monitor behavioral health care using data from HEDIS indicators, and member, practitioner and provider surveys.
   - Audits, both internal and external reviews, to ensure that CalViva maintains compliance with all regulatory and accreditation requirements.
   - Surveys including HEDIS, CAHPS/behavioral health member experience survey, health risk assessments, and provider satisfaction surveys, full scope facility site review surveys, and physical accessibility review surveys.
   - Mobile mammography units to improve access to services to complete breast cancer screenings.
   - Provider resources including report cards, gap reports, provider portal, educational resources, and trainings.
   - Pediatric and Maternal Health Programs promoting provider and member engagement with projects to improve immunizations, well-child visits, prenatal and postpartum care, lead screenings, and maternal health equity. Providers are supported to engage with immunization registries and the Vaccines for Children Program.

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- Projects to improve hospital quality, including collaboration with leading external stakeholders to address priority metrics, s patient safety and maternal health indicators.
- Promote evidence-based preventive care and chronic disease management to improve self-management skills for individuals with chronic diseases.

2. Incentive Programs

CalViva rewards targeted members for healthy behaviors and collaborates with providers to build performance-based incentive programs. Development and implementation of incentives are aligned with CalViva's provider partnership, and strategies.

Member:

- Tailored member incentives offered to target CalViva populations to assist in closing care gaps for priority HEDIS measures including breast cancer screening, cervical cancer screening, diabetes management, well-child visits and childhood immunizations.

Provider:

- Tailored provider and PPG incentive programs for CalViva providers for HEDIS outcomes and encounter submissions.

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VII. Provider Communications

Effective communication with network providers and subcontractors is crucial in advancing CalViva Health's quality improvement initiatives, studies, and fulfilling contractual obligations. Engagement with the Quality Improvement Health Education (QIHEd) Program is facilitated through various methods, including:

- Practitioner and provider office visits: Conducted by Provider Engagement team members to ensure direct and personalized communication.
- Online training and educational webinars: These resources provide continuous learning opportunities and keep participants informed about the latest guidelines and best practices.
- Joint Operation Meetings (JOMs) and work groups: These collaborative forums foster active participation and dialogue, ensuring alignment with quality improvement goals.

This structured approach ensures that all participants are well-informed and actively contributing to CalViva Health's mission of enhancing health care quality and efficiency.

To keep health care providers informed about QIHEd and Wellness program activities, modifications and outcomes, as well as available quality resources and programs, several key methods are utilized. The resources described below can be accessed through the Provider Library at providerlibrary.healthnetcalifornia.com or on other provider resource pages available on the provider portal. Additionally, CalViva's provider resource webpage (www.calvivahealth.org/providers) also includes provider resources and communications.

Available Resources:

- Provider Operations Manuals and Medi-Cal Operations Guides: Comprehensive manuals and guides outlining the operational policies and procedures necessary for providers to effectively deliver services.
- Provider Updates and Letters: Regular updates and communications sent to providers to keep them informed about important changes and developments.
- Provider Newsletters: Quarterly newsletters offering insights and updates about various health programs, initiatives, engagement in our communities, and best practices.
- Forms and Reference Documents: Essential forms and reference materials needed for administrative and operational purposes.
- Educational Materials and Resources: Resources aimed at enhancing provider knowledge and skills related to QIHEd and Wellness programs.

Communication Channels:

Provider updates, letters, and educational materials and resources are distributed via multiple channels including fax, mail and email. Additionally, these communications and materials are available in the Provider Library under the "Updates and Letters" section, or on other provider resource pages healthnet.com. Additionally, CalViva's provider resource webpage (www.calvivahealth.org/providers) also includes provider resources and communications.

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VIII. Corrective Actions

CalViva takes timely and appropriate action to correct any significant or systemic problems identified through audits, internal reports, complaints, appeals, grievances, and delegation oversight activities.

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IX. Program Evaluation and Work Plan

A. *Review and Oversight*

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

B. *Annual QIHEd Evaluation*

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

C. *Annual QIHEd Work Plan*

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

- Objectives, scope and population demographics
- Improvement activities planned for the year covering quality and safety of clinical care, quality of service, and members' experience.
- Timeframes within which each activity is to be achieved and/or reported
- Responsible department(s) and/or person(s) for each activity
- Goals and benchmarks for each activity
- Number of objectives met
- Number of activities met
- Planned monitoring of previously identified issues

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- Barriers identified when goals are not achieved, and
- Follow-up action plan, including continuation status (close, continue, or continue with modifications).

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D. *QIHEd Program Information Availability*

Information about CalViva's QIHEd Program including program description, activities and progress toward goals is available upon request, to members, prospective members and providers. CalViva notifies members of the availability of information about the QIHEd Program through the member's evidence of coverage and through the annual member newsletter highlighting CalViva's QIHEd Program. Network providers and subcontractors are notified of the availability of information about the QIHEd Program through committee meetings, JOMs, new practitioner/provider welcome letters, Provider Updates (including updates regarding quality improvement findings and outcomes), and through the operations manuals available electronically in the Provider Library on Health Net's online provider portal.

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X. Approval

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

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

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

Date

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

Date

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B. *Health Net Medi-Cal Quality Management Program Approval*

The Chief Medical Officer and Vice President of Quality Management have reviewed and approved this Work Plan.

Alex Chen, MD
Chief Medical Officer

Date

Cathrine Misquitta, Pharm.D.
Vice President of Quality Management

Date

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Quality Improvement, Health Education, and Wellness 2025 Work Plan

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, Health Education, and Wellness Work Plan encompasses quality improvement and health education activities for 2025. 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
CH&W:	California Health & Wellness
CS:	Community Solutions
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
AISE	Vaccine Adult Immunization Status
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
AMM	Antidepressant Medication Management (
AMO	Annual Monitoring for Persons on Long-Term Opioid Therapy
AMR	Asthma Medication Ratio
BCS	Breast Cancer Screening
CBP	Controlling Blood Pressure
CCO	Cervical Cancer Overscreening
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
COA-FA	Care of Older Adults-Functional Assessment
COA-MR	Care of Older Adults –Medication Review
COA-PA	Care of Older Adults- Pain Assessment
COB	Concurrent Use of Opioids and Benzodiazepines
COL	Colorectal Cancer Screening
CWP	Appropriate Testing for Pharyngitis
DEV	Developmental Screening in the First Three Years of Life
DSF	Depression Screening and Follow-up for Adolescents and Adults
EED	Eye Exam for Patients with Diabetes
FMC	Follow up After Emergency Dept Visit/Chronic Condition
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

Acronym:	Description
GSD	Glycemic Status Assessment for Patients with Diabetes (>9%)
HBD	Diabetes Care -Blood Sugar Controlled (>9%)
HDO	Use of Opioids at High Dosage
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMA-2	Immunizations for Adolescents – Combo 2
IMMH	Improving Mental Health
IMPH	Improving Physical Health
KED	Kidney Health Evaluation for Patients with Diabetes
LSC	Lead Screening in Children
MAC	Medication Adherence for Cholesterol (Statin) (MAC)
MAD	Medication Adherence for Diabetes Medications (MAD)
MAH	Medication Adherence for Hypertension (RASA) (MAH)
MPA	Monitoring Physical Activity
MRSA	Methicillin-resistant Staphylococcus aureus
MTM-CMR	MTM Program Completion Rate – Comprehensive Medication Review
MUI-OA	Improving Bladder Control
NTSV	Nulliparous, Term, Singleton, Vertex
OMW	Osteoporosis Management in Women who had a Fracture
OED	Oral Evaluation, Dental Services
OMW	Osteoporosis Management in Women who had a Fracture
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack
PCR	Plan All Cause Readmission
PDC-DM	Proportion of Days Covered - Diabetes
PDC-RAS	Proportion of Days Covered - Renin Angiotensin System
PDC-Statin	Proportion of Days Covered - Statin
POD	Pharmacotherapy for Opioid Use Disorder

Glossary of Abbreviations/Acronyms (Measure Specific) - continued

Acronym:	Description
PPC-Pre	Prenatal and Postpartum Care: Prenatal Care
PPC-Pst	Prenatal and Postpartum Care: Postpartum Care
RRF	Reducing Risk of Falls
SPC-RCV	Statin Therapy for Patients with Cardiovascular Disease - Received Therapy
SPD-RCV	Statin Therapy for Patients with Diabetes - Received Therapy
SSI-Colon	Surgical site infection following colorectal surgery
SUPD	Statin Use in Persons with Diabetes
TFL-CH	Topical Fluoride for Children
TRC	Transitions Of Care- Average
URI	Appropriate Treatment for Upper Respiratory Infection
W30	Well-Child Visits in the First 30 Months of Life
W30+6	Well-Child Visits 0-15 months – Six or more visits
W302+	Well-Child Visits 15-30 months – 2 or more visits
WCC	Children/Adolescents: BMI Percentile Documentation
WCV	Child & Adolescent Well-Care Visits

Acronym:	Description

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	Product Line	Responsible Party	Objectives	2024 (MY 2023) Objectives Met (%, ratio):	2025 (MY 2024) Objectives Met (%, ratio): (Populate at Mid-Year)	2025 Activities Completed (%, ratio):	Projected Progress Towards MY 2025 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	CVH: Medi-Cal (Fresno, Kings, Madera)	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): • Follow-Up After ED Visit for Substance Abuse – 30 days (FUA-30): MPL is 36.18% • Follow-Up After ED Visit for Mental Illness – 30 days (FUM-30): MPL is 53.82%.	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): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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: • Glycemic Status Assessment for Patients with Diabetes: GSD (new 2024 measure replaces Diabetes Care -Blood Sugar Controlled - HBD): MPL is 33.33% **(inverted rate).**	MY 2023: •GSD >9: (100%, 3/3) Fresno: 35.31% Kings: 25.42% Madera: 30.79%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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: • Controlling Blood Pressure (CBP): MPL is 64.48%.	MY 2023: • CBP: (100%, 3/3) Fresno: 64.29% Kings: 72.81% Madera: 71.04%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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.	MY 2023 (9/11, 82%) •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: Rate=<23.6%: 60%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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. * Required by DHCS for NEW Medi-Cal members within 120 days of enrollment. * Goal: To ensure newly enrolled Medi-Cal members connect with a medical home/PCP, receive a comprehensive evaluation of health needs and receive needed care services across the care continuum (MPL is 78%)	MY 2023 •IHA: 57.26%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		

Program Details	Product Line	Responsible Party	Objectives	2024 (MY 2023) Objectives Met (%, ratio):	2025 (MY 2024) Objectives Met (%, ratio): (Populate at Mid-Year)	2025 Activities Completed (%, ratio):	Projected Progress Towards MY 2025 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	CVH: Medi-Cal (Fresno, Kings, Madera)	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or >=50th percentile benchmark for MCAS measure: • Topical Fluoride for Children (TFL-CH): MPL is 19%.	MY 2023 • TFL-CH: (33%, 1/3) Fresno: 19.21% Kings: 9.63% Madera: 27.66%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
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	CVH: Medi-Cal (Fresno, Kings, Madera)	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or >=**75th percentile benchmark** for MCS measures: Prenatal and Postartum Care: Prenatal Care (PPC-pre): MPL is 88.58%, and Postpartum Care (PPC-pst): MPL is 83.33%.	MY 2023 • PPC-pre: (33.33%, 1/3) Fresno: 90.39% Kings: 91.27% Madera: 90.82% • PPC-pst: (66.67%, 2/3) Fresno: 82.1% Kings: 83.84% Madera: 80.1%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
5.C. 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	CVH: Medi-Cal (Fresno, Kings, Madera)	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or >=50th percentile benchmark for MCAS measures: • Childhood Immunization Status - Combo 10 (CIS-10): MPL is 27.49% • Lead Screening in Children (LSC): MPL is 63.84 • Developmental Screening in the First Three Years of Life (CDEV): MPL is 35.70% • Well-Child Visits 0-15 months – Six or more visits (W30-6+): MPL is 60.38% • Well-Child Visits 15-30 months – 2 or more visits (W30-2+): MPL is 69.43%.	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): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
5.D. 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	CVH: Medi-Cal (Fresno, Kings, Madera)	Juli Coulthurst, Program Manager III, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	MCL: Meet directional improvement of 1-5% from prior year or >=50th percentile benchmark for MCAS measures: • Immunizations for Adolescents Combo 2 (IMA-2): MPL is 34.30% • Well Child Visits (WCV): MPL is 51.81%.	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): (%, X/X) Year-End (Jul-Dec): (%, X/X)		

Program Details	Product Line	Responsible Party	Objectives	2024 (MY 2023) Objectives Met (%, ratio):	2025 (MY 2024) Objectives Met (%, ratio): (Populate at Mid-Year)	2025 Activities Completed (%, ratio):	Projected Progress Towards MY 2025 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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: • Asthma Medication Ratio (AMR): MPL is 66.24%.	MY 2023: • MCL: (66.67%, 2/3) Fresno: 63.66% Kings: 59.29% Madera: 72.2%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
7.A. Preventive Health – Cancer and STI 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	CVH: Medi-Cal (Fresno, Kings, Madera)	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: • Breast Cancer Screening (BCS): MPL is 52.68% • Cervical Cancer Screening (CCS): MPL is 57.18% • Chlamydia Sreening in Women (CHL): MPL is 55.95.	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): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
7.B. Preventive Health – Flu Campaign Type of activity: • Ongoing activity – (monitoring of previously identified issue – improve performance for Member Experience) Type of program: • Quality of Care • Member Experience	CVH: Medi-Cal (Fresno, Kings, Madera)	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 (AISE Flu). Targets: • Fresno: >=22.45% • Kings: >=23.97% • Madera: >=24.92%	MY 2023 AISE Flu: 100% (3/3) Fresno: 21.45% Kings: 21.97% Madera: 23.92%		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
8.A Provider Communication/ Engagement – Improving Member Experience (CAHPS) – Provider Focus Type of activity: • Ongoing activity – (monitoring of previously identified issue – improve performance for Member Experience) Type of program: • Quality of Care • Quality of Service • Member Experience	CVH: Medi-Cal (Fresno, Kings, Madera)	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. MY2023 CAHPS Scores (Prior Year Results): - Getting Needed Care - 73.5% - Getting Care Quickly - NR, 25% Percentile QC benchmark - 77.4% - Care Coordination - NR, 25% Percentile QC benchmark - 83.0% *MY2024 QC benchmarks are not available until Q3 2025.	MY 2023 CAHPS: N/A since there was no Regulatory CAHPS survey done in MY2023 HSAG CAHPS: Getting Needed Care, (0/1, 0%) N/A for Getting Care Quickly and Care Coordination. Non-reportable due to small sample size (n<100).		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		

Program Details	Product Line	Responsible Party	Objectives	2024 (MY 2023) Objectives Met (%, ratio):	2025 (MY 2024) Objectives Met (%, ratio): (Populate at Mid-Year)	2025 Activities Completed (%, ratio):	Projected Progress Towards MY 2025 Objectives (Glidepath) (>= 75% is on track)	Program Continuation (Populate at year-end)
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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. MY2023 CAHPS Scores (Prior Year Results): - Rating of Health Plan - 81.98% - Customer Service - NR, 25% Percentile QC benchmark - 87.2% - Ease of Filling Out Forms - 96.82% *MY2024 QC benchmarks are not available until Q3 2025.	MY 2023 CAHPS: N/A since there was no Regulatory CAHPS survey done in MY2023 HSAG CAHPS: Rating of Health Plan (1/1, 100%) NR for Customer Service and Ease of Filling out Forms. Non-reportable due to small sample size (n<100).		Mid-Year (Jan-Jun): (%, X/X) Year-End (Jul-Dec): (%, X/X)		
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	CVH: Medi-Cal (Fresno, Kings, Madera)	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 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): (%, X/X) Year-End (Jul-Dec): (%, X/X)		

Section II: Ongoing Work Plan Activities

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

Health Plan	Program Type	Activity Description	Product Lines	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	Medi-Cal	D. Saldarriaga; Manager, A&G S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical	12/31/25	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	Medi-Cal	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	7/1/25 - 12/31/25	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	Medi-Cal	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q1-Q2 2025	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	Medi-Cal	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	7/1/25 - 12/31/25	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Complete and submit DMHC Timely Access Reporting (TAR) by May 1, 2025 filing due date.	Medi-Cal	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	5/1/25	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Coordinate data and reporting for annual Provider Satisfaction Survey.	Medi-Cal	M. Miyashiro R. Davila S. Si, CVH Compliance	Q3 2025	Not started			
CalViva	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.	Medi-Cal	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q3 2025	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Engage with CalViva provider offices to complete MY 2025 MCAS training focused on best practices for closing care gaps.	Medi-Cal	A. Wittig, Director, Quality Improvement Erica Valdivia, Provider Engagement Amy Schneider RN, Sr. Director Medical Management	Q3 2025	Not started			
CalViva	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.	Medi-Cal	D. Fang, Manager, Health Equity S. Si, CVH Compliance	Q3 2025	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Health Equity Report: Analyze and report on Cultural and Linguistics.	Medi-Cal	D. Fang, Manager, Health Equity S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	Q2 and Q3 2025	Not started			

Health Plan	Program Type	Activity Description	Product Lines	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to improve access and complete interventions addressing systemic barriers to HEDIS performance.	Medi-Cal	Michelle Najarro, Manager, Accreditation Erica Valvidia, Director, Provider Engagement	12/31/25	Not started			
CalViva	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.	Medi-Cal	T. Jaghasspanian M. Anderson G. Toland S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	1/1/25 - 12/31/25	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	Maintain compliance with DHCS Initial Health Appointment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	Medi-Cal	A. Wittig, Director, Quality Improvement S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer Amy Schneider RN, Sr. Director Medical Management	Q3 2025	In progress			
CalViva	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.	Medi-Cal	M. Miyashiro R. Davila S. Si, CVH Compliance	Q3-Q4 2025	Not started			
CalViva	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.	Medi-Cal	Manisha Makwana S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	Q1-Q4 2025	Not started			
CalViva	ACCESS, AVAILABILITY, SATISFACTION AND SERVICE	TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	Medi-Cal	P. Fuentes, PR Specialist, Access & Availability S. Si, CVH Compliance	Q1-Q2 2025	Not started			
CalViva	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/ECHO results, and identifies barriers, areas of opportunity, and ongoing initiatives.	Medi-Cal	T. Jaghasspanian G. Toland G. Gomez (BH) S. Si, CVH Compliance Amy Schneider RN, Sr. Director Medical Management	1/1/25 - 12/31/25	Not started			
CalViva	BEHAVIORAL HEALTH	Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, etc.)	Medi-Cal	G. Gomez, Director, QI Amy Schneider RN, Sr. Director Medical Management	Q1-Q4 2025	Not started			
CalViva	CONTINUITY AND COORDINATION OF CARE	Educate providers on importance of well-child visits. Well-child visits include developmental screenings.	Medi-Cal	J. Coulthurst, PMIII, QI Amy Schneider RN, Sr. Director Medical Management	12/31/2025	Not started			

Health Plan	Program Type	Activity Description	Product Lines	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CalViva	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).	Marketplace, Medi-Cal	K. Lesser/ M. Rosales Program Manager III, Quality Improvement	To be determined. Specs for RY 2025 have not been assigned.	Not started			
CalViva	CREDENTIALING / RECREDENTIALING	Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	Medi-Cal	M. Catello, Sr. Manager	12/31/25	Not started			
CalViva	CREDENTIALING / RECREDENTIALING	PPG Delegates Credentialing/Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	Medi-Cal	K. Bowling, Sr. Manager	12/31/25	Not started			
CalViva	DISEASE/CHRONIC CONDITIONS MANAGEMENT	Monitor Chronic Conditions (Disease) Management Program for appropriate member outreach quarterly.	Medi-Cal	Denise Miller, Program Manager III Customer Experience	1/23/25	Not started			
CalViva	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.	Medi-Cal	K. Bowling A. Tonkogolosuk	12/31/25	Not started			
CalViva	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.	Medi-Cal	L. Carrera Amy Schneider RN, Sr. Director Medical Management	12/31/25	Not started			
CalViva	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	Medi-Cal	C. Patnaude, Director, Care Management	Annually by December 2025	In progress. See 2024 year-end work plan evaluation.			
CalViva	QUALITY AND SAFETY OF CARE AND SERVICE	Monitor credentialing findings and report to CalViva Credentialing Sub Committee quarterly.	Medi-Cal	P. Carpenter, Director, Quality Improvement	12/31/25	Not started			
CalViva	QUALITY AND SAFETY OF CARE AND SERVICE	Monitor peer review determinations and report to CalViva Credentialing Sub Committee quarterly.	Medi-Cal	P. Carpenter, Director, Quality Improvement	12/31/25	Not started			
CalViva	QUALITY AND SAFETY OF CARE AND SERVICE	Monitor potential quality incidents (PQI) and quality of care (QOC) findings and report to CalViva quarterly. Complete all PQIs/QOCs received thin 90 day TAT to maintain internal compliance.	Medi-Cal	P. Carpenter, Director, Quality Improvement	12/31/25	Not started			
CalViva	QUALITY AND SAFETY OF CARE AND SERVICE	Update Clinical A&G Quality of Care Concerns Policy & Procedure and Peer Review Committee Policy & Procedure.	Medi-Cal	P. Carpenter, Director, Quality Improvement Amy Schneider RN, Sr. Director Medical Management	12/31/25	Not started			

Health Plan	Program Type	Activity Description	Product Lines	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CalViva	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).	Medi-Cal	A. Wittig S. Wright Pamela Carpenter Barbara Wentworth	Q1 2025	Not started			
CalViva	QUALITY IMPROVEMENT AND COMPLIANCE	Evaluation of the QIHEd program of the previous year (Q1). Complete QIHEd Work Plan evaluation semi-annually.	Medi-Cal	L. Aaronson M. Gumatay A. Wittig S. Wright T. Jaghasspanian L. Pak A. Schneider	Q1 2025	Not started			
CalViva	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.	Medi-Cal	P. Carpenter, Director, Quality Improvement	12/31/25	Not started			
CalViva	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.	Medi-Cal	HEDIS D. Mehlhouse	12/31/25	Not started			
CalViva	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.	Medi-Cal	S. Pao S. Myers	12/31/25	Not started			
CalViva	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.	Medi-Cal	T. Jaghasspanian G. Toland M. Anderson	12/31/25	In progress			
CalViva	QUALITY IMPROVEMENT INFASTRUCTURE	Support development of HEDIS best practice tools.	Medi-Cal	S. Wright (lead)	6/30/2025	Not started			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	Medi-Cal	CalViva Health/HN K. Macsicza Director, Clinical Programs A. Schneider, RN, Sr. Director Med Management	6/30/25	Not started			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Distribute and/or make available Preventive Screening Guidelines (PSG) to Members and Providers.	Medi-Cal	B. Head J. Felix	12/31/25	Not started			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Distribute the Health Education Programs and Services Flyer to members via the Medi-Cal member welcome packet.	Medi-Cal	M. Lin S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	12/31/25	In progress			

Health Plan	Program Type	Activity Description	Product Lines	Responsible Party	Completion Due Date(s)	Status	Completion Date(s)	Mid-Year Update	Year End Update
CalViva	WELLNESS/ PREVENTIVE HEALTH	Health education material management	Medi-Cal	L. Aaronson, Director of Quality and Health Education A. Wittig, Director of Quality Improvement and Health Education A. Jayme, Program Manager II	12/31/25	In progress			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Health Education System P&Ps, monitoring of initiatives, maintenance of printed materials, digital programs and requirements, health promotion to providers.	Medi-Cal	A. Wittig L. Aaronson S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	12/31/25	In progress			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016. Quarterly monitoring of HEDIS Lead Screening for Children (LSC.) Member education materials include 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.	Medi-Cal	A. Wittig P. Carpenter S. Wright J. Coulthurst L. Armbruster A. Schneider	12/31/25	Not started			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Member newsletter- Supports Medi-Cal NCQA guidelines that requires specific member communication to be mailed to members' homes.	Medi-Cal	B. Head/K. Kaila (Medi-Cal) S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	10/31/2025-Medi-Cal	In progress			
CalViva	WELLNESS/ PREVENTIVE HEALTH	Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	Medi-Cal	C. Patnaude, Director, Care Management S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	Annually by December 2025	In progress. See 2024 year-end work plan evaluation.			
CalViva	WELLNESS/ PREVENTIVE HEALTH	New vendor onboarding and ongoing management to provide Diabetes Prevention Program (DPP) services to our eligible Medi-Cal population.	Medi-Cal	A. Mojadedi S. Si, CVH Compliance S. Lopez, CVH Health Equity Officer	6/30/2025	Off track/ Delayed			

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	PODS	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	Planned End Date	Status	Department Owner	Mid-Year Update	Year End Update
10771	BEHAVORIAL HEALTH	CalViva Health Teladoc Mental Health Digital Program	BEHAVIORAL HEALTH - CalViva Health Teladoc Mental Health Digital Program oversight, and management	IMMH - Improving or Maintaining Mental Health	CVH-ALL	1/1/2025	12/31/2025	PLANNING	Maria Lin		
10775	BEHAVORIAL HEALTH	CVH mystrength PSV (Primary Source Verification)-DSF	BEHAVIORAL HEALTH- myStrength PHQ9 screening data approved by the HEDIS auditor as a supplemental data for HEDIS Measure Depression Screening and Follow Up (DSF-E).	IMMH - Improving or Maintaining Mental Health	CalViva Health-All counties	1/1/2025	12/31/2025	ON TRACK	Maria Lin		
10708	BEHAVORIAL HEALTH	MHN PSV (FUM/FUH/FUA)	BEHAVIORAL HEALTH: FUM/FUA MHN FUOT uses HN ADT reports to conduct member outreach calls to close gaps; FUH: MHN FUOT uses internal discharge reports to conduct member phone outreach to close gaps	FUH - F/U Hospital MH 30-day,FUH - F/U Hospital MH 7-day,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	1/1/2025	12/31/2025	ON TRACK	Kelli Lesser		
10762	MEMBER COMMUNICATION/ENGAGEMENT	CHWs for HRA completion	CARE COORDINATION & MEMBER ENGAGEMENT- Identify dual eligible members to target for H3561 and verify they have a qualifying condition to meet need of using CHW benefit.	HRA - Special Needs Plan (SNP) Care Management	CalViva	1/1/2025	12/31/2025	ON TRACK	Miriam Rosales		
10877	MULTI-CONDITIONS	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, Everlywell, to directly mail A1c Kits (to support an A1c home test).	CDC - Diabetes HbA1c < 8	All	1/1/2025	12/31/2025	PLANNING	Martha Zuniga		
10883	HEALTH EDUCATION/WELLNESS	Digital Health Education Resources to Support Patients	HEALTH EDUCATION/WELLNESS - Create a PowerPoint (PPT) presentation resource designed to promote Krames and nationally credible health education resources that providers can effectively share with their patients. This PPT will encompass a broad spectrum of health-related topics, which also includes addressing topics that support various measures.	AMR - Asthma Med Ratio Total 5 to 64,CBP - Controlling Blood Pressure,CDC - Comprehensive Diabetes Care,SUPD - Statin Use in Persons with Diabetes (SUPD),MAH - Medication Adherence for Hypertension (RAS antagonists),MAD - Medication Adherence for Diabetes Medications,MAC - Medication Adherence for Cholesterol,PBH - Persistence of Belta-Blocker Treatment after a Heart Attack,POD - Pharmacotherapy for Opioid Use Disorder,IMPH - Improving or Maintaining Physical Health,MPA - Monitoring Physical Activity,RRF - Reducing the Risk of Falling,MUI_OA - Improving Bladder Control,OMW - Osteoporosis Management in Women who had a Fracture	CVH -All	1/1/2025	12/31/2025	NOT STARTED	Brittany Head		
10676	HEALTH EDUCATION/WELLNESS	Annual Member Newsletter-Medi-Cal CalViva	HEALTH EDUCATION/WELLNESS The newsletter meets the Medi-Cal guideline that requires specific member communication to be mailed to members' homes. The member newsletter is also a mode of communication for NCQA, Health Equity and Regulatory articles. Promotion of wellness programs and quality improvement interventions.	CAHPS - Access to Care	CVH-All	10/2/2024	10/31/2025	ON TRACK	Brittany Head		
10899	HOSPITAL QUALITY/PATIENT SAFETY	Engagement with external collaboratives to promote hospital quality: Cal Hospital Compare collaboration	HOSPITAL QUALITY: Collaboration with Cal Hospital Compare to promote their hospital Honor Rolls, leverage their Poor Performer list, partner with their staff to engage specific poor-performing hospitals, and identify new opportunities to drive hospital quality improvements.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barbara Wentworth		
10895	HOSPITAL QUALITY/PATIENT SAFETY	Engagement with external collaboratives to promote hospital quality: Health Services Advisory Group (HSAG)	HOSPITAL QUALITY: Collaboration with Health Services Advisory Group to provide our network hospitals with access to their online platform and QI resources to provide them with technical guidance on how to improve their performance on priority measures.	HPQI - Health Plan Quality Improvement	CVH - All	1/1/2025	12/31/2025	PLANNING	Barbara Wentworth		

Work Plan ID	PODS	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	Planned End Date	Status	Department Owner	Mid-Year Update	Year End Update
10897	HOSPITAL QUALITY/PATIENT SAFETY	Engagement with external collaboratives to promote hospital quality: California Health Care Foundation collaboration	HOSPITAL QUALITY: Collaboration with the California Health Care Foundation (CHCF) to coordinate and consult on improving hospital maternal health metrics, particularly with respect to equity.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barb Wentworth		
10901	HOSPITAL QUALITY/PATIENT SAFETY	Engagement with external collaboratives to promote hospital quality: CMQCC	HOSPITAL QUALITY: Collaboration with the California Maternal Quality Care Collaborative (CMQCC) to coordinate and consult on improving hospital maternal health metrics.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barb Wentworth		
10903	HOSPITAL QUALITY/PATIENT SAFETY	Participation on Leapfrog Partners Advisory Committee	HOSPITAL QUALITY: Participation in Leapfrog's Partners Advisory Committee (serving as co-chair) and related activities.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barb Wentworth		
10912	HOSPITAL QUALITY/PATIENT SAFETY	Hospital outreach about C-section overuse and maternal health issues	OVERUSE/HOSPITAL QUALITY: Outreach to hospitals about C-section overuse, standards/expectations, and opportunities to improve. Includes focus on maternal health equity.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barb Wentworth		
10914	HOSPITAL QUALITY/PATIENT SAFETY	Hospital outreach about patient safety	OVERUSE/HOSPITAL QUALITY: Outreach to hospitals about patient safety metrics, standards/expectations, and opportunities to improve. Focus on metrics and reports including hospital acquired infections, sepsis management, the Patient Safety Honor Roll, and the Opioid Care Honor Roll.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barb Wentworth		
10909	HOSPITAL QUALITY/PATIENT SAFETY	Hospital Quality Scorecard program	OVERUSE/HOSPITAL QUALITY: Track and produce internally-developed Hospital Quality Scorecard for use by quality and contracting staff. Features individual hospital performance on priority metrics in areas including patient safety, maternal health, patient experience, readmissions, and overall CMS rating.	HPQI - Health Plan Quality Improvement	CVH-All	1/1/2025	12/31/2025	PLANNING	Barb Wentworth		
10816	PEDIATRICS/ADOLESCENTS	DHCS Annual LSC Reporting	PEDIATRIC/PERINATAL/DENTAL - DHCS requires all health plans to submit an annual report on blood lead screening in children	LSC - Lead Screening in Children	CVH: All	1/1/2025	12/31/2025	COMPLETED	Linda Armbruster		
10861	PEDIATRICS/ADOLESCENTS	CIS Provider Email Outreach (Power Automate)	PEDIATRIC/PERINATAL/DENTAL - Emails will be sent to provider offices, asking about member's immunization status. Email will ask provider to either fax over immunization record or to encourage members to schedule an appointment to get the immunizations done. Gap will be utilized from COZEVA	CIS - Childhood Immunization Status	CVH-All	1/12/2025	12/31/2025	NOT STARTED	Brittany Head		
10826	PEDIATRICS/ADOLESCENTS	CVH Family Unit HEDIS/MultiGap Outreach Calls	PEDIATRIC/PERINATAL/DENTAL - HEDIS team outreach to anchor members and all household members with care gaps.	WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC)	CVH-ALL	5/19/2025	12/19/2025	PLANNING	Juli Coulthurst		
10811	PEDIATRICS/ADOLESCENTS	POC Lead Analyzer - CVH	PEDIATRIC/PERINATAL/DENTAL - Lead Analyzer Initiative. Using QI EDGE funding to purchase POC lead analyzers for provider offices.	LSC - Lead Screening in Children	CVH - All	1/1/2025	12/31/2025	ON TRACK	Linda Armbruster		
10869	PEDIATRICS/ADOLESCENTS	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	1/1/2025	12/31/2025	NOT STARTED	Brittany Head		
10854	PEDIATRICS/ADOLESCENTS	Monthly birthday POM messaging - WCV	PEDIATRIC/PERINATAL/DENTAL - Monthly birthday POM messaging to parents of 3 to 17 year old members to schedule and complete their annual well child visit (WCV)	WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC)	CVH-All	1/31/2025	12/31/2025	NOT STARTED	Brittany Head		
10945	PEDIATRICS/ADOLESCENTS	Postpartum Outreach to Inpatient MCAL members after delivery.	PEDIATRIC/PERINATAL/DENTAL - Population Health new inpatient Transition of Care Team reaches out to members still in the hospital after delivery to schedule a postpartum visit, the first infant well care visit after discharge and enroll in the First Year of Life Program.	W30 - Well Child Visits in the First 30 Months of Life (previously W15),PPC - PPC - Postpartum Visit	CVH-All	1/1/2025	12/31/2025	PLANNING	Meena Dhonchak		

Work Plan ID	PODS	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	Planned End Date	Status	Department Owner	Mid-Year Update	Year End Update
10951	PEDIATRICS/ADOLESCENTS	PPC Compliance - Maternal Health Equity Resources and Trainings for Providers	PEDIATRIC/PERINATAL/DENTAL - Provide implicit bias training to OB providers. Provide maternal health equity resources and training links for providers.	PPC - Prenatal and Postpartum Care	CVH- All	1/1/2025	12/31/2025	ON TRACK	Meena Dhonchak		
10814	PEDIATRICS/ADOLESCENTS	LSC Quarterly Reporting	PEDIATRIC/PERINATAL/DENTAL - Quarterly UM/QI LSC reporting	LSC - Lead Screening in Children	CVH-All	1/1/2025	12/31/2025	ON TRACK	Linda Armbruster		
10932	PEDIATRICS/ADOLESCENTS	Health Disparity PIP W30-6+ Measure	PEDIATRIC/PERINATAL/DENTAL - W30-6+ CVH Health Disparity PIP: DHCS has assigned to CalViva Health for the 2023 to 2026 a performance improvement project. he topic is infant well care visits targeting improvements in the B/AA population.	W30 - Well Child Visits in the First 30 Months of Life (previously W15)	CVH - Fresno	1/1/2025	12/31/2025	ON TRACK	Meena Dhonchak		
10841	PEDIATRICS/ADOLESCENTS	Pfizer 1st Birthday IVR	PEDIATRIC/PERINATAL/DENTAL - Well Visit Program - sends IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1-year checkup.	CIS - Childhood Immunization Combo 10	CVH-All	1/1/2025	12/31/2025	NOT STARTED	Brittany Head		
10938	PEDIATRICS/ADOLESCENTS	Update Newborn Checklist	PEDIATRIC/PERINATAL/DENTAL- Update Infant Well Care Affinity Group Newborn Checklist in collaboration with HPSJ after hospital gateway newborn enrollment process is launched	W15 - Well Child Mth Six or more well child visits	CVH Counties	1/1/2025	12/31/2025	ON TRACK	Meena Dhonchak		
10844	PEDIATRICS/ADOLESCENTS	CIS-10/W30 Email Outreach	PEDIATRIC/PERINATAL/DENTAL- WCV and IZ reminder: Email outreach to encourage members to schedule their child's well visit and immunizations appointment.	W30 - Well Child Visits in the First 30 Months of Life (previously W15),CIS - Childhood Immunization Combo 10	CVH-All	1/1/2025	1/31/2025	NOT STARTED	Brittany Head		
10954	PEDIATRICS/ADOLESCENTS	Promote CDC'S Milestone Tracker APP	PEDIATRIC/PERINATAL/DENTAL: Promote the CDC's Milestone Tracker App by promoting in future newsletters, website locations, adding QR codes to our Provider QR resource, promote it to our Health Pregnancy and First Year of Life programs, etc.	CIS - Childhood Immunization Combination 3 Immunizations,CIS - Childhood Immunization Combo 10,CIS - Childhood Immunization Status,WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC),W15 - Well Child Mth Six or more well child visits,W30 - Well Child Visits in the First 30 Months of Life (previously W15)	CVH-ALL	1/1/2025	12/31/2025	ON TRACK	Meena Dhonchak		
10821	PEDIATRICS/ADOLESCENTS	PE training and QFT (Quality Focus Touchbase) for all Pediatric, Perinatal, Dental Measures Training on Pediatric HEDIS measures for MY 2024	PEDIATRIC/PERINATAL/DENTAL: QI PM to train Provider Engagement on MY2025 Pediatric, Perinatal and Dental HEDIS measures. Review action items for PE to take to improve rates. sing MY2023 Cozeva data, before the MY2024 caregap data is available.	CIS - Childhood Immunization Combo 10,LSC - Lead Screening in Children,W30 - Well Child Visits in the First 30 Months of Life (previously W15),WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC),ADV - Annual Dental All members,PPC - PPC - Postpartum Visit,PPC - PPC - Prenatal Visit (Timeliness)	CVH - All	1/1/2025	6/30/2025	ON TRACK	Juli Coulthurst		
10784	PEDIATRICS/ADOLESCENTS	CalViva Health Quarterly Dental POM	PEDIATRIC/PERINATAL/DENTAL-Dental POM calls to Health Net Medi-Cal members to promote dental checkup and topical fluoride applications.	ADV - Annual Dental All members	CVH-All Counties	1/1/2025	12/31/2025	ON TRACK	Maria Lin		
10891	PEDIATRICS/ADOLESCENTS	Q1-Gap Calls-WCV	PEDIATRICS/ADOLESCENTS - Member with WCV not completed in the prior year will get a call encouraging gap closure by seeing provider. If in the household another member has CIS10 (missing Flu only) gap and/or W30/30 those gaps will addressed as well.	WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC),CIS - Childhood Immunization Combo 10,W30 - Well Child Visits in the First 30 Months of Life (previously W15)	CVH-ALL	1/1/2025	3/31/2025	PLANNING	Alicia Bednar		
10947	PEDIATRICS/ADOLESCENTS	QI Referrals to SSFB	PERINATAL/PERINATAL/DENTAL - Health Equity QI is referring all Exchange pregnancies to SSFB. QI is referring Medi-Cal African-American/Black Pregnancies in Fresno County. Referrals will be sent to CM/SSFB monthly.	PPC - PPC - Postpartum Visit,W30 - Well Child Visits in the First 30 Months of Life (previously W15),PPC - Prenatal and Postpartum Care	CVH-Fresno	1/1/2025	12/31/2025	ON TRACK	Meena Dhonchak		

Work Plan ID	PODS	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	Planned End Date	Status	Department Owner	Mid-Year Update	Year End Update
10786	PHARMACY	Q1-Gap Calls-WCV	PHARMACY & RELATED MEASURES - member with WCV not completed in the prior year will get a call encouraging gap closure by seeing provider. If in the household another member has CIS10 (missing Flu only) gap and/or W30/30 those gaps will addressed as well.	WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC),CIS - Childhood Immunization Combo 10,W30 - Well Child Visits in the First 30 Months of Life (previously W15)	CVH-All	1/1/2025	3/31/2025	PLANNING	Alicia Bednar		
10795	PHARMACY	Kick It California - Smoking Cessation Services	PHARMACY & RELATED MEASURES - Explore expanding partnership with Kick It California (KIC) to outreach to members to facilitate program utilization and offer Nicotine Replacement Therapy (NRT) kits. Health plan will initiate outreach using notification letter to member prior to KIC outreaching to members. Contracts will need to be updated (SOW, BAA, MSA, IRQ Form etc.).	CAHPS - Adult-Smoking Advice	CVH - All	2/3/2025	12/31/2025	NOT STARTED	Justina Felix		
10747	PHARMACY	Community Supports Asthma Remediation Email Campaign	PHARMACY & RELATED MEASURES - Increase awareness of the Asthma Remediation Services Program to Medi-Cal members with a focus on asthma denominator.	AMR - Asthma Med Ratio Total 5 to 64	CVH-All	10/1/2024	6/30/2025	PLANNING	Justina Felix, Alicia Bednar		
10806	PHARMACY	Multi-Gap Family Unit (MCL) Live Call Outreach	PHARMACY & RELATED MEASURES - Measure are subject to change. Live calls via HEDIS team CSR's addressing barriers to accessing care for CVH Medi-cal members with multiple gaps. Call will occur between the health plan representatives and the member (includes inbound and outbound calls). The intention of this call is to inform the member of the importance of having preventive care visits / screenings. Callers offer members home tests that would be sent directly to member's home. During a call callers would inform about additional services, offer other resources as appropriate, and remind members about the myStrength tool. The call will also help to assess patient's access to medical care and underlying social determinants of health for possible referral to case management.	WCV - Child and Adolescent Well-Care Visits (previously W34 and AWC),BCS - Breast Cancer Screening,IMA - IMA - Adolescent Immunizations Combo 2,LSC - Lead Screening in Children,CBP - Controlling Blood Pressure,CCS - Cervical Cancer Screen - Pap Test,W30 - Well Child Visits in the First 30 Months of Life (previously W15),W15 - Well Child Mth Six or more well child visits,CIS - Childhood Immunization Combo 10	CVH-All	5/1/2025	12/31/2025	ON TRACK	Alicia Bednar		
11071	PREVENTATIVE CARE	CHL In-home screening	PREVENTATIVE CARE - Launch In-home screening campaign for CHL	CHL - Chlamydia Testing	TBD	1/21/2025	12/31/2025	NOT STARTED	Ravneet K. Gill		
10990	PREVENTATIVE CARE	COZEVA Notification In-Home COL Screening	PREVENTATIVE CARE - Submit QIRA request for an in-home screening notification as per in-home screening.	COL - Colorectal Cancer Screening	CVH-All	1/7/2025	12/31/2025	In Process	Justina B. Felix		
11062	PREVENTATIVE CARE	Office Hours - Alinea Mobile Mammography	PREVENTATIVE CARE - Update Alinea strategy to focus on specific target PPGs. Develop the updated process and share with Medical Affairs team.	BCS - Breast Cancer Screening	CVH-ALL	1/21/2025	1/21/2025	In Process	Ravneet K. Gill		
10997	PREVENTATIVE CARE	CalViva Pilot Program: CCS Self-Test	PREVENTATIVE CARE- CalViva - Explore a potential partnership with one CalViva PPG/Provider to better understand the feasibility of using CCS Self-Tests in the clinic setting.	CCS - Cervical Cancer Screen - Pap Test	CVH-ALL	1/7/2025	8/31/2025	In Process	Elisa H. Stomski		
10999	PREVENTATIVE CARE	CalViva - Every Woman Counts CBO Outreach - BCS, CCS for MCAL	PREVENTATIVE CARE- CalViva - Use monies that Health Net is granting Every Woman Counts (EWC) to conduct member reminder outreach for BCS and CCS.	BCS - Breast Cancer Screening,CCS - Cervical Cancer Screen - Pap Test	CVH-ALL	1/7/2025	9/30/2025	In Process	Elisa H. Stomski		
10998	PREVENTATIVE CARE	CalViva Text Message Campaign - BCS, CCS	PREVENTATIVE CARE- CalViva member text message reminders for BCS and CCS	BCS - Breast Cancer Screening,CCS - Cervical Cancer Screen - Pap Test	CVH-ALL	1/7/2025	8/31/2025	In Process	Elisa H. Stomski		

Work Plan ID	PODS	Intervention Name	Intervention Description	Measures	Counties/ Regions	Planned Start Date	Planned End Date	Status	Department Owner	Mid-Year Update	Year End Update
11005	PREVENTATIVE CARE	CalViva - FQHC Outreach for CCS, CHL Gap Closure	PREVENTATIVE CARE- Identify FQHCs in CalViva counties who are high volume/low performing in targeted counties. Work with our PE team to explore opportunities for member outreach by the FQHC, including outreach supported by EDGE funding.	CCS - Cervical Cancer Screen - Pap Test,CHL - Chlamydia Testing - Total	CVH-ALL	1/20/2025	11/17/2025	In Process	Elisa H. Stomski		
10793	PPG SUPPORT	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	4/1/2025	6/30/2025	NOT STARTED	Gladys Lazaro, Lora Maloof-Miller		

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 #7
Attachment 7.A

Financials as of 1/31/25

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of January 31, 2025

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	218,188,121.19
5	Total Bank Accounts	$ 218,188,121.19
6	Accounts Receivable	
7	Accounts Receivable	216,036,013.65
8	Total Accounts Receivable	$ 216,036,013.65
9	Other Current Assets	
10	Interest Receivable	996,390.92
11	Investments - CDs	0.00
12	Prepaid Expenses	984,911.59
13	Security Deposit	0.00
14	Total Other Current Assets	$ 1,981,302.51
15	Total Current Assets	$ 436,205,437.35
16	Fixed Assets	
17	Buildings	5,769,930.01
18	Computers & Software	24,888.80
19	Construction in Progress	0.00
20	Land	3,161,419.10
21	Office Furniture & Equipment	129,817.15
22	Total Fixed Assets	$ 9,086,055.06
23	Other Assets	
24	Investment -Restricted	301,772.40
25	Lease Receivable	1,734,537.82
26	Total Other Assets	$ 2,036,310.22
27	TOTAL ASSETS	$ 447,327,802.63
28	LIABILITIES AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	154,352.04
33	Accrued Admin Service Fee	4,735,412.00
34	Capitation Payable	119,420,520.09
35	Claims Payable	166,407.29
36	Directed Payment Payable	665,811.83
37	Total Accounts Payable	$ 125,142,503.25
38	Other Current Liabilities	
39	Accrued Expenses	1,245,284.81
40	Accrued Payroll	134,781.74
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	124,666,666.67
48	Total Other Current Liabilities	$ 147,438,912.59
49	Total Current Liabilities	$ 272,581,415.84
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	$ 272,607,322.63
55	Deferred Inflow of Resources	1,321,734.33
56	Equity	
57	Retained Earnings	161,689,933.96
58	Net Income	11,708,811.71
59	Total Equity	$ 173,398,745.67
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 447,327,802.63

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2024 - January 2025

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Income	6,792,100.86	2,500,000.00	4,292,100.86
3	Premium/Capitation Income	1,177,908,954.47	1,069,719,484.00	108,189,470.47
4	**Total Income**	**1,184,701,055.33**	**1,072,219,484.00**	**112,481,571.33**
5	Cost of Medical Care			
6	Capitation - Medical Costs	783,640,567.49	694,551,684.00	89,088,883.49
7	Medical Claim Costs	3,466,436.42	3,291,667.00	174,769.42
8	**Total Costs of Medical Care**	**787,107,003.91**	**697,843,351.00**	**89,263,652.91**
9	**Gross Margin**	**397,594,051.42**	**374,376,133.00**	**23,217,918.42**
10	Expenses			
11	Admin Service Agreement Fees	33,526,823.00	31,756,725.00	1,770,098.00
12	Bank Charges	0.00	4,200.00	(4,200.00)
13	Computer & IT Services	90,234.33	150,476.69	(60,242.36)
14	Consulting & Accreditation Fees	40,413.00	233,333.31	(192,920.31)
15	Depreciation Expense	197,872.36	217,000.00	(19,127.64)
16	Dues & Subscriptions	141,089.16	173,600.00	(32,510.84)
17	Grants	2,910,536.29	3,040,910.00	(130,373.71)
18	Insurance	203,967.17	261,083.06	(57,115.89)
19	Labor	2,490,088.36	2,892,220.00	(402,131.64)
20	Legal & Professional Fees	70,282.75	188,300.00	(118,017.25)
21	License Expense	867,867.92	831,341.56	36,526.36
22	Marketing	753,084.89	875,000.00	(121,915.11)
23	Meals and Entertainment	13,848.76	18,175.00	(4,326.24)
24	Office Expenses	52,539.79	66,500.00	(13,960.21)
25	Parking	214.98	910.00	(695.02)
26	Postage & Delivery	1,056.70	2,870.00	(1,813.30)
27	Printing & Reproduction	2,239.28	2,870.00	(630.72)
28	Recruitment Expense	(549.00)	91,875.00	(92,424.00)
29	Rent	0.00	7,000.00	(7,000.00)
30	Seminars & Training	10,478.71	17,200.00	(6,721.29)
31	Supplies	7,358.09	7,583.31	(225.22)
32	Taxes	344,666,666.67	328,854,166.69	15,812,499.98
33	Telephone & Internet	31,772.25	24,500.00	7,272.25
34	Travel	13,452.05	16,800.00	(3,347.95)
35	**Total Expenses**	**386,091,337.51**	**369,734,639.62**	**16,356,697.89**
36	**Net Operating Income**	**11,502,713.91**	**4,641,493.38**	**6,861,220.53**
37	Other Income			
38	Other Income	206,097.80	253,750.00	(47,652.20)
39	**Total Other Income**	**206,097.80**	**253,750.00**	**(47,652.20)**
40	**Net Other Income**	**206,097.80**	**253,750.00**	**(47,652.20)**
41	**Net Income**	**11,708,811.71**	**4,895,243.38**	**6,813,568.33**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

July 2024 - January 2025

		Total	
		July 2024 - Jan 2025	July 2023 - Jan 2024 (PY)
1	Income		
2	Interest Income	6,792,100.86	4,495,472.55
3	Premium/Capitation Income	1,177,908,954.47	1,234,218,289.26
4	**Total Income**	**1,184,701,055.33**	**1,238,713,761.81**
5	Cost of Medical Care		
6	Capitation - Medical Costs	783,640,567.49	764,620,469.73
7	Medical Claim Costs	3,466,436.42	775,132.53
8	**Total Costs of Medical Care**	**787,107,003.91**	**765,395,602.26**
9	**Gross Margin**	**397,594,051.42**	**473,318,159.55**
10	Expenses		
11	Admin Service Agreement Fees	33,526,823.00	33,569,371.00
12	Computer & IT Services	90,234.33	78,657.50
13	Consulting & Accreditation Fees	40,413.00	32,800.00
14	Depreciation Expense	197,872.36	191,062.90
15	Dues & Subscriptions	141,089.16	138,959.05
16	Grants	2,910,536.29	2,627,272.70
17	Insurance	203,967.17	204,814.45
18	Labor	2,490,088.36	2,111,502.27
19	Legal & Professional Fees	70,282.75	49,775.50
20	License Expense	867,867.92	737,944.08
21	Marketing	753,084.89	770,843.59
22	Meals and Entertainment	13,848.76	9,224.20
23	Office Expenses	52,539.79	40,176.04
24	Parking	214.98	109.00
25	Postage & Delivery	1,056.70	1,414.64
26	Printing & Reproduction	2,239.28	1,835.12
27	Recruitment Expense	(549.00)	1,003.41
28	Rent	0.00	0.00
29	Seminars & Training	10,478.71	4,484.14
30	Supplies	7,358.09	7,424.01
31	Taxes	344,666,666.67	423,384,970.14
32	Telephone & Internet	31,772.25	18,166.70
33	Travel	13,452.05	10,922.67
34	**Total Expenses**	**386,091,337.51**	**463,992,733.11**
35	**Net Operating Income**	**11,502,713.91**	**9,325,426.44**
36	Other Income		
37	Other Income	206,097.80	297,805.61
38	**Total Other Income**	**206,097.80**	**297,805.61**
39	**Net Other Income**	**206,097.80**	**297,805.61**
40	**Net Income**	**11,708,811.71**	**9,623,232.05**

Item #7
Attachment 7.B

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 2/2025 TGI Training Completed for CVH Staff that has direct Contact with members. No CVH provider pushback was recorded for this specific training

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. 1/2025 Goal identified: by 2028 increase the availability of diabetes and chronic disease prevention and management classes and programs. Objectives: Develop and promote 10 Diabetes Prevention Programs cohort per year. Expand access to these programs to at least 4 new partners per year. Look into health plans available in Madera County for partnership to offer reimbursement/ incentives for participants. Develop or enhance a current referral process that track these specific activities and develop a resource directory with service, support groups available.
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 3/2025: Mental Health Conference has been scheduled for April 4pm at Westside Church.
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. The first meeting is planned for 2/21/25. 3/2025: working on identifying provider champion in Kings County to assist with this project

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) 2/2025 DEI training was approved with minor edits
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. 3/2025- All Evidence for Health Equity was Submitted 3/11 for NCQA review

Item #7
Attachment 7.C

Medical Management
Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2025

Current as of End of the Month: January
Revised Date: 02/21/2025

CalViva - 2025																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2024**
Expedited Grievances Received	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	126
Standard Grievances Received	177	0	0	177	0	0	0	0	0	0	0	0	0	0	0	0	177	1761
Total Grievances Received	**184**	**0**	**0**	**184**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**184**	**1887**
Grievance Ack Letters Sent Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	10
Grievance Ack Letter Compliance Rate	**99.4%**	**0.0%**	**0.0%**	**99.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.44%**	**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	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	126
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	138	0	0	138	0	0	0	0	0	0	0	0	0	0	0	0	138	1702
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.9%**
Total Grievances Resolved	**145**	**0**	**0**	**145**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**145**	**1829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**130**	**0**	**0**	**130**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**130**	**1468**
Access - Other - DMHC	29	0	0	29	0	0	0	0	0	0	0	0	0	0	0	0	29	270
Access - PCP - DHCS	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	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	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	78
Administrative	21	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	21	186
Balance Billing	23	0	0	23	0	0	0	0	0	0	0	0	0	0	0	0	23	0
CalAim	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	122
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	339
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Transportation - Access	15	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	15	175
Transportation - Behavior	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	89
Transportation - Other	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	86
Quality Of Care Grievances	**15**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**361**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	60
PCP Care	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	94
PCP Delay	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	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	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	60
Specialist Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	24
Exempt Grievances Received	**183**	0	0	**183**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**183**	1885
Access - Avail of Appt w/ PCP	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	15
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Other	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	0
Access - Wait Time - wait too long on telephone	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	7
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Panel Disruption	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	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	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	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	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	14
Attitude/Service - Provider	10	0	0	**10**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**10**	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	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	12
Authorization - Authorization Related	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	6
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
Eligibility Issue - Member not eligible per Provider	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	48
Health Plan Materials - ID Cards-Not Received	27	0	0	**27**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**27**	210
Health Plan Materials - ID Cards-Incorrect Information on Card	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	2

Health Plan Materials - Other	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	4
Behavioral Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	58	0	0	**58**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**58**	652
PCP Assignment/Transfer - HCO Assignment - Change Request	19	0	0	**19**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**19**	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	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	37
PCP Assignment/Transfer - Rollout of PPG	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	7
PCP Assignment/Transfer - Mileage Inconvenience	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	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	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	65
Transportation - Access - Provider Late	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	32
Transportation - Behaviour	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	76
Transportation - Other	9	0	0	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**9**	53
OTHER - Other	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	14
Claims Complaint - Balance Billing from Provider	30	0	0	**30**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**30**	235

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	34
Standard Appeals Received	66	0	0	66	0	0	0	0	0	0	0	0	0	0	0	0	66	331
Total Appeals Received	**68**	**0**	**0**	**68**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**68**	**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%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.4%**
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	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	2	35
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**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	42	0	0	42	0	0	0	0	0	0	0	0	0	0	0	0	42	325
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.8%**
Total Appeals Resolved	**44**	**0**	**0**	**44**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**	**361**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**42**	**0**	**0**	**42**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**	353
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	9
CalAim	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	0
DME	10	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	10	37
Experimental/Investigational	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	162
Other	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	35
Pharmacy/RX Medical Benefit	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	47
Surgery	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	62
Transportation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Post Service Appeals	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	22	0	0	**22**	0	0	0	0	0	0	0	0	0	0	0	0	22	156
Uphold Rate	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**43.2%**
Overturns - Full	18	0	0	**18**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	18	194
Overturn Rate - Full	**40.9%**	**0.0%**	**0.0%**	**40.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**40.9%**	**53.7%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	10
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**0.0%**	**2.8%**
Withdrawal	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**4**	1
Withdrawal Rate	**9.1%**	**0.0%**	**0.0%**	**9.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**9.1%**	**0.3%**
Membership	428,829	0	0	**428,829**	0	0	0	**0.00%**	0	0	0	**0.00%**	0	0	0	**0.00%**	**428829**	430,517
Appeals - PTMPM	0.10	0	0	0.10	0	0	0	0.00%	0	0	0	0.00%	0	0	0	0.00%	0.10	0.09
Grievances - PTMPM	0.34	0	0	0.34	0	0	0	0.00%	0	0	0	0.00%	0	0	0	0.00%	0.34	0.24

CalViva Health Appeals and Grievances Dashboard (Fresno County)

Fresno County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2024**
Expedited Grievances Received	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	71
Standard Grievances Received	142	0	0	142	0	0	0	0	0	0	0	0	0	0	0	0	142	1694
Total Grievances Received	**146**	**0**	**0**	**146**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**146**	**1765**
Grievance Ack Letters Sent Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Grievance Ack Letter Compliance Rate	**99.3%**	**0.0%**	**0.0%**	**99.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.3%**	**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	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	71
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	110	0	0	110	0	0	0	0	0	0	0	0	0	0	0	0	110	1713
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.9%**
Total Grievances Resolved	**114**	**0**	**0**	**114**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**114**	**1785**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**101**	**0**	**0**	**101**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**101**	**1537**
Access - Other - DMHC	22	0	0	22	0	0	0	0	0	0	0	0	0	0	0	0	22	228
Access - PCP - DHCS	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	116
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	62
Administrative	16	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	16	364
Balance Billing	18	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0	18	244
CalAim	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	155
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	121
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Transportation - Access	12	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	12	92
Transportation - Behaviour	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	38
Transportation - Other	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	113
Quality Of Care Grievances	**13**	**0**	**0**	**13**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13**	**248**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Other	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	30
PCP Care	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	90
PCP Delay	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	62
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	39
Specialist Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	21

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	YTD
Expedited Appeals Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	22
Standard Appeals Received	48	0	0	48	0	0	0	0	0	0	0	0	0	0	0	0	48	375
Total Appeals Received	**50**	**0**	**0**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	50	**397**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	22
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
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	35	0	0	35	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	35	346
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**37**	**0**	**0**	**37**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**	**368**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**35**	**0**	**0**	**34**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**	**366**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Consultation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	28
CalAim	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	0
DME	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	63
Experimental/Investigational	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	9
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	130
Other	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	65
Pharmacy/RX Medical Benefit	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	30
Surgery	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	40
Transportation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Post Service Appeals	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**3**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CalAim	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	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	19	0	0	**19**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	19	134
Uphold Rate	**51.4%**	**0.0%**	**0.0%**	**51.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**51.4%**	**36.4%**
Overturns - Full	14	0	0	**14**													14	213
Overturn Rate - Full	**37.8%**	**0.0%**	**0.0%**	**37.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.8%**	**57.9%**
Overturns - Partials	0	0	0	**0**													0	15
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%**	**4.1%**
Withdrawal	4	0	0	**4**													4	6
Withdrawal Rate	**10.8%**	**0.0%**	**0.0%**	**10.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**10.8%**	**1.6%**
Membership	340,965	0	0	**340,965**	0	0	0	**0**	0	0	0	**0**	0	0	0	**(340,965)**	**(340,965)**	
Appeals - PTMPM	0.11	0	0	0.11	0	0	0	0.00	0	0	0	0.00	0	0	0	0.00	0.04	0.06
Grievances - PTMPM	0.33	0	0	0.33	0	0	0	0.00	0	0	0	0.00	0	0	0	0.00	0.04	0.32

Kings County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2024**
Expedited Grievances Received	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	8
Standard Grievances Received	14	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	14	143
Total Grievances Received	**15**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**151**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**1**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	8
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	15	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	15	144
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Grievances Resolved	**16**	**0**	**0**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	16	**152**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**137**
Access - Other - DMHC	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	18
Access - PCP - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	8
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Administrative	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	33
Balance Billing	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	16
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	11
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	0	0	0	0	0	0	0	0	0	0	0	1	9
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Transportation - Access	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	11
Transportation - Behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Transportation - Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	22
Quality Of Care Grievances	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**15**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	0	0	0	0	0	0	0	0	0	0	0	1	2
PCP Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

CalViva Health Appeals and Grievances Dashboard (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Standard Appeals Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	21
Total Appeals Received	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	2	**23**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**1**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	21
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Total Appeals Resolved	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**23**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**23**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
CalAim	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	2
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Surgery	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
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
CalAim	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	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	11
Uphold Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**47.8%**
Overturns - Full	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	11
Overturn Rate - Full	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**47.8%**
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%**	**0.00%**
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%**	**4.3%**
Membership	**38,244**	0	0	**38244**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**38244**	
Appeals - PTMPM	0.03	0	0	0.03	0	0	0	0.00	0	0	0	0.00	0	0	0	0.00	0.01	**0.05**
Grievances - PTMPM	0.42	0	0	0.42	0	0	0	0.00	0	0	0	0.00	0	0	0	0.00	0.14	**0.33**

Madera County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2024
Expedited Grievances Received	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	7
Standard Grievances Received	21	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	21	189
Total Grievances Received	**23**	**0**	**0**	**23**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**23**	**196**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	7
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13	190
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**15**	**0**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**197**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**0**	**0**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**168**
Access - Other - DMHC	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	25
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	7
Administrative	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	33
Balance Billing	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	20
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
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	14
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Transportation - Access	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	23
Transportation - Behaviour	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3
Transportation - Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	11
Quality Of Care Grievances	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**29**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
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	8
PCP Care	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	7
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2

CalViva Health Appeals and Grievances Dashboard (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Received	16	0	0	16	0	0	0	0	0	0	0	0	0	0	0		16	66
Total Appeals Received	**16**	**0**	**0**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	16	**67**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	6	0	0	6	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	6	63
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**6**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**64**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**6**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**64**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	11
Experimental/Investigational	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
Advanced Imaging	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	27
Other	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Surgery	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	4
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CalAim	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	3	0	0	**3**	0	0	0	**0**	0	0	0		0	0	0		3	**25**
Uphold Rate	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	**39.1%**
Overturns - Full	3	0	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	3	35
Overturn Rate - Full	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**50.0%**	**54.7%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	4
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%**	**6.3%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Membership	49,620	0	0	**16,540**	0	0	0	**0.00%**	0	0	0	**0.00%**	0	0	0	**0.00%**	**16,540**	
Appeals - PTMPM	0.12	0	0	0.36	0	0	0	0.00	0		0	0.00	0	0	0	0.00	0.04	**0.11**
Grievances - PTMPM	0.30	0	0	0.91	0	0	0	0.00	0		0	0.00	0	0	0	0.00	0.04	**0.33**

CalViva SPD only																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**YTD**	**2024**
Expedited Grievances Received	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	1	19
Standard Grievances Received	59	0	0	59	0	0	0	0	0	0	0	0	0	0	0	59	59	612
Total Grievances Received	**60**	**0**	**0**	60	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**60**	**60**	**631**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.00%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	19
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	51	0	0	51	0	0	0	0	0	0	0	0	0	0	0	0	51	607
Standard Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.8%**
Total Grievances Resolved	**52**	**0**	**0**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**627**
Grievance Descriptions - Resolved Cases	**52**	**0**	**0**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**627**
Access to primary care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35
Access to specialists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	87
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	0	0	0	0	0	0	0	0	0	0	0	1
Other	26	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	151
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	55
QOS Non Access	24	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24	280
Exempt Grievances Received	**26**	0	0	**26**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**26**	**187**
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
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	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
Access - Wait Time - in office for appt	1	0	0	**1**	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**	0
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Attitude/Service - Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	24
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Vendor	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	22
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Authorization - Authorization Related	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	6
Health Plan Materials - ID Cards-Not Received	5	0	0	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	26
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Health Plan Materials - Other	1	0	0	**1**	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
PCP Assignment/Transfer - Health Plan Assignment - Change Request	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	18
PCP Assignment/Transfer - HCO Assignment - Change Request	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	25
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Rollout of PPG	1	0	0	**1**	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**	0

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	7	0	0	**7**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	15
Claims Complaint - Balance Billing from Provider	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	30

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**	**YTD**
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	3
Standard Appeals Received	23	0	0	23	0	0	0	0	0	0	0	0	0	0	0	0	**23**	132
Total Appeals Received	**23**	**0**	**0**	**23**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**23**	**135**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Appeals Ack Letter Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Standard Appeals Resolved Compliant	13	0	0	13	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**13**	126
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**13**	**0**	**0**	**13**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13**	**129**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**9**	**0**	**0**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**125**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17
CalAim	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	37
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Behavioral Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	29
Other	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	25
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Surgery	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	10
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	8	0	0	**8**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	8	51
Uphold Rate	**61.5%**	**0.0%**	**0.0%**	**61.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**61.5%**	**39.5%**
Overturns - Full	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	4	72
Overturn Rate - Full	**30.8%**	**0.0%**	**0.0%**	**30.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**30.8%**	**55.81%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	6
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%**	**4.7%**
Withdrawal	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	5
Withdrawal Rate	**7.7%**	**0.0%**	**0.0%**	**7.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**7.7%**	**3.9%**
Membership	47,731	0	0	**15,910**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**15,910**	
Appeals - PTMPM	0.27	0	0	0.82	0	0	0	0.00	0	0	0	0.00	0	0	0	0.00	0.09	**0.15**
Grievances - PTMPM	1.09	0	0	3.27	0	0	0	0.00	0	0	0	0.00	0	0	0	0.00	0.36	**0.65**

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 #7
Attachment 7.D

Medical Management
Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 1/01/2025 to 1/31/2025

Report created 2/25/2025

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:

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

Contact Information

Sections	Contact Person
Concurrent Inpatient TAT Metric	
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	Loren Hillburn
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.con

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 1/01/2025 to 1/31/2025
Report created 2/25/2025

ER utilization based on Claims data	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
MEMBERSHIP															**Quarterly Averages**									**Annual Averages**		
Expansion Mbr Months	119,572	119,992	120,073	120,279	120,769	122,044	122,125	122,163	122,244	121,961	121,430		121,277		118,378	120,374	122,111	121,878	40,426	0	0	0		120,685	121,277	
Adult/Family/O TLIC Mbr Mos	267,059	267,730	267,209	266,454	266,050	266,607	265,991	264,882	264,720	263,023	261,420		261,031		265,833	266,571	265,827	263,054	87,010	0	0	0		265,321	261,031	
Aged/Disabled Mbr Mos	47,506	47,234	46,940	46,026	46,962	47,175	47,366	47,622	47,822	48,280	48,512		47,624		47,003	46,643	47,388	48,205	15,875	0	0	0		47,310	47,624	
COUNTS																										
Admits - Count	2,114	2,173	2,024	2,195	2,183	2,278	2,224	2,150	2,112	2,039	2,081		2,170		2,181	2,134	2,217	2,077	1,001	0	0	0		2,152	3,003	
Expansion	692	672	669	746	753	761	775	705	692	677	716		811		707	723	747	695	367	0	0	0		718	1,101	
Adult/Family/O TLIC	858	945	862	930	904	943	911	969	905	871	862		918		908	899	941	879	432	0	0	0		907	1,297	
Aged/Disabled	564	556	493	519	526	574	538	476	515	491	503		441		566	513	529	503	202	0	0	0		528	605	
Admits Acute - Count	1,438	1,436	1,384	1,451	1,425	1,508	1,455	1,365	1,354	1,346	1,385		1,476		1,430	1,419	1,424	1,420	1,461	0	0	0		1,414	2,040	
Expansion	546	515	528	590	592	599	598	560	532	541	582		656		538	570	586	552	295	0	0	0		561	884	
Adult/Family/O TLIC	460	493	452	465	422	466	411	411	416	425	379		451		468	446	429	407	218	0	0	0		438	655	
Aged/Disabled	432	428	404	396	411	443	446	394	406	380	424		369		424	404	428	403	167	0	0	0		415	501	
Readmit 30 Day - Count	259	241	225	256	276	240	260	233	253	231	245		150		247	252	244	243	51	0	0	0		247	154	
Expansion	92	95	88	108	124	100	103	83	83	88	105		77		94	107	95	92	26	0	0	0		97	79	
Adult/Family/O TLIC	48	35	50	51	44	37	43	46	50	38	38		23		40	48	42	42	8	0	0	0		43	23	
Aged/Disabled	119	111	87	97	108	103	114	104	120	105	102		50		113	97	107	109	17	0	0	0		107	52	
**ER Visits - Count	13,732	14,728	14,871	15,842	14,971	14,694	14,308	14,606	14,399	13,515	13,854		7,875		14,073	15,228	14,536	13,923	2,625	0	0	0		14,440	7,875	
Expansion	3,523	3,826	3,943	4,171	4,221	4,425	4,321	4,276	4,144	3,664	3,773		2,339		3,704	4,112	4,341	3,860	780	0	0	0		4,004	2,339	
Adult/Family/O TLIC	8,320	8,930	8,964	9,622	8,652	8,128	8,150	8,574	8,552	8,202	8,396		4,790		8,474	9,079	8,284	8,383	1,597	0	0	0		8,555	4,790	
Aged/Disabled	1,889	1,972	1,964	2,049	2,098	2,141	1,837	1,756	1,703	1,649	1,685		746		1,895	2,037	1,911	1,679	249	0	0	0		1,881	746	
PER/K																										
Admits Acute - PTMPY	39.7	39.6	38.2	40.2	39.4	41.5	40.1	37.7	37.4	37.3	38.5		41.2		39.8	39.3	39.2	39.3	122.4	0	0	0		39.1	56.9	
Expansion	54.8	51.5	52.8	58.9	58.8	58.9	58.8	55.0	52.2	53.2	57.5		64.9		54.5	56.8	57.6	54.3	87.5	0	0	0		55.8	87.5	
Adult/Family/O TLIC	20.7	22.1	20.3	20.9	19.0	21.0	18.5	18.6	18.9	19.4	17.4		20.7		21.1	20.1	19.4	18.6	30.1	0	0	0		19.8	30.1	
Aged/Disabled	109.1	108.7	103.3	103.2	105.0	112.7	113.0	99.3	101.9	94.4	104.9		93.0		108.2	103.9	108.3	100.4	126.2	0	0	0		105.2	126.2	
Bed Days Acute - PTMPY	208.7	212.8	205.6	201.4	205.5	205.2	197.2	185.8	176.2	186.0	194.8		202.0		215.1	204.2	196.1	185.6	274.6	0	0	0		200.2	274.6	
Expansion	313.5	318.7	325.8	291.5	337.7	315.5	282.1	285.4	243.0	279.9	309.0		330.6		322.8	318.4	294.3	277.2	437.1	0	0	0		303.0	437.1	
Adult/Family/O TLIC	74.8	82.9	73.3	81.6	66.6	72.0	68.9	69.9	74.3	70.8	70.6		81.0		79.5	73.9	70.3	71.9	121.7	0	0	0		73.9	121.7	
Aged/Disabled	697.7	680.6	651.4	659.4	652.6	672.3	698.5	575.5	569.4	576.1	578.6		537.7		710.8	654.4	648.6	574.7	699.2	0	0	0		646.7	699.2	
ALOS Acute	5.3	5.4	5.4	5.0	5.2	4.9	4.9	4.9	4.7	5.0	5.1		4.9		5.4	5.2	5.0	4.7	2.2	#DIV/0!	#DIV/0!	#DIV/0!		5.1	4.8	
Expansion	5.7	6.2	6.2	5.0	5.7	5.4	4.8	5.2	4.7	5.3	5.4		5.1		5.9	5.6	5.1	5.1	5.0	#DIV/0!	#DIV/0!	#DIV/0!		5.4	5.0	
Adult/Family/O TLIC	3.6	3.8	3.6	3.9	3.5	3.4	3.7	3.8	3.9	3.7	4.1		3.9		3.8	3.7	3.6	3.9	4.0	#DIV/0!	#DIV/0!	#DIV/0!		3.7	4.0	
Aged/Disabled	6.4	6.3	6.3	6.4	6.2	6.0	6.2	5.8	5.6	6.1	5.5		5.8		6.6	6.3	6.0	5.7	5.5	#DIV/0!	#DIV/0!	#DIV/0!		6.1	5.5	
Readmit % 30 Day	12.3%	11.1%	11.1%	11.7%	12.6%	10.5%	11.7%	10.8%	12.0%	11.3%	11.8%		6.9%		11.3%	11.8%	11.0%	11.7%	5.1%	#DIV/0!	#DIV/0!	#DIV/0!		11.5%	5.1%	
Expansion	13.3%	14.1%	13.2%	14.5%	16.5%	13.1%	13.3%	11.8%	12.0%	13.0%	14.7%		9.5%		13.3%	14.8%	12.8%	13.2%	7.2%	#DIV/0!	#DIV/0!	#DIV/0!		13.5%	7.2%	
Adult/Family/O TLIC	5.6%	3.7%	5.8%	5.5%	4.9%	3.9%	4.7%	4.7%	5.5%	4.4%	4.4%		2.5%		4.4%	5.4%	4.5%	4.8%	1.8%	#DIV/0!	#DIV/0!	#DIV/0!		4.8%	1.8%	
Aged/Disabled	21.1%	20.0%	17.6%	18.7%	20.5%	17.9%	21.2%	21.8%	23.3%	21.4%	20.3%		11.3%		19.9%	19.0%	20.2%	21.7%	8.6%	#DIV/0!	#DIV/0!	#DIV/0!		20.2%	8.6%	
**ER Visits - PTMPY	379.6	406.3	411.0	439.3	414.2	404.6	394.3	403.2	397.4	374.3	385.4		219.8		391.6	421.5	400.7	385.7	219.8	0	0	0		399.9	219.8	
Expansion	353.6	382.6	394.1	416.1	419.4	435.1	424.6	420.0	406.8	360.5	372.9		231.4		375.5	409.9	426.6	380.1	231.4	0	0	0		398.1	231.4	
Adult/Family/O TLIC	373.8	400.3	402.6	433.3	390.2	365.8	367.7	388.4	387.7	374.2	385.4		220.2		382.5	408.7	374.0	382.4	220.2	0	0	0		386.9	220.2	
Aged/Disabled	477.2	501.0	502.1	534.2	536.1	544.6	465.4	442.5	427.3	409.9	416.8		188.0		483.9	524.1	484.0	418.0	188.0	0	0	0		477.0	188.0	
Services	TAT Compliance Goal: 100%												Compliance Goal: 1		TAT Compliance Goal: 100%									TAT Compliance Goal: 100%		
Preservice Routine	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%	94.6%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%				
Preservice Urgent	100.0%	96.0%	94.0%	98.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%		100.0%		98.2%	96.9%	99.1%	100.0%	0.0%	0.0%	0.0%	0.0%				
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%	0.0%	0.0%	0.0%	0.0%				
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%	0.0%	0.0%	0.0%	0.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		94.0%		100.0%	99.1%	99.1%	100.0%	0.0%	0.0%	0.0%	0.0%				
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%	0.0%	0.0%	0.0%	0.0%				
Deferrals - Post Service	null	null	NA	NA	NA	NA	NA	NA	NA	NA	NA		null		null	null	null	null	null	null	null	null				
	CCS ID RATE												CS ID RAT		CCS ID RATE									CCS ID RATE		
CCS %	7.59%	7.63%	8.57%	8.53%	8.47%	8.50%	8.52%	8.51%	8.52%	8.55%	8.51%		8.43%		7.59%	8.52%	8.51%	8.51%	0.00%	0.00%	0.00%	0.00%		8.28%	8.43%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand												ternity Utilizatin AL Rate Per Thousand		Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand											
Births	12.8	13.8	12.6	13.9	14.8	15.3	15.6	16.7	15.4	13.9	14.9		14.9		13.8	13.8	15.9	14.7	-	-	-	-		14.5		
OB % Days	2.1%	3.0%	3.3%	3.5%	3.1%	4.3%	4.9%	6.8%	6.6%	5.8%	8.1%		9.7%		2.1%	3.3%	5.3%	6.8%	-	-	-	-		17.0%		
OB % Admits	21.1%	22.7%	22.0%	22.6%	23.8%	24.1%	25.1%	27.7%	25.8%	24.1%	25.3%		24.4%		21.9%	22.8%	25.6%	25.1%	-	-	-	-		30.0%		

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 1/01/2025 to 1/31/2025
Report created 2/25/2025

ER utilization based on Claims data	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
	Perinatal Case Management												natal Case Managen						Perinatal Case Management					Perinatal Case Management		
Total Number Of Referrals	203	163	280	257	64	134	137	203	196	157	134		231		686	601	474	487	0	0	0	0		2,248	231	
Pending	0	0	0	0	0	0	0	0	0	1	21		31		0	0	0	22	0	0	0	0		22	31	
Ineligible	21	9	10	9	18	17	13	14	27	17	15		16		40	37	44	59	0	0	0	0		180	16	
Total Outreached	182	154	270	248	46	117	124	189	169	139	98		184		646	564	430	406	0	0	0	0		2,046	184	
Engaged	137	103	145	160	41	103	105	87	71	77	51		106		466	346	295	199	0	0	0	0		1,306	106	
Engagement Rate	75%	67%	54%	65%	89%	88%	85%	46%	42%	55%	52%		58%		72%	61%	69%	49%	0%	0%	0%	0%		64%	58%	
Total Cases Managed	687	603	612	619	505	489	422	392	383	368	346		277		937	809	670	513	0	0	0	0		1779	277	
Total Cases Closed	184	136	152	153	119	164	102	68	88	58	82		70		471	424	334	228	0	0	0	0		1,457	70	
Cases Remained Open	509	442	439	467	388	318	295	306	287	291	247		199		442	388	306	247	0	0	0	0		247	199	
	Physical Health Case Management												l Health Case Mana						Physical Health Case Management					ysical Health Case Managem		
Total Number Of Referrals	274	314	268	343	189	224	272	173	313	177	153		168		774	800	669	643	0	0	0	0		2,886	168	
Pending	0	0	0	0	1	1	0	1	2	1	12		17		0	1	2	15	0	0	0	0		18	17	
Ineligible	23	33	37	79	18	4	25	14	12	8	4		2		81	134	43	24	0	0	0	0		282	2	
Total Outreached	251	281	231	264	170	219	247	158	299	168	137		149		693	665	624	604	0	0	0	0		2,586	149	
Engaged	123	138	119	123	77	103	107	67	114	69	82		95		339	319	277	265	0	0	0	0		1,200	95	
Engagement Rate	49%	49%	52%	47%	45%	47%	43%	42%	38%	41%	60%		64%		49%	48%	44%	44%	0%	0%	0%	0%		46%	64%	
Total Screened and Refused/Decline	33	39	29	38	15	26	43	27	62	35	16		9		108	82	96	113	0	0	0	0		399	9	
Unable to Reach	95	104	83	103	78	90	97	64	123	64	39		45		246	264	251	226	0	0	0	0		987	45	
Total Cases Closed	105	89	76	106	94	110	109	85	96	83	88		58		312	276	304	267	0	0	0	0		1,159	58	
Cases Remained Open	252	296	350	376	339	331	324	300	323	297	300		277		296	339	300	300	0	0	0	0		300	277	
Total Cases Managed	372	405	435	484	441	450	444	402	429	401	398		342		622	615	601	582	0	0	0	0		1479	342	
Complex Case	59	64	62	65	65	62	51	46	45	45	40		33		99	86	69	60	0	0	0	0		176	33	
Non-Complex Case	313	341	373	419	376	388	393	356	384	356	358		309		523	529	532	522	0	0	0	0		1303	309	
	Transitional Care Services												nsitional Care Servi						Transitional Care Services							
Total Number Of Referrals	291	147	128	238	431	493	611	641	827	680	572		573		704	797	1745	2079	0	0	0	0		5,325	573	
Pending	0	0	0	0	0	0	0	0	2	8	117		15		0	0	0	127	0	0	0	0		127	15	
Ineligible	40	14	7	6	13	3	17	4	22	12	7		3		97	26	24	41	0	0	0	0		188	3	
Total Outreached	251	133	121	232	418	490	594	637	803	660	448		555		607	771	1721	1911	0	0	0	0		5,010	555	
Engaged	164	110	88	146	232	321	359	402	440	346	246		478		375	466	1082	1032	0	0	0	0		2,955	478	
Engagement Rate	65%	83%	73%	63%	56%	66%	60%	63%	55%	52%	55%		86%		62%	60%	63%	54%	0%	0%	0%	0%		59%	86%	
Total Screened and Refused/Decline	24	3	9	6	24	36	33	34	35	34	27		10		58	39	103	96	0	0	0	0		296	10	
Unable to Reach	63	20	24	80	162	133	202	201	328	280	175		67		174	266	536	783	0	0	0	0		1,759	67	
Total Cases Closed								310	343	354	326		308		279	298	795	1023	0	0	0			2,395	308	
Cases Remained Open	132	107	92	109	233	305	386	423	490	419	383		298		107	233	423	383	0	0	0	0		383	298	
Total Cases Managed	204	260	211	245	387	608	735	849	938	932	797		645		399	587	1148	1560	0	0	0	0		2,981	645	
	Behavioral Health Care Management												al Health Care Man						Behavioral Health Care Management					avioral Health Care Managen		
Total Number Of Referrals	94	73	68	138	81	115	122	83	98	94	88		133		245	287	320	280	0	0	0	0		1,132	133	
Pending	0	0	0	0	0	0	0	0	0	0	11		19		0	0	0	11	0	0	0	0		11	19	
Ineligible	5	2	2	5	6	2	6	5	3	2	1		12		14	13	13	6	0	0	0	0		46	12	
Total Outreached	89	71	66	133	75	113	116	78	95	92	76		102		231	274	307	263	0	0	0	0		1,075	102	
Engaged	73	52	35	65	52	73	82	58	78	68	52		77		162	152	213	198	0	0	0	0		725	77	
Engagement Rate	82%	73%	53%	49%	69%	65%	71%	74%	82%	74%	68%		75.0%		70%	55%	69%	75%	0%	0%	0%	0%		67%	75%	
Total Screened and Refused/Decline	2	1	7	10	1	1	5	0	1	3	1		1		5	18	6	5	0	0	0	0		34	1	
Unable to Reach	14	18	24	58	22	39	29	20	16	21	23		24		64	104	88	60	0	0	0	0		316	24	
Total Cases Closed	27	31	55	60	36	63	50	60	71	53	52		44		93	151	173	176	0	0	0	0		593	44	
Cases Remained Open	119	142	121	127	141	145	160	152	152	157	161		153		142	141	152	161	0	0	0	0		161	153	
Total Cases Managed	150	176	182	193	184	217	233	234	243	240	232		203		237	297	341	366	0	0	0	0		801	203	
Complex Case	11	10	10	15	13	17	14	19	20	18	16		15		19	19	25	23	0	0	0	0		51	15	
Non-Complex Case	139	166	172	178	171	200	219	215	223	222	216		188		218	278	316	343	0	0	0	0		750	188	

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ER utilization based on Claims data	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2024-Trend	2025-01	2025-Trend	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Qtr Trend	CY- 2024	YTD-2025	YTD-Trend
	First Year of Life Care Management												Year of Life Care Manage		First Year of Life Care Management									First Year of Life Care Management		
Total Number Of Referrals	29	47	35	29	22	56	34	25	25	24	28		34		108	86	115	77	0	0	0	0		386	34	
Pending	0	0	0	0	0	0	0	0	0	0	0		0		0	0	0	0	0	0	0	0		0	0	
Ineligible	0	0	0	0	0	0	0	0	0	0	0		0		2	1	2	0	0	0	0	0		5	0	
Total Outreached	0	0	0	0	0	0	0	0	25	24	28		34		106	85	113	77	0	0	0	0		381	34	
Engaged	0	0	0	0	0	0	0	0	24	24	28		34		106	85	103	76	0	0	0	0		370	34	
Engagement Rate	0%	0%	0%	0%	0%	0%	0%	0%	96%	100%	100%		100.0%		100.0%	100.0%	91.0%	99.0%	0.0%	0.0%	0.0%	0%		97.0%	100.0%	
Total Screened and Refused/Decline	0	0	0	0	0	0	0	0	1	0	0		0		0	0	4	1	0	0	0	0		5	0	
Unable to Reach	0	0	0	0	0	0	0	0	0	0	0		0		0	0	6	0	0	0	0	0		6	0	
Total Cases Closed	0	0	0	0	0	0	0	0	21	27	23		24		20	28	37	71	0	0	0	0		156	24	
Cases Remained Open	0	0	0	0	0	0	0	0	319	317	322		278		196	254	319	322	0	0	0	0		322	278	
Total Cases Managed	0	0	0	0	0	0	0	0	342	345	346		303		217	282	357	394	0	0	0	0		480	303	

Item #7
Attachment 7.E

Medical Management
Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: March 20, 2025

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2025

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2025 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 20th, 2025. At the February meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the third quarter for 2024 were reviewed for delegated entities and for the fourth quarter 2024 for Health Net including Behavioral Health. Quarter 3 data for all organizations is summarized in Table 1. below.

III. Table 1. Quarter 3 2024 Credentialing/Recredentialing,

	Sante	ChildNet	BH	HN	LaSalle	ASH	Envolve	IMG	CVMP	Adventist	UPN	Totals
Initial credentialing	45	28	30	7	89	0	1	5	47	37	43	**332**
Recredentialing	121	83	12	3	48	0	10	29	26	36	14	**382**
Suspensions	0	0	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	0	**0**
Totals	**166**	**111**	**42**	**10**	**137**	**0**	**11**	**34**	**73**	**73**	**57**	**714**

IV. **The 2024 Adverse Events Report** for fourth quarter (October through December) was presented to the Credentialing Sub-Committee. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period.

- There were no (0) cases identified in Q4 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no reconsiderations or fair hearings during the fourth quarter of 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. (NCQA CR.5.A.4)

V. The **Access & Availability Substantial Harm Report Q4 2024** was presented and reviewed. The purpose of this report is to identify incidents involving 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 fourth 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).

VI. **Credentialing Adverse Actions** for Q4 for CalViva Credentialing Sub-Committee from Health Net Credentialing Committee was presented. There was one (1) case presented for discussion for October, November, and December for CalViva Health. The Medical Board of California issued the practitioner a public letter of reprimand, with terms and conditions to include and not limited to: 1) The practitioner shall complete an education course. 2) The practitioner shall complete a medical recordkeeping course. The case will be monitored to ensure compliance with the Medical Board terms and conditions.

VII. Follow-up activities will be scheduled, and ongoing monitoring and reporting will continue.

Item #7
Attachment 7.F

Medical Management
Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD, Chief Medical Officer Amy R. Schneider, RN, Senior Director Medical Management
COMMITTEE DATE:	March 20, 2025
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2025

Purpose of Activity:

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

I. The Peer Review Sub-Committee met on February 20th, 2025. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2024 were reviewed for approval. There were no significant cases to report.

II. The **2024 Adverse Events Report for Q4** 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 11 cases identified in Q4 that met the criteria for reporting and were submitted to the Peer Review Committee. Four (4) of these cases involved a practitioner and seven (7) cases involved organizational providers (facilities).
- Of the 11 cases, six (6) were tabled, zero (0) were deferred, zero (0) were closed to track and trend with a letter of concern, two (2) were closed to track and trend with a letter of education, and three (3) were closed to track and trend.
- Six (6) cases were quality of care grievances, three (3) were potential quality issues, zero were lower level, and zero were track and trend.

- Three (3) 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 Q4.
- There were no (0) cases that met the Peer Review trended criteria for escalation.
- There was one (1) case identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4)
- There were 23 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management.

III. **The Access & Availability Substantial Harm Report for Q4 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 severity level.

- Fifteen* (15) cases were submitted to the Peer Review Committee in Q4 2024. There were four (4) incidents 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. *One case appeared twice in the quarter.
- There were zero (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in Q4 2024.

IV. **Quarter 3, 2024 Peer Count Report** was presented at the meeting with a total of 15 cases reviewed. The outcomes for these cases are as follows:

- There were nine (9) cases closed and cleared. There were six (6) cases tabled for further information.

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

Item #7

Attachment 7.G

Executive Dashboard

	2024	2024	2024	2024	2024	2024	2024	2024	2024	2024	2024	2024	2025
Month	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**
CVH Members													
Fresno	343,493	347,888	348,065	348,349	347,954	347,975	349,399	348,729	347,975	348,113	346,388	344,539	343,331
Kings	38,232	38,901	38,877	38,831	38,563	38,404	38,370	38,254	38,133	38,078	38,137	38,356	38,319
Madera	46,717	48,656	48,684	48,579	48,666	48,888	49,258	49,373	49,507	49,666	49,757	49,814	49,686
Total	428,442	435,445	435,626	435,759	435,183	435,267	437,027	436,356	435,615	435,857	434,282	432,709	431,336
SPD	47,393	47,212	47,029	46,869	46,763	46,841	47,066	47,185	47,411	47,615	48,116	48,373	47,384
CVH Mrkt Share	67.15%	66.84%	66.83%	66.81%	66.83%	66.85%	66.90%	66.92%	66.92%	66.91%	66.87%	66.86%	66.70%
ABC Members													
Fresno	151,485	155,843	155,594	155,721	155,374	155,027	155,215	154,520	154,078	154,265	153,460	152,518	152,847
Kings	25,311	25,600	25,550	25,522	25,234	25,053	24,915	24,819	24,689	24,659	24,681	24,705	24,836
Madera	28,693	29,862	29,595	29,230	28,949	28,785	28,665	28,541	28,385	28,149	27,966	27,944	27,940
Total	205,489	211,305	210,739	210,473	209,557	208,865	208,795	207,880	207,152	207,073	206,107	205,167	205,623
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	8,130
Kings	2	54	67	87	98	102	113	121	129	154	153	171	187
Madera	574	673	800	884	918	987	1,054	1,098	1,151	1,202	1,253	1,302	1,372
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	9,689
Default													
Fresno	48.76%	57.21%	55.65%	57.56%	59.38%	64.17%	56.65%	59.99%	55.98%	58.51%	57.19%	60.02%	
Kings	62.64%	53.82%	55.67%	56.78%	57.36%	57.76%	53.88%	53.85%	54.72%	54.02%	47.49%	56.30%	
Madera	55.86%	54.76%	61.60%	65.92%	72.97%	77.26%	61.66%	65.08%	66.39%	72.04%	57.60%	81.46%	
County Share of Choice as %													
Fresno	66.82%	59.92%	62.71%	62.52%	62.40%	64.25%	62.86%	62.71%	62.50%	63.30%	63.27%	59.51%	
Kings	65.78%	62.47%	63.07%	65.75%	67.10%	65.56%	66.07%	58.59%	61.86%	69.74%	62.45%	60.92%	
Madera	69.02%	58.71%	60.62%	65.83%	58.80%	62.24%	65.38%	68.13%	69.84%	65.30%	64.17%	63.15%	

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 were provided during the February 20, 2025 RHA Commission Meeting. At present time, there are no other significant issues or concerns as it pertains to the Plan's Call Center and Website activities. The Plan is launching a Member Portal for the CalViva Health Membership on March 18, 2025.							

Provider Network & Engagement Activities	**Year**	**2024**	**2024**	**2024**	**2024**	**2024**	**2024**	**2025**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**156**	**158**	**157**	**157**	**160**	**161**	**161**
	PCP	**409**	**418**	**423**	**433**	**434**	**435**	**440**
	PCP Extender	**413**	**442**	**440**	**455**	**447**	**439**	**450**
	Specialist	**1531**	**1563**	**1565**	**1574**	**1612**	**1623**	**1635**
	Ancillary	**302**	**312**	**315**	**315**	**316**	**332**	**333**
	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**	**2025**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Providers Interactions by Provider Relations	**498**	**638**	**546**	**588**	**450**	**354**	**428**
	Reported Issues Handled by Provider Relations	**10**	**6**	**4**	**2**	**5**	**1**	**4**
	Documented Quality Performance Improvement Action Plans by Provider Relations	**93**	**36**	**26**	**13**	**22**	**1**	**43**
	Interventions Deployed for PCP Quality Performance Improvement	**93**	**36**	**26**	**13**	**22**	**1**	**43**
Message From the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network.							

	Year	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
Claims Processing	**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 were provided during the February 20, 2025 RHA Commission Meeting. Q4 numbers are not yet available.							

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 were provided during the February 20, 2025 RHA Commission Meeting. Q4 numbers are not yet available.							