FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

***Fresno County***

David Pomaville, Director
Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

***Kings County***

Joe Neves
Board of Supervisors

Ed Hill, Director
Public Health Department

Harold Nikoghosian
At-large

***Madera County***

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

***Regional Hospital***

Brian Smullin
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

***Commission At-large***

John Frye
Fresno County

Derrick Gruen
Kings County

Paulo Soares
Madera County

Gregory Hund
Chief Executive Officer
7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: April 10, 2020

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, April 16, 2020**
**1:30 pm to 3:30 pm**

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

**Teleconference: 605-313-4819**
**Participant Code: 270393**

***A separate number will be provided to you for Closed Session***

Meeting materials have been emailed to you.

Currently, there are **10** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum is maintained

Thank you

# AGENDA

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

**Commission Meeting**

April 16, 2020

1:30pm - 3:30pm

**Meeting Location:** CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

**Teleconference: 605-313-4819**
**Participant Code: 270393**

| Item | Attachment # | Topic of Discussion | Presenter |
|---|---|---|---|
| **1** | | **Call to Order** | D. Hodge, MD, Chair |
| **2** | | **Roll Call** | C. Hurley, Clerk |
| **3 Information** | Attachment 3.A | **Kings County At-Large BOS Reappointed Commissioner**<br>• Harold Nikoghosian | D. Hodge, MD, Chair |
| **4 Action** | Attachment 4.A | **Kings County Vacancy: At-Large-Commission Appointed**<br>• Application: Kerry Hydash, FHCN<br><br>*Action: Approve Applicant to fill Kings County At-Large position* | D. Hodge, MD, Chair |
| **5 Action** | Attachment 5.A<br>Attachment 5.B<br>Attachment 5.C<br>Attachment 5.D<br>Attachment 5.E<br>Attachment 5.F | **Consent Agenda:**<br>• Commission Minutes dated 2/20/2020<br>• Finance Committee Minutes dated 10/17/2019<br>• Finance Committee Minutes dated 2/20/2020<br>• QIUM Committee Minutes dated 11/21/2019<br>• QIUM Committee Minutes dated 2/28/2020<br>• Public Policy Minutes dated 12/4/2019<br><br>*Action: Approve Consent Agenda* | D. Hodge, MD, Chair |
| | *Handouts will be available at meeting* | *PowerPoint Presentations will be used for item 6 & 7*<br>***One vote will be taken for combined items 6 & 7*** | |
| **6 Action** | Attachment 6.A<br>Attachment 6.B | **2020 Quality Improvement**<br>• 2020 Program Description<br>• 2020 Work Plan<br><br>*Action: see item #7 for Action* | P. Marabella, MD, CMO |
| **7 Action** | Attachment 7.A | **2020 Utilization Management & Case Management**<br>• 2020 UMCM Work Plan | P. Marabella, MD, CMO |

| | | | |
|---|---|---|---|
| | | *Action: Approve 2020 Quality Improvement Program Description;2020 Quality Improvement Work Plan and 2020 Utilization Management & Case Management Work Plan* | |
| **8 Action** | | **Standing Reports** | |
| | Attachment 8.A | **Finance Report**<br>• Financials as of February 29, 2020 | D. Maychen, CFO |
| | Attachment 8.B | **Compliance**<br>• Compliance Report | M.B. Corrado, CCO |
| | Attachment 8.C<br>Attachment 8.D<br>Attachment 8.E<br>Attachment 8.F | **Medical Management**<br>• Appeals and Grievances Report<br>• Key Indicator Report<br>• Credentialing Sub-Committee Quarterly Report<br>• Peer Review Sub-Committee Quarterly Report | P. Marabella, MD, CMO |
| | Attachment 8.G | **Operations**<br>• Operations Report | J. Nkansah, COO |
| | Attachment 8.H | **Executive Report**<br>• Executive Dashboard | G. Hund, CEO |
| | | *Action: Accept Standing Reports* | |
| **9** | | **Closed Session:**<br><br>**The Board of Directors will go into closed session to discuss the following item(s)**<br><br>**A. Government Code section 54954.5 – Conference Report Involving Trade Secret –** Discussion of service, program, or facility. | |
| **10 Action** | Attachment 10.A | **Community Support Funding**<br>• BL 20-003 and Grant Recommendations<br><br>*Action: Approve Community Funding Grant Recommendations* | G. Hund, CEO |
| **11** | | **Final Comments from Commission Members and Staff** | D. Hodge, MD, Chair |
| **12** | | **Announcements** | D. Hodge, MD, Chair |
| **13** | | **Public Comment**<br>*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* | D. Hodge, MD, Chair |

| | | |
|---|---|---|
| | *except to request that the topic be placed on a subsequent agenda for discussion.* | |
| **14** | **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 21, 2020 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

Reappointed Kings County
At-Large Commissioner

# COUNTY OF KINGS
# BOARD OF SUPERVISORS

MAILING ADDRESS: KINGS COUNTY GOVERNMENT CENTER, HANFORD, CA 93230
OFFICES AT: 1400 W. LACEY BLVD., ADMINISTRATION BUILDING # 1, HANFORD
(559) 582-3211, EXT. 2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

March 11, 2020

Harold Nikoghosian
10175 Excelsior Avenue
Hanford, CA 93230

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

Dear Harold:

It is a pleasure to inform you that on March 10, 2020 at the regular meeting of the Kings County Board of Supervisors they took action to re-appoint you to serve as the Kings County community at large member/primary member on the **CalViva/Tri-County (Fresno/Kings/Madera) Health Authority Commission.**

Congratulations on your re-appointment and thank you for your continued interest to serve Kings County in this capacity. A copy of this letter is being sent to the Committee Coordinator to inform them of your appointment. Please call if you have any questions concerning the above.

Sincerely,

Catherine Venturella
**Clerk of the Board of Supervisors**

Enclosure

cc: Committee Coordinator

# Item #4

## Attachment 4.A

Kings County At-Large
Commission Appointed
Applicant

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

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

Name of Applicant: _____Kerry L Hydash_____
Address: __250 West 5th St._____City: _Hanford_____Zip:__93230__
Current Employer: ___Family HealthCare Network_____
Business Address: _____305 E. Center Ave_____City: __Visalia___Zip: ___93291___
Home Phone: __ __Work Phone: 559-737-4731__E-mail Address: khydash@fhcn.org

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

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

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

NA

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

I serve as Family HealthCare Network's President & CEO. Family HealthCare Network has 40 sites in three counties where we serve over 200,000 unique users, of which 132,352 are Medi-Cal managed care lives.

**List community organizations to which you belong:**

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

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

NA

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

NA

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

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

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

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

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

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

_____ (Signature) 4/6/20 (Date)

COMPLETE FORM AND RETURN TO:

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

**Applications will be kept on file for a year.**

# Item #5

## Attachment 5.A

Commission Minutes
dated 2/20/2020

Fresno-Kings-Madera
Regional Health Authority

# CalViva Health
# Commission
## Meeting Minutes
February 20, 2020

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

| | | | |
|---|---|---|---|
| | **Commission Members** | | |
| | **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 | ✓ | **Harold Nikoghosian**, Kings County At-large Appointee |
| ✓ | **Sara Bosse**, Director, Madera Co. Dept. of Public Health | ✓ | **David Pomaville**, Director, Fresno County Dept. of Public Health |
| ✓ | **John Frye**, Commission At-large Appointee, Fresno | ✓* | **Sal Quintero**, Fresno County Board of Supervisor |
| ✓ | **Soyla Griffin**, Fresno County At-large Appointee | | **Joyce Fields-Keene,** Fresno County At-large Appointee |
| | **Derrick Gruen**, Commission At-large Appointee, Kings County | | **David Rogers**, Madera County Board of Supervisors |
| ✓ | **Ed Hill**, Director, Kings County Dept. of Public Health | ✓* | **Brian Smullin**, Valley Children's Hospital Appointee |
| ✓ | **David Hodge**, M.D., Chair, Fresno County At-large Appointee | ✓ | **Paulo Soares**, Commission At-large Appointee, Madera County |
| ✓ | **Aftab Naz**, Madera County At-large Appointee | | |
| | **Commission Staff** | | |
| ✓ | **Gregory Hund**, Chief Executive Officer (CEO) | ✓ | **Amy Schneider**, R.N., Director of Medical Management |
| ✓ | **Daniel Maychen**, Chief Financial Officer (CFO) | ✓ | **Mary Lourdes Leone**, Director of Compliance |
| ✓ | **Patrick Marabella, M.D.,** Chief Medical Officer (CMO) | ✓ | **Cheryl Hurley**, Commission Clerk |
| ✓ | **Mary Beth Corrado**, Chief Compliance Officer (CCO) | | |
| ✓ | **Jeff Nkansah**, Chief Operations Officer (COO) | | |
| | **General Counsel and Consultants** | | |
| ✓ | **Jason Epperson**, General Counsel | | |
| ✓= Commissioners, Staff, General Counsel Present | | | |
| * = Commissioners arrived late/or left early | | | |
| ● = Attended via Teleconference | | | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **#1 Call to Order** | The meeting was called to order at 1:31 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 | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| Cheryl Hurley, Clerk to the Commission | | |
| **#3 Appointment/Reappointment of Board of Supervisors Commissioners**<br><br>Information<br>David Hodge, MD, Chairman | Fresno County has re-appointed Supervisor Sal Quintero as Commissioner, and Supervisor Brian Pacheco as alternate. Kings County has re-appointed Supervisor Joe Neves as Commissioner and Supervisor Doug Verboon as alternate. Madera County has re-appointed Supervisor David Rogers as Commissioner and Supervisor Brett Frazier as alternate. | ***Motion:*** *Ratify reappointment of County BOS Commissioners*<br>*10 – 0 – 0 – 7*<br><br>*(Frye / Soares)* |
| **#4 Consent Agenda**<br>a) Commission Minutes 10/17/19<br>b) Finance Committee Minutes 9/19/19<br>c) QIUM Committee Minutes 9/19/19<br>d) QIUM Committee Minutes 10/17/19<br>e) Public Policy Committee Minutes 9/4/19<br>f) Compliance Report<br>Action<br>David Hodge, MD, Chairman | All consent items were presented and accepted as read.<br><br>*Brian Smullin arrived at 1:33 pm* | ***Motion****: Approve Consent Agenda*<br>*11 – 0 – 0 – 6*<br><br>*(Neves / Nikoghosian)* |
| **#5 Closed Session**<br><br>A. **Government Code section 59454.5 – Report Involving Trade Secret –** Discussion of service, program, or facility | Jason Epperson, General Counsel, reported out of Closed Session. Commissioners discussed the item agendized for closed session. Direction was given to staff.<br><br>Closed Session concluded at 1:44 pm.<br><br>*Supervisor Sal Quintero arrived at 1:38 pm* | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **#6 Annual Administration**<br><br>Information<br>David Hodge, MD, Chairman | Dr. Hodge reminded the Commission the Form 700 is due on an annual basis and all Commissioners will receive a notification from the Commission Clerk via email. In addition, if anyone is due for an updated Ethics Certification, they will be notified. | |
| **#7 CEO Annual Review Ad-Hoc Committee Selection**<br><br>Action<br>David Hodge, MD, Chairman | Commission members selected for the CEO Annual Review ad-hoc committee are: Dr. Hodge, Harold Nikoghosian, David Pomaville, and Paulo Soares. | ***No Motion taken*** |
| **#8 Community Support Program – Ad-Hoc Committee Selection**<br><br>Action<br>David Hodge, MD, Chairman | A new ad-hoc committee was selected for the Community Support Program. Those Commission members are: Ed Hill, John Frye, and Sara Bosse. | ***No Motion taken*** |
| **#9 2019 Annual Quality Improvement Work Plan Evaluation**<br><br>Action<br>David Hodge, MD, Chairman | Dr. Marabella presented the 2019 Annual Quality Improvement Work Plan Evaluation.<br><br>The planned activities and Quality Improvement focus for 2019 included the following:<br>• Access, Availability and Service:<br>o Improve Access to Care:<br>▪ Provider Appointment Availability Survey assessment.<br>▪ Corrective Action Plans were issued to all non-compliant PPGs and telephone audits were conducted for providers identified to be non-compliant for two years in a row.<br>▪ Provider Office Wait Time met overall goal for 30 minutes or less for all three counties in Q2. | *See #14 for Action Taken* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | ▪ Pending results for RY 2020 Appointment Availability & After-Hours Survey.<br><br>• Quality and Safety of Care: All three counties exceeded the DHCS Minimum Performance Level (MPL) in five of the six Default Enrollment Measures; The six measures are:<br>o Childhood Immunization Combo 3<br>o Well Child Visits 3-6 years<br>o Prenatal Care<br>o HbA1c Testing<br>o Controlling High Blood Pressure<br>o Cervical Cancer Screening<br>Only Fresno County fell below the MPL for both Breast Cancer Screening and HbA1c testing.<br><br>• Performance Improvement Projects (PIPs): The two PIPs closed in 2019 were:<br>o Childhood Immunizations (CIS-3)<br>o Postpartum Care Disparity Project (PPC) | |
| **#10 2019 Annual Utilization Management Case Management Work Plan Evaluation; 2020 UM Program Description; and 2020 CM Program Description** | Dr. Marabella presented the Annual Utilization Management Case Management Work Plan Evaluation.<br><br>Utilization Management & Case Management focused on the following areas for 2019:<br><br>• Compliance with Regulatory & Accreditation Requirements:<br>o Licensure and credentialing requirements maintained. | **Motion:** Approve the 2019 Annual Quality Improvement Work Plan Evaluation and 2019 Annual Utilization Management Case Management Work Plan Evaluation; 2020 UM Program Description; and 2020 CM Program Description |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| Action<br>David Hodge, MD, Chairman | o Program documents and policies were updated to incorporate new regulatory requirements into practice.<br>o DHCS Medi-Cal Managed Care Division Medical Director meetings attended by Medical Directors and CVH CMO.<br>• Monitoring the UM Process:<br>o Turn-around times for Prior Authorizations fell below the 100% goal for certain metrics. A formal Corrective Action Plan has been implemented and is being monitored.<br>o Annual trends for Appeal rates were reviewed including: Overturns, Partial Upholds, Upholds, and Withdrawals. In addition, it was noted that the turn-around-time compliance rate increased in 2019 from previous years even as volumes have increased each year.<br>• Monitoring Utilization Metrics:<br>o All UM metrics for Monitoring Utilization met the objectives.<br>o Comparison of Q1-Q3 2019 to Q1-Q3 2018 demonstrates a 13.5% reduction in acute admissions, exceeding the goal.<br>o A barrier was encountered when attempting to capture the data for discharge to recuperative/alternative care. This measure will be reassessed for 2020 including data capture.<br>o Challenges continue in this area due to fragmented aftercare and inadequate placement options for patients with multiple social determinants of health.<br>• Monitoring Coordination with Other Programs and Vendor Oversight:<br>o All metrics for Behavioral Health met goal with the exception of Behavioral Health Performance Measures.<br>o Timeliness non-compliance was for non-ABA requests. A Corrective Action Plan has been implemented | *12-0-0-5 ( Naz / Neves )* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | ○ Network Availability not met due to Open Practice metric for Behavioral Health in Q3. Q4 data pending.<br>• Monitoring Activities for Special Populations:<br>○ CCS, SPD, CBAS, and Mental Health tracking and monitoring is ongoing.<br>○ All monitoring activities met goals.<br><br>• Utilization Management Program Description Changes include:<br>○ Updated Utilization decision Criteria.<br>○ Health Plan leadership titles.<br>○ Other minor updates.<br><br>• Case Management Program Description Changes include:<br>○ Goals of Case Management Program.<br>○ Care Team Staffing Model.<br>○ Screening & Assessments.<br>○ Condition specific Case Management & Disease Management programs.<br>○ Updated Health Plan leadership titles. | |
| **#11 - 15**<br>• **11**. 2019 Annual Compliance Evaluation<br>• **12**. 2020 Compliance Program Description<br>• **13**. 2020 Code of Conduct<br>• **14**. 2020 Anti-Fraud Plan<br>• **15**. 2020 Privacy and Security Plan | MB Corrado reported on the Annual Compliance Evaluation, the Compliance Program Description, the Code of Conduct, and the Anti-Fraud Plan. No updates on the Privacy and Security Plan were needed.<br><br>**<u>2019 Annual Compliance Evaluation</u>**<br><br>2019 DHCS Regulatory Audits, Corrective Action Plans (CAPs), and Assessments include:<br>• 2017 DHCS Encounter Data CAP – closed.<br>• 2018 DHCS Medical Survey CAP Approval – closed. | **Motion:** Approve 2019 Annual Compliance Evaluation, 2020 Compliance Program Description, 2020 Code of Conduct, 2020 Anti-Fraud Plan, and 2020 Privacy & Security Plan.<br><br>*12-0-0-5 (Neves / Frye)* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| Action<br>David Hodge, MD, Chairman | • DHCS 2018 HEDIS® Quality of Care CAP – closed.<br>• 2019 DHCS Annual Network Certification – closed.<br>• February 2019 DHCS Annual Audit – CAP in progress.<br>• HEDIS 2019 Compliance Audit – passed.<br>• DHCS 2017-2018 Performance Evaluation – completed.<br>• DHCS 2018 Encounter Data Validation – results issued.<br>• February 2020 DHCS Annual Audit – completed.<br>• February 2019 (Triennial) DMHC Audit – CAP submitted, awaiting DMHC final report.<br>• 2019 Triennial Routine Financial Exam – final report issued; no action required.<br>• Measurement Year (MY) 2018 Timely Access Report – submitted; pending preliminary findings.<br><br>The CVH Medical Management Department was awarded the Health Equity Award for the CalViva Postpartum Visit Disparities Project with United Health Centers Mendota Clinic.<br><br>Reports of Suspected Fraud and Abuse Cases:<br>• 16 cases of potential fraud/abuse were reported to DHCS; all of which were provider-related.<br>• California Department of Justice has open cases on 4 of the 16.<br>• Most cases involved provider billing practices, providers billing the highest level E & M codes for new and established patients, and provider prescribing practices.<br><br>Key activities completed in 2019:<br>• Updated the Plan's prior risk analysis. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | • New vendor for risk analysis beginning 2020.<br>• Cybersecurity Assessment.<br>• Periodic and ongoing privacy and security training for staff.<br><br>Reports of Possible Privacy & Security Incidents/Breaches:<br>• 25 privacy and security incidents were reported to DHCS; 2 incidents occurred within CalViva Heath, while the remaining 23 involved the Plan's Administrator Health Net.<br><br>Several functions delegated to Health Net were audited in 2019 which includes: Access & Availability, Claims, Continuity of Care, Cultural & Linguistic Services, Emergency Services, Health Education, Marketing, Pharmacy, Privacy & Security, Provider Dispute Resolution, Quality Improvement. Ongoing oversight of Health Net will continue in the areas of performance metrics and key indicator data.<br><br>Implementation of new ASA and CPSA amendments effective 7/1/19:<br>• Extended terms of ASA and CPSA to 6/30/2024.<br>• Added or updated performance measures.<br>• Increased penalty to Health Net for failure to meet standards.<br>• Enhanced process to review Health Net performance.<br><br>CalViva Health employees participated in and passed all annual mandatory trainings. One new hire completed training.<br><br>Seventy member communications were reviewed and approved. The 2019 Annual Mailing was sent out. Reviewed and approved 32 informational letter templates and 18 forms for provider use. 217 Provider updates were sent to contracted providers. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | Provider Relations completed 1,932 provider visits and 1,353 training visits in the CalViva Health service area.<br><br>The total number of regulatory cases increased in 2019 from 2018.<br><br>Looking ahead into 2020 regulatory audit, performance monitoring, and program implementations activity will increase.<br><br>**2020 Compliance Program Description**<br>• Added new Discrimination language.<br>• Annual review, no other changes.<br><br>**2020 Code of Conduct**<br>• Added new Discrimination language.<br>• Added Independent Medical Review.<br>• Annual review, editorial changes.<br><br>**2020 Anti-Fraud Plan**<br>• Revised Table of Contents.<br>• Added CalViva – Health Net reporting relationship.<br>• Changed name of General Counsel firm.<br>• Deleted duplicate information.<br>• Revisions to meet Medi-Cal contract requirements.<br>• Updated DHCS PIU email address.<br>• Annual review, editorial changes.<br><br>**2020 Privacy and Security**<br>• Clarified definition of vulnerability. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | • Corrected publishing date for a previously released regulatory law.<br>• Added language referencing new policy HI-031.<br>• Annual review, no other changes. | |
| **#16 Public Policy Committee Charter – Revised per DHCS APL 19-011**<br><br>Action<br>David Hodge, MD, Chairman | The Public Policy Charter was revised per DHCS APL 19-011. | ***Motion**: Approve Revised Public Policy Committee Charter*<br><br>*12 – 0 – 0 – 5*<br>*(Soares / Griffin)* |
| **#17 Standing Reports**<br><br>• **Finance Report**<br>Daniel Maychen, CFO | **<u>Finance</u>**<br><br>Total current assets were approximately $249.5M; total current liabilities were approximately $184.4M. Current ratio is 1.35. TNE as of December 31, 2019 was approximately $75.6M, which is approximately 581% above the minimum DMHC required TNE amount.<br><br>Premium capitation income actual recorded for first six months of FY 2020 was approximately $516.5M which is approximately $49M less than budgeted amounts, primarily due to MCO taxes. MCO taxes are still in the renewal process with CMS. With the MCO tax adjusted out of the budgeted amount, actual revenues are ahead of what was budgeted by approximately $13.9M, primarily due to rates being higher than estimated. Capitation medical costs are over budget by $13M for the same reason. Furthermore, on 9/30/19, DHCS sent an MCO tax renewal to CMS and on 1/30/2020, CMS responded with a denial of the MCO tax renewal request, specifically stating that it appeared as if the MCO tax renewal had a hold harmless provision, citing the MCO tax renewal was applying the taxes to Medicaid plans and not to non-Medicaid plans. | **Motion:** *Approve Standing Reports*<br><br>*12 – 0 – 0 – 5*<br><br>*(Neves / Frye)* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| • **Medical Management**<br>P. Marabella, MD, CMO | DHCS has made revisions applying the taxes to non-Medicaid plans and sent the revised MCO tax renewal to DHCS on 2/10/2020. DHCS believes they have appropriately addressed concerns by CMS and are relatively confident it will be approved; outcome is pending. Total net income for the first six months of the fiscal year is approximately $5.3M which is approximately $1.6M more than budgeted.<br><br>**<u>Medical Management</u>**<br><br>**Appeals and Grievances Dashboard**<br><br>Dr. Marabella presented the Appeals & Grievances Dashboard through December 2019.<br><br>**Appeals & Grievances Data:**<br>• The total number of grievances received in 2019 increased compared to 2018 data.<br>• The majority of Quality of Service grievances were noted in the areas of Access to PCP, Access to Specialist, and Transportation.<br>• Quality of Care grievances increased in the areas of Access to Specialist and PCP care.<br>• A significant decrease was noted in Exempt grievances for 2019.<br>• An increase in the total number of Appeals Received/Resolved is also noted in 2019. This increase is attributable primarily to advanced imaging, pharmacy denials, and surgery denials.<br>• Overall, an evaluation of the per thousand member per month rates for grievances and appeals when comparing 2018 to 2019, the rate for grievances increased from 0.23 to 0.30 and appeals increased from 0.12 to 0.21. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | **Key Indicator Report**<br><br>Dr. Marabella presented the Key Indicator Report through December 31, 2019.<br><br>• Admission and Readmission rates are down slightly from 2018.<br>• ER Visits remain consistent.<br>• Admits and Bed Days for SPD PTMPY have decreased from 2018.<br>• Outreach and Engagement for Case Management categories show a significant increase when compared to previous year.<br><br>**QIUM Quarterly Summary Report**<br><br>Dr. Marabella provided the QI/UM Qtr. 4, 2019 update. Two QI/UM meetings were held in Q4; one in October and one in November.<br><br>The following guiding documents were approved at the October and November meetings:<br><br>• 2019 Health Education Mid-Year Evaluation & Executive Summary<br>• 2019 Culture & Linguistics Work Plan Mid-Year Evaluation & Executive Summary<br>• Culture & Linguistics Language Assistance Program Report<br>• Preventive Health Guidelines<br>• Culture & Linguistics Geo Access Report<br><br>In addition, the following general documents were approved at the meetings: | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | • Results of the Appointment Availability & After-Hours Access Survey<br>• Pharmacy Formulary & Provider Updates<br>• Medical Policies<br><br>The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard for September 2019, Potential Quality Issues Report & Corrective Action Plan, MHN Performance Indicator Report for Behavioral Health, Facility Site and Medical Record Review & PARS, and other QI reports.<br><br>The Utilization Management & Case Management reports reviewed included the Key Indicator Report, and Specialty Referrals Reports.<br><br>The quarterly Pharmacy reports were reviewed covering Operations Metrics, Top Medication Prior Authorization Requests and quarterly Formulary Changes. All third quarter 2019 prior authorization metrics were within 5% of standard.<br><br>HEDIS® Activity:<br><br>In Q4, HEDIS® related activities focused on the new mandates established by our new governor and DHCS' response to these new mandates. Managed Care Medi-Cal health plans will have 21 quality measures that they will be evaluated on next year and the new Minimum Performance Level (MPL) is the 50th percentile rather than the 25th. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | For CalViva in RY19, two (2) measures were below the MPL (25th percentile). The two measures are:<br>• Breast Cancer Screening (BCS)<br>• Diabetes Care– HbA1c testing<br><br>A new Disparity Performance Improvement Project has been launched for Breast Cancer Screening and a Diabetes Team will continue completing PDSA cycles to improve performance in Fresno County. No significant compliance issues have been identified. Oversight and monitoring processes will continue.<br><br>**Credentialing Sub-Committee Quarterly Report**<br><br>In Quarter 4 the Credentialing Sub-Committee met on October 17th, 2019. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q2 2019 were reviewed for delegated entities, Q3 2019 reports were reviewed for both Health Net and MHN. There were no cases to report on the Q3 2019 Credentialing Report from Health Net.<br><br>**Peer Review Sub-Committee Quarterly Report**<br><br>The Peer Review Sub-Committee met on October 17, 2019. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2019 were reviewed for approval. There were no significant cases to report. The Q3 2019 Peer Count Report was presented with a total of nine (9) cases reviewed. There were three (3) cases closed and cleared. There was one case pending closure for Corrective Action Plan compliance. There were four (4) cases pended for further information, | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| • **Operations**<br>J. Nkansah, COO | and one (1) case with an outstanding CAP. Follow up will be initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue.<br><br>*Dr. Naz stepped out @ 2:47 pm and returned @ 2:48 pm*<br>*Paulo Soares stepped out @ 2:50 pm and returned @ 2:51 pm*<br><br>**Operations Report**<br><br>Jeff Nkansah presented the Operations Report.<br><br>Currently, there are no issues, concerns, or items of significance as it relates to IT Communications and Systems.<br><br>For Privacy and Security, a new vendor was hired for internal risk analysis. The Notice of Privacy Practices (NPP) is included in the Member Handbook. Member Handbooks are currently being mailed to members. There was one (1) high risk Privacy & Security case that took place in December 2019 impacting one member. Cases for 2020 continue to be routine in nature year and nothing systemic to the process.<br><br>Transportation calls continue to increase through Q3 and Q4 2019. One metric was not met in Q3; however, rebounded in Q4 2019. The website continues to reflect users primarily searching for a Provider.<br><br>With regard to Provider Network Activities, information was provided during the Annual Compliance Evaluation presentation in item #11. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| • **Executive Report**<br>G. Hund, CEO | With regard to Claims Processing and Provider Disputes activity, Q3 numbers have been updated and partial information provided for Q4.<br><br>**<u>Executive Report</u>**<br><br>The membership for January decreased; however, is consistent with other health plans throughout California for Medi-Cal. Market share has remained consistent. | |
| **#18 Final Comments from Commission Members and Staff** | | |
| **#19 Announcements** | None. | |
| **#20 Public Comment** | | |
| **#21 Adjourn** | The meeting was adjourned at 2:59 pm<br>The next Commission meeting is scheduled for March 19, 2020 in Fresno County. | |

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

# Item #5

## Attachment 5.B

Finance Committee Minutes
dated 10/17/2019

# CalViva Health
# Finance
# Committee Meeting Minutes

October 17, 2019

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

| Finance Committee Members in Attendance | | CalViva Health Staff in Attendance | |
|---|---|---|---|
| ✓ | Daniel Maychen, Chair | ✓ | Cheryl Hurley, Office Manager |
| ✓ | Gregory Hund, CEO | ✓ | Jiaqi Liu, Sr. Accountant |
| ✓ | Paulo Soares | | |
| ✓ | Joe Neves | | |
| ✓ | Harold Nikoghosian | | |
| ✓ | David Rogers | | |
| ✓ | John Frye | | |
| | | ✓ | Present |
| | | * | Arrived late |
| | | • | Teleconference |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #1 Call to Order<br>D. Maychen, Chair | The meeting was called to order at 11:30 am, a quorum was present. | |
| #2 Finance Committee Minutes dated September 19, 2019<br>Attachment 2.A<br>Action<br>D. Maychen, Chair | The minutes from the September 19, 2019 Finance meeting were approved as read. | Motion: *Minutes were approved*<br>*7 – 0 – 0 – 0*<br>*(Frye / Soares)* |
| #3 Presentation of Fiscal Year 2019 Audit Results – Moss Adams (R. Suico) | Rianne Suico, representative from Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an unmodified opinion on the financial | Motion: *Approve FY 2019 Audit Results*<br>*7 – 0 – 0 – 0*<br>*(Frye / Soares)* |

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| Action<br>D. Maychen, Chair | statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances were discussed.<br><br>The required communications and the organization's accounting policies are in compliance with GAAP. After completing the work, it was found that the financial statements do not need to be adjusted and no issues were encountered when completing the work. | |
| #4 Financial Statements as of August 31, 2019<br><br>Action<br>D. Maychen, Chair | Total current assets were approximately $220.1M; total current liabilities were approximately $158.3M. Current ratio is 1.39. New liability account, Directed Payment Payable, was added to balance sheet to account for amounts due to various hospitals/entities as part of DHCS' new directed payment program which provides enhanced supplemental funds to various hospitals and health care providers. TNE as of August 31, 2019 was approximately $72.4M, which is approximately 606% above the minimum DMHC required TNE amount.<br><br>Premium capitation actual income was approximately $174M which is approximately $14.5M less than budgeted amounts primarily due to MCO taxes pending approval for renewal. The MCO tax was signed and approved by the Governor on September 30, 2019 and is currently pending federal approval. California Association of Health Plans ("CAHP") is confident the federal government will approve. If approved, MCO taxes will go retroactive back to 7/1/19. Revenues are higher than budget by approximately $6.5M when MCO tax is adjusted out due to rates paid by DHCS being higher than budgeted. Capitation medical costs are | Motion: *Approve Financials as of August 31, 2019*<br>*7 – 0 – 0 – 0*<br><br>*(Nikoghosian / Neves)* |

| | | |
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| | over budget for the same reason.<br><br>Two new financial statement accounts added to income statement as a result of DHCS' directed payment program.<br><br>Grants are less than budgeted amount due to the Valley Health Team ("VHT") residency grant. How it was structured and approved was based on a contribution amount up to their net operating loss. $2.2M was available; however, VHT's net operating loss was $2.1M. The difference was trued up in the month of August 2019, when VHT's reporting was due to CalViva.<br><br>All other expense items are in line or below what was budgeted, with the exception of License expense. License expense was higher due to estimates being lower than actual cost. For the first two months of FY 2020, total net income is approximately $2.1M which is approximately $809K more than budgeted. | |
| #5 Announcements | One tenant will be leaving the complex early 2020. The space is on the market and there is a potential tenant to possibly occupy the space.<br><br>CVH is exploring the potential to add EV chargers to the property. Grants are available and substantial enough to potentially cover the majority of the cost. | |
| #6 Adjourn | Meeting was adjourned at 12:00 pm | |

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

Dated: February 20, 2020

Approved by Committee: Daniel Maychen **Finance Committee**
Daniel Maychen, Committee Chairperson

Dated: 2/20/20

# Item #5

## Attachment 5.C

Finance Committee Minutes
dated 2/20/2020

# CalViva Health
# Finance
# Committee Meeting Minutes

February 20, 2020

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

| Finance Committee Members in Attendance | | CalViva Health Staff in Attendance | |
|---|---|---|---|
| ✓ | Daniel Maychen, Chair | ✓ | Cheryl Hurley, Office Manager |
| ✓ | Gregory Hund, CEO | ✓ | Jiaqi Liu, Sr. Accountant |
| ✓ | Paulo Soares | | |
| ✓ | Joe Neves | | |
| ✓ | Harold Nikoghosian | | |
| | David Rogers | | |
| ✓ | John Frye | | |
| | | ✓ | Present |
| | | * | Arrived late |
| | | • | Teleconference |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| #1 Call to Order<br>D. Maychen, Chair | The meeting was called to order at 11:30 am, a quorum was present. | |
| #2 Finance Committee Minutes dated October 17, 2019<br>Attachment 2.A<br>Action<br>D. Maychen, Chair | The minutes from the October 17, 2019 Finance meeting were approved as read. | Motion: *Minutes were approved*<br>*6 – 0 – 0 – 1*<br>*(Frye / Soares)* |
| #3 Financial Statements as of December 31, 2019 | Total current assets were approximately $249.5M; total current liabilities were approximately $184.4M. Current ratio is 1.35. TNE as of December 31, 2019 was | Motion: *Approve Financials as of December 31, 2019*<br>*6 – 0 – 0 – 1* |

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| Action<br>D. Maychen, Chair | approximately $75.6M, which is approximately 581% above the minimum DMHC required TNE amount.<br><br>Premium capitation income actual recorded for first six months of FY 2020 was approximately $516.5M which is approximately $49M less than budgeted amounts, primarily due to MCO taxes. MCO taxes are still in the renewal process with CMS. With the MCO tax adjusted out of the budgeted amount, actual revenues are ahead of what was budgeted by approximately $13.9M, primarily due to rates being higher than estimated. Capitation medical costs are over budget by $13M for the same reason. Furthermore, on 9/30/19, DHCS sent an MCO tax renewal to CMS and on 1/30/2020, CMS responded with a denial of the MCO tax renewal request, specifically stating that it appeared as if the MCO tax renewal had a hold harmless provision, citing the MCO tax renewal was applying the taxes to Medicaid plans and not to non-Medicaid plans. DHCS has made revisions applying the taxes to non-Medicaid plans and sent the revised MCO tax renewal to DHCS on 2/10/2020. DHCS believes they have appropriately addressed concerns by CMS and are relatively confident it will be approved; outcome is pending. Total net income for the first six months of the fiscal year is approximately $5.3M which is approximately $1.6M more than budgeted. | *(Nikoghosian / Neves)* |
| 4 Fiscal Year 2021 – Review and Discuss Budget<br>Action<br>D. Maychen, Chair | D.Maychen discussed the FY 2021 budget timeline.<br>A formalized budget is planned for presentation at the March 2020 meeting with intent to accept and adopt. Any changes as a result of the March 2020 meeting will carry on to an April 2020 meeting, if necessary. The formal budget will be presented at the May 2020 Commission meeting. | Motion: *Approve Budget Assumptions*<br>*6 – 0 – 0 – 1*<br><br>*(Frye / Soares)* |

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| | During the meeting, D. Maychen discussed the basic assumptions being used to create the FY 2021 budget. Enrollment projected to be relatively consistent with current membership. Rates are projected to increase due to various factors, including but not limited to additional Prop 56 programs such as trauma and developmental screening, and long-term care along with major organ transplants moving into Medi-Cal managed care effective 1/1/2021, net of pharmacy carve out effective 1/1/2021.<br><br>Knox Keene licensing fee, marketing expense, consulting expense, and community support grants expected to increase in comparison to FY 2020. The MCO tax renewal is still pending CMS approval; DHCS is relatively confident that the MCO tax renewal addresses CMS' concerns regarding a hold harmless provision. As such, MCO tax will be included in the FY 2021 budget. | |
| #5 Announcements | D. Maychen reported information on the Voluntary Rate Range program previously IGT to the Finance Committee. This program resulted in increased funds to the Plan for FY 2020. More information will be provided in the coming months.<br><br>D. Maychen provided an update on MFAR. In November 2019, CMS issued a proposed Medicaid Fiscal Accountability Rule to strengthen the fiscal integrity of the Medicaid program. They are specifically looking at Medicaid financing arrangements and proposing to make changes without clear guidance in relation to proposed changes. Several Plans, DHCS, and trade associations representing Plans have stated this is in violation of the federal Administrative Procedure Act. The Proposed Rule would add an "undue burden" test to Provider Tax arrangements such as the Managed Care | |

| | | |
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| | Organization ("MCO") Tax, without providing clear guidance as to what criteria would be used to determine what would be deemed an "undue burden." The Proposed Rule would reduce or limit the Prop 56 payments and any supplemental payments. Supplemental payments would be limited to 50% of base pay of Provider. DHCS has said this would be administratively burdensome and agrees that there needs to be more transparency and oversight; however, they would like at minimum, three full years to implement any requested changes from the effective date. They would like the ceiling of supplemental payments to be comparative to commercial payers. It would limit Intergovernmental Transfers ("IGTs") to local taxes, noting that local taxes are not clearly defined in the Proposed Rule. In summary, billions of Medicaid federal dollars would be at stake. Overall, comment letters have requested that the Proposed Rule be rescinded or revised substantially to better fulfill its stated purpose. CMS is currently in the process of receiving comment letters; final decision is pending. | |
| #6 Adjourn | Meeting was adjourned at 12:06 pm | |

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

Dated: March 19, 2020

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 3/19/2020

# Item #5

## Attachment 5.D

QIUM Committee Minutes
Dated 11/21/2019

Fresno-Kings-Madera
Regional Health Authority

# CalViva Health
# QI/UM Committee
# Meeting Minutes

November 21st, 2019

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

| | Committee Members in Attendance | | CalViva Health Staff in Attendance |
|---|---|---|---|
| ✓ | **Patrick Marabella, M.D.,** CalViva Chief Medical Officer, Chair | | **Mary Beth Corrado**, Chief Compliance Officer (CCO) |
| ✓ | **Fenglaly Lee, M.D.,** Central California Faculty Medical Group | ✓ | **Amy Schneider, RN,** Director of Medical Management Services |
| ✓ | **Brandon Foster, PhD.** Family Health Care Network | ✓ | **Mary Lourdes Leone**, Director of Compliance |
| | **David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers | | **Melissa Mello, MHA,** Medical Management Specialist |
| ✓ | **John Zweifler, MD.,** At-large Appointee, Kings County | ✓ | **Ashelee Alvarado**, Medical Management Administrative Coordinator |
| | **Joel Ramirez, M.D.,** Camarena Health Madera County | | **Lori Norman**, Compliance Manager |
| | **Rajeev Verma, M.D.,** UCSF Fresno Medical Center | | |
| | **David Hodge, M.D.**, Fresno County At-large Appointee, Chair of RHA **(Alternate)** | | |
| | **Guests/Speakers** | | |
| | | | |
| | | | |

✓ = in attendance

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #1 **Call to Order**<br>Patrick Marabella, M.D, Chair | The meeting was called to order at 10:48 am. A quorum was present. | |
| #2 **Approve Consent Agenda**<br>- Committee Minutes: October 17, 2019<br>- Provider Preventable Conditions (PPC) (Q3)<br>- Standing Referrals Report (Q3)<br>- Medical Policies Provider Update (Q3) | The October 2019 QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. The full November Formulary (PDL) was available for review at the meeting. | Motion: Approve Consent Agenda (Zweifler/Lee)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| - Appeals & Grievances Inter-Rater Reliability Report (IRR) (Q3)<br>- Appeals & Grievances Classification Audit Report (Q3)<br>- Quarterly A&G Member Letter Monitoring Report (Q3)<br>- Customer Contact Center (CCC) DMHC Expedited Grievance Report (Q3)<br>- California Children's Service Report (CCS) (Q3)<br>- Pharmacy Provider Update (Q3)<br>- Provider Update: PDL Changes related to Opioid Abuse<br>- Full November PDL (Attachments A-K)<br>Action<br>Patrick Marabella, M.D<br>Chair | | |
| #3 **QI Business**<br>- Appeals & Grievances Dashboard & Turn Around Time Report | The A & G Dashboard provides monthly data to facilitate monitoring for trends in the number and types of cases over time. This Dashboard included data through Quarter 3 2019.<br>The following items were noted for Quarter 3 2019: | Motion: Approve<br>- Appeals & Grievances Dashboard & |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| (September)<br>- Appeals & Grievances Executive Summary (Q3)<br>- Appeals & Grievances Quarterly Member Report (Q3)<br>(Attachment L-N)<br>Action<br>Patrick Marabella, M.D, Chair | **Grievances:**<br>➢ There was a total of 367 grievances resolved in Quarter 3 2019 with 274 Quality of Service Grievances and 93 Quality of Care Grievances.<br>➢ Number of grievances received in Quarter 3 has increased compared to recent months due to transportation issues and PCP Care issues.<br>➢ An increase is noted in Exempt grievances in Quarter 3 due to Transportation, PCP Assignment and PPG related administrative issues.<br>**Appeals:**<br>➢ The number of appeals received in Quarter 3 compared to Quarters 1 and 2 2019, has increased. The majority of this increase can be attributed to the areas of Advanced Imaging and Pharmacy.<br><br>The Appeals and Grievances Executive Summary and Quarterly Member Report for Q3 were presented and reviewed.<br>**Access Grievances**<br>➢ The top Access grievance classifications for Quarter 3 2019 are:<br>o Access to Care- PCP Referral for Services<br>o Access to Care- Availability of Appointment with Specialist<br>o Access to Care- Availability of Appointment with PCP<br>**Transportation Grievances**<br>All transportation related grievances are included in the Quarterly A & G Report. The transportation vendor tracks all exempt grievances and forwards any formal grievances to CalViva Health for processing.<br>**Exempt Grievances**<br>➢ There was a decrease of over 350 exempt grievances in Q3 2019 as compared to Q3 2018.<br>➢ Trends were similar for both Quarters. | Turn Around Time Report (September)<br>- Appeals & Grievances Executive Summary (Q3)<br>- Appeals & Grievances Quarterly Member Report (Q3)<br>(Foster/Lee)<br>4-0-0-3 |
| #3 **QI Business**<br>- Potential Quality Issues Report (Q3)<br>(Attachment O)<br>Action<br>Patrick Marabella, M.D, Chair | Potential Quality Issues (PQI) Report<br>This report provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data was reviewed for all case types including the follow up actions taken when indicated.<br>➢ Non-member initiated PQI category cases were in range when compared to the last three Quarters. Two | Motion: Approve<br>- Potential Quality Issues Report (Q3)<br>(Zweifler/Foster)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | cases were generated from Provider Preventable Conditions (PPCs).<br>➢ Member generated PQI's have increased compared to the previous three Quarters.<br>➢ A decrease in the number of peer review cases processed was noted. Follow up has been initiated when appropriate. PQI and PPC cases will continue to be tracked, monitored and reported. | |
| #3 **QI Business**<br>- MHN Performance Indicator Report for Behavioral Health Services (Q3)<br>(Attachment P)<br>Action<br>Patrick Marabella, M.D, Chair | The MHN Performance Indicator Report for Behavioral Health Services (Q3 2019) was presented. 13 out of the 15 metrics met or exceeded their targets.<br>➢ Performance was below target by 15% for Authorization Decision Timeliness for Non-ABA authorization decisions. This is the second time this indicator has fallen below target in the last 8 Quarters. A corrective action plan is in development.<br>➢ The Q2 2019 utilization rate was 1.9%. There was one non-life-threatening emergent case and the appointment access standard was met.<br>➢ There were 352 ABA reviews in Q3 2019 and 350 were compliant with timeliness standards. This results in a 99% performance rate, which is 4% above the target.<br>➢ There were two PQI cases in Q3 2019 and they were resolved within timeliness standards.<br>➢ MHN Provider Relations staff have implemented several interventions to increase the percentage of providers accepting new CalViva members. | Motion: Approve<br>- MHN Performance Indicator Report for Behavioral Health Services (Q3)<br>(Zweifler/Lee)<br>4-0-0-3 |
| #3 **QI Business**<br>- Facility Site & Medical Record & PARS Review Report<br>(Attachment Q)<br>Action<br>Patrick Marabella, M.D, Chair | The Facility Site & Medical Record Review & PARS Report was presented and reviewed for the first and second Quarters of 2019.<br>➢ There were 22 Facility Site Reviews (FSR) and 26 Medical Record Reviews (MRR) completed.<br>➢ The overall mean FSR score for Fresno, Kings and Madera Counties was 97% and the overall mean MRR score for Fresno, Kings and Madera Counties was 93%.<br>➢ The Pediatric Preventive Care section mean score was 93%.<br>➢ The Adult Preventive Care section mean score was 84%, which is consistent with previous reports.<br>➢ Pediatric Initial Health Assessment (IHA) compliance scores for the 3 counties averaged 96% and the Adult IHA scores averaged 74%.<br>➢ Pediatric SHA compliance was 77%.<br>➢ Adult SHA compliance was 47%. CAPs are required for metrics that do not meet standards. See the IHA Report for additional information. | Motion: Approve<br>- Facility Site & Medical Record & PARS Review Report<br>(Zweifler/Foster)<br>4-0-0-3 |
| #3 **QI Business**<br>- Initial Health Assessment Quarterly | The Department of Health Care Services (DHCS) requires completion of the Initial Health Assessment (IHA) for new Medi-Cal members within 120 days of enrollment. A multi-faceted approach to monitoring is performed and includes the following: | Motion: Approve<br>- Initial Health Assessment |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| Audit Report (Q3)<br>(Attachment R)<br>Action<br>Patrick Marabella, M.D, Chair | 1. Medical Record Review (MRR) via onsite provider audits.<br>2. Monitoring of claims and encounters data.<br>3. Member outreach following a three-step methodology.<br><u>FSR/MRR Data:</u><br>➢ Data from Quarter 3 FSR/MRRs reviewed.<br>➢ Combined IHA/IHEBA completion and compliance rates were noted to be higher for pediatric patients compared to adult patients.<br>➢ In addition, total site compliance was reviewed. A total of nine sites were visited during Q3 2019 to complete FSRs/MMRs, and of those sites audited, three sites were compliant <u>Claims Data</u>: Both pediatric and adult completion rates improved in Q3 compared previous 6 months.<br><u>Outreach Attempts:</u><br>➢ Three Step outreach includes:<br>1. Welcome Packet<br>2. Welcome Call and<br>3. Welcome Postcard.<br>Outreach attempts for Quarter 3 were 93.03% which is a slight decrease from previous Quarters. | Quarterly Audit Report (Q3)<br>(Lee/Zweifler)<br>4-0-0-3 |
| #3 **QI Business**<br>- County Relations Quarterly Update Report (Q3)<br>(Attachment S)<br>Action<br>Patrick Marabella, M.D, Chair | County Relations Quarterly Report (Q3)<br>This report provides a summary of the relevant Public Health, Behavioral Health (BH) and Regional Center Activities, initiatives and updates for Fresno, Kings and Madera Counties.<br>Highlights for this Quarter include:<br>➢ Fresno County has elected to switch to a monthly meeting schedule to increase opportunities for more topic-specific meetings/discussions.<br>➢ Fresno County Suicide Prevention Collaborative updates:<br>o Free Applied Suicide Intervention Skills Training (ASIST) being offered by Sanger Unified on January 28th and 29th 2020.<br>o The Pacific Southwest Mental Health Technology Transfer Center (MHTTC) is also offering a series of no-cost trainings.<br>➢ Kings County Behavioral Health (KCBH) is developing a Medication Assisted Treatment (MAT) Symposium to educate Kings County (providers).<br>➢ KCBH recently started an acute care coordination meeting, which is comprised of their specialty mental health providers and is convened twice weekly. They will focus on 51/50's and discharge planning. | Motion: Approve<br>- County Relations Quarterly Update Report (Q3)<br>(Foster/Zweifler)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | ➢ Sexually Transmitted Infections (STIs) rates continue to rise and are a recurring issue. Kings County Public Health Department continues to provide clinical updates to community providers regarding the STI rates. KCPHD reported that they are in the State's top 5 for STI's. KCPHD is working on a STI response plan for the community.<br>➢ Madera County Behavioral Health (MCBH) continues to struggle with regard to staff retention. MCBH is currently interviewing for licensed clinicians to fill the open positions.<br>➢ MCPHD is working to become an accredited public health department. Site visit will be on January 2020.<br>➢ Sexually Transmitted Infection rates continue to be high in Madera County as well with similar challenges as Kings County.<br>➢ Central Valley Regional Center continues to see a rise in members requesting BHT services and psychiatric evaluations for members needing ABA referrals.<br><br>Quarter 3 data for BH referrals, TB screening and CCS enrollment in Fresno, Kings and Madera counties were also reviewed. | |
| #3 **QI Business**<br>- SPD HRA Outreach Report (Q2)<br>(Attachment T)<br>Action<br>Patrick Marabella, M.D, Chair | Envolve People Care (EPC) performs SPD Health Risk Assessments (HRAs) for CalViva members. The CalViva Health SPD HRA Assessment Outreach Report monitors compliance with member outreach performance standards.<br><br>This report provides results of outreach for the first, second and third Quarter of 2019, showing CalViva's SPD HRA findings. Efforts for Quarter 2 2019 include the following:<br>➢ Between confirmed and completed data, timely outreach for both first and second Quarters was achieved with 100% compliance.<br>➢ Timely outreach has also been met at 100% for those records we have received back for Quarter 3.<br>➢ At the time of this report, 623 member records were yet to be returned to complete Quarter 3 results.<br>➢ Meetings with EPC will continue on a regular basis to ensure service levels are met in a timely manner. | Motion: Approve<br>- SPD HRA Outreach Report (Q2)<br>(Zweifler/Lee)<br>4-0-0-3 |
| #4 **Summary of 2019 PDSA & Performance Improvement Project Activities**<br>- *(PowerPoint Presentation -* | Six QI Summaries were reviewed with the committee including: Monitoring Persistent Medications, Avoiding Antibiotics for Bronchitis, Breast Cancer Screening, Comprehensive Diabetes Care, Childhood Immunizations Status Combo 3 and Postpartum Care Disparity Performance Improvement Project. The QI Summaries quality improvement activities are associated with measures that have performed below the minimum performance level or when other opportunities for improvement have been identified. Four projects were focused in Fresno County and two projects were focused in Madera County. Our process has been to work with a high volume, low | Motion: Approve<br>- Summary of 2019 PDSA & Performance Improvement Project Activities |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| *Presentation handouts available at meeting)*<br>Action<br>Patrick Marabella, M.D, Chair | compliance clinic to identify strategies for improvement and support the clinic to implement and test the effectiveness of these interventions. Our goal is to improve clinic and county rates and share successful strategies with other clinics/providers in the service area. The QI presentation illustrates improvement interventions, results, and recommendations for each project. Positive results were noted for all measures.<br><br>➢ *CalViva Health won the 2019 DHCS Health Equity Award for the Postpartum Visit Disparities Project with United Health Centers Mendota Clinic.* | (Zweifler/Lee)<br>4-0-0-3 |
| #5 **Access Business**<br>- Provider Office Wait Time Report (Q3)<br>- Specialty Referrals Report – HN (Q3)<br>- Specialty Referrals Reports: La Salle (Q1-Q3), First Choice (Q1-Q3), IMG (Q3), Adventist (Q1-Q3), Central Valley Medical Physicians (Q1-Q3), Sante (Q3)<br>(Attachment U-W)<br>Action<br>Patrick Marabella, M.D, Chair | **Provider Office Wait Time Report (Q3 2019)**<br>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 Quarter 3 2019 wait times for Fresno, Kings and Madera Counties. All counties are within the 30-minute office wait time threshold for both mean and median metrics. Outliers are tracked with follow up occurring when thresholds are passed. Results of monitoring are reported back to the participating providers. Monitoring and analysis will continue in 2020 to identify opportunities for improvement associated with specific providers.<br><br>**Specialty Referrals Report – HN (Q3)**<br>The Health Net Specialty Referrals Report provides a summary of Specialty Referral Services that require prior authorization in the tri-county area. This report provides evidence of the tracking process in place to ensure appropriate access to specialty care for CalViva Health members.<br><br>Similar reports are prepared for delegated entities serving CalViva members. Reports on specialty services requiring prior authorization were presented and reviewed for the following delegated entities: La Salle, First Choice, IMG, Adventist, Sante and Central Valley Medical Providers. Reporting parameters for these reports have recently been clarified with Delegation Oversight staff.<br><br>These reports provide evidence of the tracking process in place to ensure appropriate access to specialty care for CalViva Health members.<br><br>Referral and denial rates are monitored on a Quarterly basis and compared over time. Top priority medical specialties are tracked along with turn-around times. Trends will continue to be monitored and follow up initiated when indicated. | Motion: Approve<br>- Provider Office Wait Time Report (Q3)<br>- Specialty Referrals Report – HN (Q3)<br>- Specialty Referrals Reports: La Salle (Q1-Q3), First Choice (Q1-Q3), IMG (Q3), Adventist (Q1-Q3), Central Valley Medical Physicians (Q1-Q3), Sante (Q3)<br>(Zweifler/Foster)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #6 **UM Business**<br>- Key Indicator Report (September)<br>- Utilization Management Concurrent Review Report (Q3)<br>- Concurrent Review IRR Audit Report (Q3) and update on InterQual IRR Testing<br><br>- Case Management and CCM Report (Q3)<br>(Attachment X-AA)<br>Action<br>Patrick Marabella, M.D, Chair | The Key Indicator Report was presented with an overview of 2019 trends.<br>➢ The Acute Admits per thousand for ER Utilization based on claims data shows a decrease for SPD's while Expansion rates are increasing.<br>➢ This trend shows improved management of SPDs due to the completion of HRAs and a local Case Management team.<br>➢ An increasing trend in the TANF population admission rate is noted for Quarter 2. Initial review of the data indicates the reason for this increase is frequently respiratory diagnoses for Quarter 3.<br>➢ The average length of stay rate demonstrate improvement for TANF and SPD populations.<br>➢ There was a decrease in 30 day re-admits for SPD population in Quarter 3 when compared to Quarter 2 and increases noted in MCE and TANF populations in Quarter 3. Will continue to monitor and analyze data to identify trends.<br>➢ Turnaround Times may be attributable to loss of staff and changes in the recruiting process.<br><br>The Concurrent Review Q3 Inter Rater Reliability (IRR) Report provides a summary of internal audits performed to ensure consistent, credible, and timely medical management decisions which promote improved member outcomes.<br>Monitoring of the concurrent review process includes regulatory compliant components such as:<br>➢ Turn-around-times (TAT) of initial medical decisions within 24 hours of receipt<br>➢ Documentation of proactive discharge planning and collaboration<br>➢ Application of standardized criteria (I.e. McKesson InterQual®, and /or evidence-based medical policies and technical assessment tools)<br>All criteria met established standard of 90% or greater compliance. Continue to monitor and follow up as indicated.<br><br>This comprehensive report also provides a summary of Case Management (CM), Transitional Care Management, Perinatal CM, Behavioral Health CM, MemberConnections and Palliative Care activities for Quarter 3 2019. A range of Case Management services are available to all CalViva members who may benefit. Members are assessed and referred to the appropriate program depending upon their needs. The effectiveness of each program is assessed using a variety of outcome and member satisfaction metrics.<br>➢ Integrated Case Management (ICM): The volume of referrals increased from 258 in Q2 2019 to 290 in Q3 2019. During the same time period the average engagement rate has increased from 33% in Q2 to 39% in | Motion: Approve<br>- Key Indicator Report (September)<br>- Utilization Management Concurrent Review Report (Q3)<br>- Concurrent Review IRR Audit Report (Q3) and update on InterQual IRR Testing<br><br>- Case Management and CCM Report (Q3)<br>(Lee/Zweifler)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | Q3 2019.<br>➢ Transitional Care Management (TCM): Percentage of members who had PCP follow-up within 30 days of discharge has been refreshed for Q2. Preliminary data is available for Q3. Q2 follow-up within 30 days increased to 60.9%; of those<br>o 17.4% within 7 days of discharge<br>o 4.3% within 8-14 days of discharge<br>o 39.1% within 15-30 days of discharge<br>➢ Readmission rates and ED Utilization per 1,000 members per year for Case Management is lower (lower is better).<br>➢ Perinatal Case Management: A new outcome measure added comparing the rate of pre-term deliveries of high-risk pregnancies has been managed to high risk pregnancies not managed. This includes members who met the following criteria: continuous enrollment, enrolled during their first trimester (prenatal) and delivered through 6/30/2019 (post-partum).<br>o 75 members met the outcome inclusion criteria for visits and 31 members met the inclusion criteria for the pre-term delivery measure<br>o Members enrolled in the Perinatal Program demonstrated:<br>▪ 8.6% greater compliance in completing the first prenatal visit within their first trimester<br>▪ 9.0% greater compliance in completing their post-partum visit<br>▪ 7% fewer pre-term deliveries<br>➢ Palliative Care: Volume of referrals has increased from Q2 to Q3 (27 to 54) and the Quarterly average engagement rate was 89%. | |
| #7 **Policy & Procedure**<br>- UM/CM Policy Grid (Attachment BB)<br>Action<br>Patrick Marabella, M.D, Chair | Utilization Management and Case Management Annual Review Policy grid was presented to the committee. The majority of policies were updated without changes or had minor edits. Eight policies that required more extensive review were included in the meeting packet.<br><br>The policy edits were discussed and the UM/CM policies were approved. | Motion: Approve<br>- UM/CM Policy Grid<br>(Zweifler/Foster)<br>4-0-0-3 |
| #7 **Policy & Procedure**<br>- Pharmacy Policy Grid (Attachment CC)<br>Action | Pharmacy Annual Policy Review grid was presented to the committee. The majority of policies were updated without changes or had minor edits. One policy required more extensive review and was included in the meeting packet:<br>➢ RX-130 Early Refill for Lost, Stolen, Spilled, or Broken Medication | Motion: Approve<br>- Pharmacy Policy Grid<br>(Foster/Lee) |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| Patrick Marabella, M.D, Chair | The policy edits were discussed and the Pharmacy policy was approved. | 4-0-0-3 |
| #8 **Pharmacy Business**<br>- Pharmacy Executive Summary (Q3)<br>- CalViva Health Pharmacy Call Report (Q3)<br>- Pharmacy Operations Metrics (Q3)<br>- Top 30 Prior Authorizations (Q3)<br>(Attachment DD-GG)<br>Action<br>Patrick Marabella, M.D, Chair | Pharmacy reports for Quarter 3 were reviewed in order to assess for emerging patterns in authorization requests, compliance around prior authorizations, and to evaluate the consistency of decision making in order to formulate potential process improvement recommendations.<br>➢ Pharmacy Prior Authorizations (PA) metrics were within 5% of standard for third Quarter 2019. PA turnaround time is monitored to identify PA requests that are approaching required turnaround time limits.<br>➢ Total PA requests were lower for Quarter 3 2019 versus Quarter 2 2019. Third Quarter 2019 top medication PA requests had variances from second Quarter 2019.<br>➢ Third Quarter 2019 Opioid PA requests decreased significantly in total number of requests from second Quarter 2019. This was mainly driven by the Preferred Drug List changes in May 2019 that included updates to quantity limits and restrictions as well as additions to the list. As a result, diabetes medications as well as other brand name medication requests moved up the list. Appeals for diabetes medication requests also increased in third Quarter which is reflected in the PA request totals.<br>➢ Effective 10/15/2019, the Preferred Drug List was updated. The CalViva Health QI/UM Committee reviews Quarterly reports on operational metrics for the CVS Caremark Call Center and reviews the call logs, action items, and resolutions to look at potential trends or barriers to service and to formulate process improvements as needed. All metrics were within the standard.<br>➢ | Motion: Approve<br>- Pharmacy Executive Summary (Q3)<br>- CalViva Health Pharmacy Call Report (Q3)<br>- Pharmacy Operations Metrics (Q3)<br>- Top 30 Prior Authorizations (Q3)<br>(Foster/Lee)<br>4-0-0-3 |
| #9 **Credentialing & Peer Review Subcommittee Business**<br>- Credentialing Subcommittee Report (Q4)<br>(Attachment HH)<br>Action<br>Patrick Marabella, M.D, Chair | In Quarter 4 the Credentialing Sub-Committee met on October 17, 2019. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q2 2019 were reviewed for delegated entities and Q3 2019 reports were reviewed for both Health Net and MHN. No significant cases were identified on the Q3 2019 Credentialing Report. | Motion: Approve<br>- Credentialing Subcommittee Report (Q4)<br>(Foster/Lee)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #9 **Credentialing & Peer Review Subcommittee Business**<br>- Peer Review Subcommittee Report (Q4)<br>(Attachment II)<br>Action<br>Patrick Marabella, M.D, Chair | The Peer Review Sub-Committee met on October 17, 2019. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2019 were reviewed for approval. There were no significant cases to report.<br><br>The Quarter 3, 2019 Peer Count Report was presented at the meeting with a total of 9 cases reviewed. The outcomes for these cases are as follows:<br>• There were three (3) cases closed and cleared. There was one case pending closure for Corrective Action Plan compliance. There were four more cases pended for further information and one case with an outstanding CAP.<br><br>Follow up will be initiated to obtain additional information for the tabled cases and ongoing monitoring and reporting will continue. | Motion: Approve<br>- Peer Review Subcommittee Report (Q4)<br>(Lee/Zweifler)<br>4-0-0-3 |
| #8 **Public Comment** | None. | |
| #9 **Adjourn**<br>Patrick Marabella, M.D, Chair | Meeting was adjourned at 12:44 pm. | |

**NEXT MEETING: February 20, 2020**

Submitted this Day: February 28th, 2020

Submitted by: Amy K Schneider

Amy Schneider, RN, Director Medical Management

**Acknowledgment of Committee Approval:**

Patrick Marabella, MD Committee Chair

# Item #5

## Attachment 5.E

QIUM Committee Minutes
Dated 2/20/2020

Fresno-Kings-Madera
Regional Health Authority

# CalViva Health
# QI/UM Committee
# Meeting Minutes

February 28th, 2020

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

| | Committee Members in Attendance | | CalViva Health Staff in Attendance |
|---|---|---|---|
| ✓ | **Patrick Marabella, M.D.**, CalViva Chief Medical Officer, Chair | ✓ | **Mary Beth Corrado**, Chief Compliance Officer (CCO) |
| | **Fenglaly Lee, M.D.,** Central California Faculty Medical Group | ✓ | **Amy Schneider, RN,** Director of Medical Management Services |
| ✓ | **Brandon Foster, PhD.** Family Health Care Network | ✓ | **Mary Lourdes Leone**, Director of Compliance |
| ✓ | **David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers | ✓ | **Ashelee Alvarado, BS,** Medical Management Specialist |
| | **John Zweifler, MD.,** At-large Appointee, Kings County | ✓ | **Lori Norman**, Compliance Manager |
| ✓ | **Joel Ramirez, M.D.,** Camarena Health Madera County | | |
| | **Rajeev Verma, M.D.,** UCSF Fresno Medical Center | | |
| | **David Hodge, M.D.**, Fresno County At-large Appointee, Chair of RHA **(Alternate)** | | |
| | **Guests/Speakers** | | |
| | | | |
| | | | |

✓ = in attendance

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #1 **Call to Order**<br>Patrick Marabella, M.D, Chair | The meeting was called to order at 10:01 am. A quorum was present. | |
| #2 **Approve Consent Agenda**<br>- Committee Minutes: November 21, 2019<br>- Medical Policies Provider Update (Q3)<br>- California Children's Service Report (CCS) (Q4)<br>- Customer Contact | The November 21, 2019 QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. The full February Formulary (PDL) was available for review at the meeting. | Motion: Approve Consent Agenda (Cardona/Foster) 4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| Center (CCC) DMHC Expedited Grievance Report (Q4)<br>- Member Incentive Programs Semi-Annual Report<br>- Appeals & Grievances Inter-Rater Reliability Report (IRR) (Q4)<br>- Appeals & Grievances Classification Audit Report (Q4)<br>- Quarterly A&G Member Letter Monitoring Report (Q4)<br>- Pharmacy Provider Update (Q4 2019 & Q1 2020<br>- Full February PDL (Attachments A-I)<br>Action<br>Patrick Marabella, M.D<br>Chair | | |
| #3 **QI Business**<br>- Appeals & Grievances Dashboard (December)<br>- Appeals & Grievances Executive Summary (Q4) | Dr. Marabella presented the Appeals & Grievances Dashboard through December 2019.<br><br>**Appeals & Grievances Data:**<br>➢ The total number of grievances received in 2019 increased compared to 2018 data.<br>➢ The majority of Quality of Service grievances were noted in the areas of Access to PCP, Access to Specialist, and Transportation.<br>➢ Quality of Care grievances increased in the areas of Access to Specialist and PCP care. | Motion: Approve<br>- Appeals & Grievances Dashboard (December)<br>- Appeals & Grievances |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| - Appeals & Grievances Quarterly Member Report (Q4)<br>(Attachment J-L)<br>Action<br>Patrick Marabella, M.D, Chair | ➢ A significant decrease was noted in Exempt grievances for 2019.<br>➢ An increase in the total number of Appeals Received/Resolved is also noted in 2019. This increase is attributable primarily to advanced imaging, pharmacy denials, and surgery denials.<br>➢ Overall, an evaluation of the per thousand member per month rates for grievances and appeals when comparing 2018 to 2019, the rate for grievances increased from 0.23 to 0.30 and appeals increased from 0.12 to 0.21. | Executive Summary (Q4)<br>- Appeals & Grievances Quarterly Member Report (Q4)<br>(Ramirez/Cardona)<br>4-0-0-3 |
| #3 **QI Business**<br>- County Relations Quarterly Report (Q4)<br>(Attachment M)<br>Action<br>Patrick Marabella, M.D, Chair | County Relations Quarterly Report (Q4)<br>This report provides a summary of the relevant Public Health, Behavioral Health (BH) and Regional Center Activities, initiatives and updates for Fresno, Kings and Madera Counties. This Report will be augmented over time due to the Governor's implementation of the CalAIM Initiative Which involves Public Health Agencies and Behavioral Health for each county.<br>Highlights for this Quarter include:<br>➢ Fresno County Department of Behavioral Health (FCDBH) continues to engage the MCPs in on-going discussions to improve care coordination for Fresno County members suffering from mental health and substance use disorders. FCDBH and the MCPs continue to exchange feedback regarding the bidirectional referral process, as well as any challenges with linking members to services, etc.<br>➢ The Fresno County Suicide Prevention Collaboration continues with a series of no-cost trainings in collaboration with the California School-Based Health Alliance for educators, clinicians, school-based health providers, and other professionals working with young people. These trainings will be offered throughout 2020.<br>➢ Fresno Unified School District (FUSD) is planning the expansion of their school-based health clinic services.<br>➢ Kings County Behavioral Health Department (KCBHD) will begin to also share their behavioral health utilization data at future quarterly meetings.<br>➢ In Kings County, on average for Q4, around 5.22% or 15,298 of the Medi-Cal population were under the age of 21 years old. Of the 15,298 Medi-Cal members, 1,097 (7.17%) are CCS eligible.<br>➢ Madera County Behavioral Health Department (MCBHD) provided an update regarding the results from their Triennial Review, advising that they are currently working through some of the items on the resulting Plan of Correction.<br>➢ Sexually Transmitted Disease (STD) program highlighted the continued challenges with syphilis and | Motion: Approve<br>- County Relations Quarterly Report (Q4)<br>(Ramirez/Foster)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | congenital syphilis.<br><br>Quarter 4 data for BH referrals and CCS enrollment in Fresno, Kings and Madera counties were also reviewed. | |
| #3 **QI Business**<br>- Provider Preventable Conditions Report (Q4)<br>(Attachment N)<br>Action<br>Patrick Marabella, M.D, Chair | Provider Preventable Conditions (PPC) (Q4 2019)<br>This report provides a summary of member impacted Provider Preventable Conditions (PPC). PPCs are identified via four (4) mechanisms:<br>1. Provider / Facility confidential submission of DHCS Form 7107<br>2. Monthly Claims Data review<br>3. Monthly Encounter Data review (POA/ Indicator Report)<br>4. Confidential Potential Quality Issue (PQI) submission of identified/suspected quality cases<br>➢ There were five reported CalViva PPCs during the fourth quarter 2019. All cases have been closed. It is important to note that although 5 cases closed during the quarter, they did not all occur in the quarter. These is a lag time for claims data and to obtain medical records from the facility where the event occurred. We continue to monitor and report. | Motion: Approve<br>- Provider Preventable Conditions Report (Q4)<br>(Cardona/ Ramirez)<br>4-0-0-3 |
| #3 **QI Business**<br>- Potential Quality Issues Report (Q4)<br>(Attachment O)<br>Action<br>Patrick Marabella, M.D, Chair | <u>Potential Quality Issues (PQI) Report</u><br>This report provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data was reviewed for all case types including the follow up actions taken when indicated.<br>➢ Non-member initiated PQI category cases were in range when compared to the last three Quarters. There were no cases generated from Provider Preventable Conditions (PPCs).<br>➢ Member generated PQI's have slightly decreased compared to the previous two Quarters.<br>➢ The number of peer review cases varies from quarter to quarter. Follow up has been initiated when appropriate. PQI and PPC cases will continue to be tracked, monitored and reported. | Motion: Approve<br>- Potential Quality Issues Report (Q4)<br>(Cardona/Foster)<br>4-0-0-3 |
| #3 **QI Business**<br>- Performance Improvement Project Update (Q4)<br>(Attachment P)<br>Action | The Quality Improvement Project to address Breast Cancer Screening (BCS) was reviewed with the committee. The report summarizes quality improvement activities associated with HEDIS® measures that have performed below the minimum performance level. The BCS project was focused in Fresno County and the BCS QI Summary described multidisciplinary team formation, barrier analysis and plans for initial intervention. Periodic updates will be provided on the progress of the project. | Motion: Approve<br>- Performance Improvement Project Update<br>(Ramirez/Cardona)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| Patrick Marabella, M.D, Chair | | |
| #4 **Quality Improvement/ Utilization Management/Case Management Business** *(PowerPoint Presentation - Presentation handouts available at meeting)*<br>- QI Executive Summary & 2019 Work Plan End of Year Evaluation (Attachment P-Q)<br>Action<br>Patrick Marabella, M.D, Chair | Dr. Marabella presented the 2019 Annual Quality Improvement Work Plan Evaluation.<br><br>The planned activities and Quality Improvement focus for 2019 included the following:<br>➢ Access, Availability and Service:<br>o Improve Access to Care:<br>▪ Provider Appointment Availability Survey assessment.<br>▪ Corrective Action Plans were issued to all non-compliant PPGs and telephone audits were conducted for providers identified to be non-compliant for two years in a row.<br>▪ Provider Office Wait Time met overall goal for 30 minutes or less for all three counties in Q2.<br>▪ Pending results for RY 2020 Appointment Availability & After-Hours Survey.<br><br>➢ Quality and Safety of Care: All three counties exceeded the DHCS Minimum Performance Level (MPL) in five of the six Default Enrollment Measures; The six measures are:<br>o Childhood Immunization Combo 3<br>o Well Child Visits 3-6 years<br>o Prenatal Care<br>o HbA1c Testing<br>o Controlling High Blood Pressure<br>o Cervical Cancer Screening<br>Only Fresno County fell below the MPL for both Breast Cancer Screening and HbA1c testing.<br><br>➢ Performance Improvement Projects (PIPs): The two PIPs closed in 2019 were:<br>o Childhood Immunizations (CIS-3)<br>o Postpartum Care Disparity Project (PPC) | Motion: Approve<br>- QI Executive Summary & 2019 Workplan End of Year Evaluation<br>(Ramirez/Cardona)<br>4-0-0-3 |
| #4 **Quality Improvement/ Utilization Management/Case Management Business** | Dr. Marabella presented the Annual Utilization Management Case Management Work Plan Evaluation.<br><br>Utilization Management & Case Management focused on the following areas for 2019: | Motion: Approve<br>- UM/CM Executive Summary & 2019 Work Plan End of Year Evaluation |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| *(PowerPoint Presentation - Presentation handouts available at meeting)*<br>- UM/CM Executive Summary & 2019 Work Plan End of Year Evaluation<br>(Attachment R)<br>Action<br>Patrick Marabella, M.D, Chair | ➢ Compliance with Regulatory & Accreditation Requirements:<br>o Licensure and credentialing requirements maintained.<br>o Program documents and policies were updated to incorporate new regulatory requirements into practice.<br>o DHCS Medi-Cal Managed Care Division Medical Director meetings attended by Medical Directors and CVH CMO.<br>➢ Monitoring the UM Process:<br>o Turn-around times for Prior Authorizations fell below the 100% goal for certain metrics. A formal Corrective Action Plan has been implemented and is being monitored.<br>o Annual trends for Appeal rates were reviewed including: Overturns, Partial Upholds, Upholds, and Withdrawals. In addition, it was noted that the turn-around-time compliance rate increased in 2019 from previous years even as volumes have increased each year.<br>➢ Monitoring Utilization Metrics:<br>o All UM metrics for Monitoring Utilization met the objectives.<br>o Comparison of Q1-Q3 2019 to Q1-Q3 2018 demonstrates a 13.5% reduction in acute admissions, exceeding the goal.<br>o A barrier was encountered when attempting to capture the data for discharge to recuperative/alternative care. This measure will be reassessed for 2020 including data capture.<br>o Challenges continue in this area due to fragmented aftercare and inadequate placement options for patients with multiple social determinants of health.<br>➢ Monitoring Coordination with Other Programs and Vendor Oversight:<br>o All metrics for Behavioral Health met goal with the exception of Behavioral Health Performance Measures.<br>o Timeliness non-compliance was for non-ABA requests. A Corrective Action Plan has been implemented<br>o Network Availability not met due to Open Practice metric for Behavioral Health in Q3. Q4 data pending.<br>➢ Monitoring Activities for Special Populations:<br>o CCS, SPD, CBAS, and Mental Health tracking and monitoring is ongoing.<br>o All monitoring activities met goals. | (Cardona/Ramirez) 4-0-0-3 |
| #4 **Quality** | Dr. Marabella presented the 2020 Utilization Management Program Description. | Motion: Approve |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| **Improvement/ Utilization Management/Case Management Business** *(PowerPoint Presentation - Presentation handouts available at meeting)*<br>- Utilization Management Program Description 2020<br>(Attachment S)<br>Action<br>Patrick Marabella, M.D, Chair | ➢ Utilization Management Program Description Changes include:<br>o Updated Utilization decision Criteria.<br>o Health Plan leadership titles.<br>o Other minor updates. | - Utilization Management Program Description 2020<br>(Foster/Cardona)<br>4-0-0-3 |
| #4 **Quality Improvement/ Utilization Management/Case Management Business** *(PowerPoint Presentation - Presentation handouts available at meeting)*<br>- Case Management Program Description 2020<br>(Attachment T)<br>Action<br>Patrick Marabella, M.D, Chair | Dr. Marabella presented the 2020 Case Management Program Description.<br>➢ Case Management Program Description Changes include:<br>o Goals of Case Management Program.<br>o Care Team Staffing Model.<br>o Screening & Assessments.<br>o Condition specific Case Management & Disease Management programs.<br>o Updated Health Plan leadership titles. | Motion: Approve<br>- Case Management Program Description 2020<br>(Ramirez/Cardona)<br>4-0-0-3 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #5 **Access Business**<br>- Specialty Referrals Reports: La Salle, First Choice, IMG, Adventist, Central Valley Medical Physicians, Sante (Q4)<br>(Attachment U)<br>Action<br>Patrick Marabella, M.D, Chair | The following delegated entities provided a summary of Specialty Referral Services for Quarter 4 in the tri-county area: La Salle, First Choice, IMG, Adventist, Central Valley Medical Physicians, and Sante. Delegation Oversight staff continue to improve the accuracy and consistency of reporting.<br><br>These reports provide evidence of the tracking process in place to ensure appropriate access to specialty care for CalViva Health members.<br><br>Referral and denial rates are monitored on a quarterly basis and compared over time. Top priority medical specialties are tracked along with turn-around times. Trends will continue to be monitored and follow up initiated when indicated. These reports will be monitored via the PPG Dashboard for Delegated Entities beginning with Q1 2020 reports. | Motion: Approve<br>- Specialty Referrals Reports: La Salle, First Choice, IMG, Adventist, Central Valley Medical Physicians, Sante (Q4)<br>(Cardona/Ramirez)<br>4-0-0-3 |
| #6 **UM Business**<br>- Key Indicator Report & Turn Around Time Report (November)<br>(Attachment V)<br>Action<br>Patrick Marabella, M.D, Chair | Dr. Marabella presented the Key Indicator Report through December 31, 2019.<br><br>➢ Admission and Readmission rates are down slightly from 2018.<br>➢ ER Visits remain consistent.<br>➢ Admits and Bed Days for SPD PTMPY have decreased from 2018.<br>➢ Outreach and Engagement for Case Management categories show a significant increase when compared to previous year.<br><br>**Dr. Cardona stepped out at 11:00 am; returned at 11:03 am.** | Motion: Approve<br>- Key Indicator Report & Turn Around Time Report (November)<br>(Ramirez/Foster)<br>4-0-0-3 |
| #6 **UM Business**<br>- Inter-Rater Reliability Results (IRR) for Physicians and non-Physicians<br>(Attachment W)<br>Action<br>Patrick Marabella, M.D, Chair | The Inter-Rater Reliability Report for Physicians and Non-physicians is an annual evaluation of UM physicians and staff to ensure InterQual® Clinical Decision Support Criteria along with other evidence-based policies and guidelines are used consistently during clinical reviews for medical necessity.<br>➢ The passing score is 90% for both physicians and non-physicians.<br>➢ Staff and Physicians who do not pass are required to retake the exam.<br>o The Utilization Management Department 2019 passed with 98% on all modules.<br>o The Medical Affairs Department for 2019 passed with 91% on all modules. | Motion: Approve<br>- Inter-Rater Reliability Results (IRR) for Physicians and non-Physicians<br>(Ramirez/Cardona)<br>4-0-0-3 |
| #7 **Compliance Update** | Mary Beth Corrado presented the Compliance Report. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| - Compliance Regulatory Report (Attachment X)<br>Action<br>Patrick Marabella, M.D, Chair | **Fraud, Waste, & Abuse Activity**<br>The California Department of Justice (DOJ) has open cases on four (4) of the sixteen (16) cases reported by CVH and requested information from the Plan. The Plan cooperated with the DOJ requests. There were no cases referred to other law enforcement agencies by the Plan.<br><br>**Independent Medical Reviews (IMRs) and State Hearings**<br>Increase in volumes noted and anticipate continued increase.<br><br>**Department of Health Care Services ("DHCS") 2020 Medical Audit**<br>DHCS was onsite at CalViva Health the week of February 3, 2020 to conduct their annual Medical Audit. The Plan is currently responding to some post onsite requests for documents. DHCS will issue a Preliminary Report of their findings later in 2020.<br><br>**Department of Health Care Services ("DHCS") Annual Network Certification CAP**<br>DHCS issued a letter to the Plan dated July 9, 2019 communicating DHCS findings regarding the Plan's 2019 Annual Network Certification (ANC) submission and requested a CAP related to non-compliant time and distance standards.<br><br>**Department of Health Care Services ("DHCS") 2019 Medical Audit**<br>DHCS issued its Final Report to the Plan on October 29, 2019 citing three deficiencies. The Plan submitted its CAP on December 3, 2019. The Plan is currently submitting monthly progress reports to DHCS regarding the status of CAP implementation.<br><br>**Department of Managed Health Care ("DMHC") 2019 Medical Survey**<br>The DMHC issued their Final Report on February 5, 2020 citing two deficiencies as corrected and two deficiencies uncorrected. DMHC will conduct an 18-month follow-up audit to validate corrective actions have been implemented.<br><br>**Medi-Cal Healthier California for All (MCHCA)** | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | In October 2019, the DHCS introduced MCHCA, a proposed framework that encompasses a broader delivery system, program and payment reform across the Medi-Cal program. MCHCA contains 20+ initiatives that will be phased in over several years. A table at the end of the report was reviewed as it outlined the planned initiatives associated with it. Periodic updates will be provided.<br><br>**Behavioral Health Integration (BHI) Incentive Program**<br>The 2019 Budget Act authorized DHCS to develop the Behavioral Health Integration (BHI) Incentive Program as part of its Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care. By January 21, 2020, eligible Medi-Cal providers had to submit applications to managed care plans in order to promote behavioral health integration.<br>CalViva Health received three (3) applications that are currently being reviewed to determine if the proposed programs will qualify for the BHI program.<br><br>**Preventive Care Outreach Project**<br>DHCS is implementing a Preventive Care Outreach project. The California State Auditor conducted an audit of DHCS' oversight of the delivery of preventive services to children in the Medi-Cal Program in 2018. The audit concludes that millions of children do not receive preventive services to which they are entitled. As a result, DHCS is implementing this Outreach Project.<br>➢ Phase 1- Outreach will be accomplished via mail and call campaign followed by a survey. Project to be completed by 12/31/20.<br><br>**Public Policy Committee**<br>The Public Policy Committee (PPC) met in Fresno County on December 4, 2019. A number of program documents were approved and routine reports such as the A&G Report were presented. | |
| #10 **Public Comment** | None. | |
| #11 **Adjourn**<br>Patrick Marabella, M.D, Chair | Meeting was adjourned at 11:37 am. | |

**NEXT MEETING: March 19, 2020**

Submitted this Day: March 19th, 2020

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

**Acknowledgment of Committee Approval:**

Patrick Marabella, MD Committee Chair

# Item #5

## Attachment 5.F

PPC Minutes

Dated 12/4/2019

# Public Policy Committee
# Meeting Minutes
# December 4, 2019

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 |
| ✓ | Leann Floyd, Kings County Representative | | **Staff Members** |
| ✓ | Sylvia Garcia, Fresno County Representative | ✓ | Courtney Shapiro, Community Relations Director |
| ✓ | Kristi Hernandez, At-Large Representative | ✓ | Cheryl Hurley, Commission Clerk |
| ✓ | Kevin Dat Vu, Fresno County Representative | ✓ | Greg Hund, CEO |
| ✓ | Norma Mendoza, At-Large Representative | ✓ | Dr. Marabella, CMO |
| | | ✓ | Amy Schneider, RN, Director of Medical Management |
| | | ✓ | Mary Lourdes Leone, Director of Compliance |
| | | * | = late arrival |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **#1 Call to Order**<br>Joe Neves, Chair | The meeting was called to order at 11:39 am. A quorum was present. | |
| **#2 Meeting Minutes from September 4, 2019 Action**<br>Joe Neves, Chair | The September 4, 2019 meeting minutes were reviewed. There were no discrepancies. | **Motion:** Approve September 4, 2019 Minutes 8-0-0-1 (R.Garcia / K. Dat Vu) |
| **#3 Enrollment Dashboard Information**<br>Mary Lourdes Leone, Director of Compliance | Mary Lourdes Leone presented the enrollment dashboard through October 2019. Membership as of the end of October was 354,110. CalViva Health maintains a steady 71% market share. | **No motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
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| **#4 Public Policy Committee Revised Charter**<br>**Action**<br>Courtney Shapiro, Director of Community Relations | The Public Policy Committee Charter was revised to add Health Education and also a new requirement per Department of Health Care Services. | **Motion:** Approve Revised PPC Charter to move to Commission for approval<br><br>8-0-0-1 (J. Garner / R. Garcia) |
| **#5 Health Education**<br>2019 Summary and Work Plan Mid-Year Evaluation<br><br>**Information**<br>Justina Feliz | The 2019 Health Education Work Plan Mid-Year Evaluation was presented to the PPC Committee. In summary, the report documents progress of 16 program initiatives. Of the 16 initiatives, 12 key initiatives have met or exceeded 50% of the year-end goal and the remaining 4 did not meet 50% of the year-end goal. Efforts are underway to meet all goals by year end. | **No motion** |
| **#6 Cultural and Linguistics**<br>2019 Summary and Work Plan Mid-Year Evaluation; 2019 Summary and Language Assistance Program Mid-Year Report; and 2019 Summary and Geo Access Report<br><br>**Information**<br>Lali Witrago | The 2019 Cultural & Linguistics Work Plan Mid-Year Evaluation was presented to the PPC Committee. In summary, the report provided information on the C&L Services Department work plan activities, which are based on providing cultural and linguistic services support and maintaining compliance with regulatory and contractual requirements. The C&L Work Plan is broken down into the following four sections: 1) Language Assistance Services (LAP), 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. As of June 30, 2019, all work plan activities are on target to be completed by the end of the year with some already completed.<br><br>The C&L Language Assistance reports provide information on the language services utilization by CalViva Health | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
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| | members for January 1 to June 30, 2019 as well as updates on Language Assistance Program (LAP) areas. This report also incorporates MHN Services' Mental Health/Behavioral Health language utilization by CalViva Health members for the same reporting period.<br><br>During January 1 to June 30, 2019, the number of calls handled by Member Services Department representatives totaled 59,717 across all languages. Of these, 10,225 (17%) were handled in Spanish and Hmong languages. Additionally, 1,341 interpreter requests were fulfilled for CalViva Health members. A total of 1,143 (85%) of these requests were fulfilled utilizing telephonic interpreter services with 148 (11%) for in-person and 50 (4%) for sign language interpretation. MHN Services' Member Services Department representatives handled a total of 2,465 calls across all languages with 205 (8%) handled in Spanish, Hmong and other non-English languages. A total of 63 requests for interpreter services were also fulfilled. Of the 63 requests, 59 (94%) were fulfilled for in-person and four (6%) for sign language interpretation.<br><br>The 2019 Geo Access report presentation provided information on counties where members who identified as speaking a given language did not live within an appropriate time and distance parameter. Gaps were identified for various languages for PCPs and specialists or both except for Spanish. All members identified as Spanish-speaking members residing in Fresno, Kings and Madera counties had | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
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| | their access needs meet. Of the members identified as Hmong speakers, seven members residing in Fresno County were identified as having an access gap to a PCP according to the parameters. Khmer and Arabic are the two member language needs with the most gaps. However, Madera demonstrates to be the county with the least gaps. When comparing this information to the 2017 analysis, 2019 analysis demonstrates less gaps in Hmong and no gaps in Spanish. Based on the geographic analysis, the Cultural and Linguistic Services Department will share the report with Provider Network Management to convey this information for the purposes of highlighting the need to develop network priorities for PCPs and specialist sites in Fresno, Kings and Madera Counties that support CalViva Health members' language needs. In addition, the Cultural and Linguistic Services Department will develop a plan to address the gaps in provider language capabilities and member language need. | |
| **#7 Medical Management**<br>RY 2019 HEDIS Data Results | Dr. Marabella reported on the RY 2019 HEDIS® data results. In 2019 Managed Care Plans (MCPs) reported on a total of 17 measures (16 HEDIS® measures and the All-Cause Readmission measure, a non HEDIS measure).<br><br>Managed Care Plans (MCP's) are required to meet MPLs and if performance levels are below MPLs (25th Percentile) an improvement plan must be developed and implemented.<br><br>For RY 2019 HEDIS® Improvement Plans, results below the MPL include the following: | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
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| | • Monitoring Persistent Meds –Madera County<br>• Monitoring Persistent Meds – Madera County - PDSA<br>• Avoidance of ABX Adults with Bronchitis – Madera County – PDSA<br>• Breast Cancer Screening – Fresno County – PDSA<br>• Diabetes Care HbA1c Testing – Fresno County – PDSA<br>• Childhood Immunizations – Fresno County – PIP<br>• Postpartum Visits (PPC) – Fresno County – PIP | |
| **#8 Appeals, Grievances and Complaints**<br><br>**Information**<br>Mary Lourdes Leone, Director of Compliance | Mary Lourdes Leone presented the appeals, grievances and complaints report for Q3 2019. Total appeals and grievances for Q3 2019 were 619. Total appeals for Q3 2019 were 274. Total grievances for Q3 2019 were 345. Turnaround time compliance standard was met at 100%. The majority of appeals and grievances were from members in Fresno County which has the largest CalViva Health enrollment. | **No motion** |
| **#9 2019 DHCS Audit Final Report; 2019 DMHC Audit Preliminary Report**<br><br>**Information**<br>Mary Lourdes Leone, Director of Compliance | Mary Lourdes Leone reported on the 2019 DHCS Audit Final Report, and the 2019 DMHC Audit Preliminary Report.<br><br>The final Corrective Action Plan as a result of the 2019 DHCS Audit Report has been sent to DHCS for review.<br><br>In November 2019 CVH sent in the responses and CAP addressing the findings of the 2019 DMHC audit. Awaiting final report from DMHC.<br><br>CVH is currently preparing for the 2020 DHCS audit. | **No motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
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| | | |
| **#10 DHCS Medi-Cal Proposal: CalAIM**<br><br>**Information**<br>Mary Lourdes Leone, Director of Compliance | Mary Lourdes reported on the DHCS Medi-Cal proposal of CalAIM. DHCS is trying to streamline the approach to provide a better framework for delivering various healthcare services. Additional information on this program is also available on the DHCS website. | **No motion** |
| **#11 Final Comments from Committee Members and Staff** | A general consensus was reached that power point presentations for the PPC meetings will no longer be printed for each committee member unless requested.<br><br>Greg Hund, CEO, provided information on the See2Succeed program. | |
| **#12 Announcements** | None. | |
| **#13 Public Comment** | None. | |
| **#14 Adjourn** | Meeting adjourned at 1:20 pm. | |

**NEXT MEETING** **March 4, 2020 in Fresno County**
**11:30 am - 1:30 pm**

Submitted This Day: March 4, 2020

Submitted By: _____
Courtney Shapiro, Director Community Relations

Approval Date: March 4, 2020

Approved By: _____
Joe Neves, Chairman

# Item #6

## Attachment 6.A

Quality Improvement
2020 Program Description

# CalViva Health Quality Improvement (QI)
# 2020 QI Program Description

## Narrative Changes

| Redline Page # | Section/Paragraph name | Description of change |
|---|---|---|
| 1 | Title Page & Footer | Updated year to reflect current year |
| 2-4 | Table of Contents | Updated page numbers |
| 16-17 | III- C: Health Promotion Programs | • Removed Disease Management paragraph due to redundancy (info is in Weight Management Program paragraph)<br>• Updated CalViva Pregnancy program to give more detail<br>• Under Healthy Hearts, Healthy Lives section, removed toolkit items.<br>• Digital Health Education- included opioid and postpartum depression<br>• Removed Health Promotion Incentive Programs<br>• Add information regarding language availability for Preventative Screening Guidelines |
| 18 | Member Connections Program | Minor grammatical edits |
| 19 | III-D:: Clinical Practice Guidelines (CPGs) | Revised section to include more descriptive language<br>Included statement about approval of CVH CMO and QIUM committee |
| 20 | III-E: Disease Management | • Removed statement regarding transition to Envolve PeopleCare<br>• Changed language from “functional status” to “clinical outcomes” |
| 22-23 | III- F: Transition Care Management Program | Expanded description regarding transition care model (TCI) that is used and the member impact. |
| 25 | III- G. Case Management Program | Minor grammatical edits |
| 27-28 | III- I: Palliative Care Program | New section added to document |
| 29 | III- J. Credentialing /Recredentialing | Minor grammatical edit changed license “expirations” to “disciplinary actions” |

| | | |
|---|---|---|
| 35 | III-O: Satisfaction | Description was expanded. |
| 37 | III-P: Access and Availability | • Added bullet regarding Provider Satisfaction Survey<br>• Updated survey name to reflect accurate title, “Telephone Answer Survey” |
| 39 | III-R: Medical Records | Updated language regarding Medi-Cal Managed Care Division, per DHCS |
| 40 | III-S: Cultural and Linguistic Services | • Added HHS Guidelines for Section 1557 of the ACA for C&L services<br>• Included paragraph regarding C&L services as a part of QI<br>• Updated report title, “Population Needs Assessment (PNA) |


# CalViva Health
## Quality Improvement (QI) Program Description

**202019**

# Table of Contents

# I.

# Introduction and Background

# A. *Health Plan Products and Membership*

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

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

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

The CalViva Quality Improvement Program (QI Program) provides members with access to network-wide safe clinical practices and services and assures they are given the information they need to make better decisions about their healthcare choices. The QI Program is designed to monitor and evaluate the adequacy and appropriateness of health and administrative services on a continuous and systematic basis and to support identification and pursuit of opportunities to improve health outcomes, services and member and provider satisfaction. Opportunities for improvement are identified through continuous monitoring of clinical outcomes, safety, access and service. The QI Program employs an organizational structure that reports to the RHA Commission and is led by committed decision-makers. The QI Program functions in collaboration with multiple departments that have QI-related functions. CalViva also collaborates externally with network physicians, other provider types and community partners for effective QI integration process.

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

# B. *Provider Network*

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

# C. *Information Systems and Analysis*

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

| | |
|---|---|
| Accounts Receivable | Membership |
| Claims and Encounters | Credentialing |
| Benefits | Member Complaints |
| Grievance and Appeals | Provider Network Management |
| Billing | Remittance |
| Medical Management | Customer Call Centers |

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

# II.

# Purpose and Goals

# A. *Mission*

CalViva mission is:

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

The mission of the CalViva QI Program is:

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

The vision of CalViva QI Program is to:

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

# B. *Purpose*

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

# C. *Goals*

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

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

# III.

# Scope

# A. *Scope of QI Program*

The CalViva QI Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance. CalViva ensures that there are no financial incentives or gain, including financial gain to providers, vendors, or facilities, to delay or withhold appropriate care. The QI Program provides oversight to ensure that RHA Commission and CalViva providers exert no economic pressure on facilities to grant privileges to providers. Facilities have in place Policies and Procedures for credentialing and re-credentialing. These processes are not subject to CalViva intervention.

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

- Health promotion, wellness and preventive care including the Initial Health Assessment
- Chronic care improvement/disease management
- Monitoring and evaluating access, availability, satisfaction and service
- Case Management (CM)
- Quality and safety of care
- Monitoring and evaluating care coordination for medical and behavioral conditions, ensuring coordination of care with other county and state programs
- Practitioner satisfaction
- Practitioner site and facility inspection including physical accessibility reviews of PCP and high-volume specialist provider sites.
- Medical record and documentation standards
- Practitioner and provider qualifications and selection through a careful credentialing and peer review process
- Utilization Management
- Credentialing & recredentialing
- Delegation Oversight
- Health Plan Clinical and Service Performance
- Member Rights & Responsibilities

- Communication to meet cultural and linguistic needs of all members
- Ensure SPD members undergo annual risk stratification, Health Risk Assessment (HRA), care plan preparation and distribution to the PCP

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

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

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

# B. *Preventive Health Screening Guidelines (PSGs)*

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

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

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

# C. *Health Promotion Programs*

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

The following interventions and resources are available at no cost to Medi-Cal members through self-referral or a referral from their primary care physician. Members and providers may obtain more information by contacting the toll-free Health Education Information Line at (800) 804-6074. Members will be directed to the appropriate service or resource based on their needs. Telephonic and website based services are available 24/7. Print educational resources are sent to members within two weeks of request.

- Weight Management Programs –Members have access to a comprehensive Fit Families for Life-Be In Charge!SM suite of programs. The Fit Families for Life-Home Edition is a 5-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. The Healthy Habits for Healthy People weight management educational resource is designed specifically for adults and seniors. Other nutrition and weight control education resources are also available upon request. Fit Families for Life community classes teaching basic nutrition and physical activity information are offered at Community Resource Centers, community based organizations and provider clinics located in areas where members reside. The Community Classes are free to all members and the community. Providers should complete and fax a copy of the Fit Families for Life - Be In Charge!SM Program Referral Form to the Health Education Department to refer members to the Home Edition program.
- ~~Disease Management Programs – Medi-Cal members with asthma, diabetes, and heart failure are enrolled into the Be In Charge!SM Disease Management programs to help them control their condition. Members receive educational resources and have unlimited 24-hour access to a nurse to address their medical concerns. High-risk members also receive nurse initiated outbound calls to help members manage their conditions.~~
- CalViva Pregnancy Program – The pregnancy program incorporates the concepts of case management, care coordination, disease management and health promotion in an effort to teach pregnant members how to have a healthy pregnancy and first year of life for babies. ~~Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby.~~ The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- California Smokers' Helpline-The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking. Helpline services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), and specialized services are available to teens, pregnant women, and tobacco chewers. Members are offered a 90 day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.
- Diabetes Prevention Program – Eligible members 18 years old and older with prediabetes can participate in a yearlong evidence-based, lifestyle change program that promotes and focuses on

emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.

- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit ~~(educational booklet, tracking journal and fitness DVD)~~ and community classes to learn how to maintain a healthy heart.
- Digital Health Education -Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and seek~~encourage members in accessing timely~~ preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with ~~deal with~~ depression, anxiety, stress, opioid and substance use, pain management, postpartum depression, ~~and~~ insomnia and more.
- ~~Health Promotion Incentive Programs Health Education partners with Quality Improvement department to offer incentive programs to encourage members to access HEDIS related preventive health care services.~~
- Know Your Numbers Community Class and Screening Events – Health Education conducts health screening on Body Mass Index (BMI), diabetes, hypertension and/or cholesterol to help participants understand their current health status. At the same event, participants are provided the appropriate preventive health education to help them adopt healthy behaviors and connect them to health care providers to control their health conditions.
- Community Health Education Classes – Free classes are offered to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs – CalViva Health participates in health fairs and community events to promote health awareness to members and the community. CalViva Health representatives provide screenings, presentations, and/or health education materials at these events.

The following resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, baby bottle-induced tooth decay, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Member Request Form –- Members complete this pre-stamped form to request free health education resources in threshold languages available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line. They can also get CalViva Health's print resources at contracted providers and health education classes.
- Health Education Programs and Services Flyer — This flyer contains information on all health education 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 Health News is mailed to members regularly and covers various health topics and the most up-to-date information on health education interventions.

## ***MemberConnections® Program***

MemberConnections is an special educational and outreach Medi-Cal program designed to help members navigate the health care system, promote preventive health practices, and connect them to health and community social services. MemberConnections Representatives (MCRs) extend the reach of member engagement and care management efforts by making 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/providers and members.

More specifically, MCRs:

- conduct assessments to better understand members' needs such as the Health Risk Screening
- 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 members to case management and disease management to better manage their chronic and/or complex health conditions
- address social needs by linking members to county and community resources
- help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services

# D. *Clinical Practice Guidelines*

CalViva Health 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~~,~~ and 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 Health adopts guidelines from recognized organizations that develop or disseminate evidenced-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, network practitioners, and CalViva Health's CMO and the QIUM Committee. The guidelines are reviewed and approved annually. ~~updated and~~ They are 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 practitioners through provider faxes and are available to providers on the Health Net website~~s~~ and to members upon request. ~~CalViva Health monitors adherence to guideline recommendations and program outcomes using HEDIS measures.Clinical practice guidelines (CPG) are developed and/or adopted to reduce variation in practice and improve the health status of members. CalViva adopts nationally recognized, evidence-based clinical practice guidelines. CalViva, Medical Directors, and network practitioners are involved in the review and update process for clinical practice guidelines. Specialty input on guidelines is obtained, when indicated. Guidelines are evaluated for consistency with CalViva's benefits, utilization management criteria, and member education materials.~~

# E. *Disease Management*

The Disease Management – *Be In Charge!* ℠ Program provides disease specific management for members with Asthma, Diabetes, and Heart Failure (HF). ~~and will transition to Envolve PeopleCare in 2018~~. The goal of the *Be In Charge!* ℠ Program is to improve member knowledge and self-management of these diseases leading to improved quality of life, and better ~~functional status~~clinical outcomes. Additionally, the program aim is to empower members to manage their diseases in accordance with national peer-reviewed published guidelines and to ensure that members receive necessary screenings and monitoring services.
Enrolled members in the program are mailed educational materials with action plans, information about the program, and contact numbers for the Nurse Advice Line. Program members receive outbound telephonic interventions and referrals are made to the Case Management program if the member is identified as being at high risk for hospitalizations or poor outcomes.

### Nurse Advice Line

The Nurse Advice Line (NAL) service is a member-centric nurse triage program that combines high-tech, patented, algorithm-based tools with high-touch call center services. The NAL provides immediate symptom assessment, and member education services. In addition to educating members how to better manage their own health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is offered 24 hours a day, seven days a week, all year long, in English and Spanish with translation services available for other languages.

Using clinical decision algorithms, the NAL registered nurse listens to each member's chief complaint, identifies member symptoms, and selects the most appropriate algorithm to be used for a thorough assessment. A combination of member input and clinical judgement allow the nurses to answer clinical questions and determine timeliness of care. Nurse Advice Line nurses may access support from a physician when needed as the nurse interacts directly with the member. The NAL is URAQ accredited.

### 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 and exercise physiologists serve as program coaches. Themes introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, tips for eating out, and more. Members are offered unlimited inbound calls 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 85$^{th}$ 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, 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.

**Audio Library**

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

# F. *Transition Care Management Program*

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

The TCM Program is a care transition model that utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation. The TCM Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

The focus of this model is based on a coaching intervention rather than a case management intervention. Under this model, the Care Transition nurse helps patients/members and/or their primary caregiver, learn transition specific self-management skills by:

1. Introducing the CTI to the member at the time of hospitalization,

2. Use of other tools to transfer skills to patients and family members on how to communicate care needs effectively during direct encounters with their health care team,

3. Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation- how to respond to medication discrepancies, how to utilize a personal health record (PHR), and

4. Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.

5. Follow-up calls with the member are conducted within **30 days** of post-discharge, which focuses interventions on:

- Reviewing ofthe progress toward established goals
- Discussing encounters with other health care professionals
- Reinforce ement of the importance of maintaining and sharing the PHR
- Supporting the patient's self-management role
- Medication reconciliation with access to pharmacist.
- Educateing the member to follow up with the PCP/and or specialist within 7 days of discharge.

During the post discharge period, staff evaluates the member for Case Management, Palliative care and other programs that may best support the member in managing their continued needs. A referral to these programs is conducted as applicable to ensure continuity of addressing outstanding member needs/goals.

***Member Impact***

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

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

~~The Transition Care Management (TCM) Program provides a comprehensive, integrated transition process that supports members during movement between levels of care. The TCM Program is a care transition model that utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period to ensure timely, safe and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating the health care continuum and addressing barriers to post discharge success for the member.~~
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# G. *Case Management (CM) Program*

CalViva partners with HNCS to provide Case 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 multiple disciplinary team, provide coordination, education and support to the member (family and caregiver) in achieving optimal health, enhancing quality of life and accessing appropriate services.

The goals of the CM program are:

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

This program seeks to identify and intervene with members:

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

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

- Health information forms~~lines~~
- Any of the Disease management programs
- The concurrent review and discharge planning process
- A member/caregiver request for case management
- A practitioner request for case management

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

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

The Case 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. ~~In addition, an in-home assessment is preferred for the highest risk complex members.~~

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

# H. *Behavioral Health Services*

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

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

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

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

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

# I. *Palliative Care (Care Connections) Program*

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

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

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

A. General Eligibility Criteria

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

B. Disease- Specific Eligibility Criteria

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

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

**C.** Pediatric Palliative Care Eligibility Criteria

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

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

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

Palliative care services shall include the following services:

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

Referrals can come from multiple sources. This may include:
Internal health plan case managers and concurrent review nurses; Primary Physician Groups (PPG), Member's Primary Care Physicians and Specialists, Palliative Care Vendors/ Providers, Hospitals, Internal Claims Data, California Children's Services (CCS) Program, Others

# ~~I.~~J. *Credentialing / Recredentialing*

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

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

All providers undergo a quality process of credentialing prior to finalizing contract agreements and are recredentialed every three years. All providers are monitored monthly for Medicare/Medicaid plan sanctions, license expirations ~~expirations~~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.

# ~~J.~~K. *Continuity and Coordination of Care*

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

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

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

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

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

- Case Management
- Pharmacy programs
- Utilization and Case Management Programs
- Member Services functions
- Communication and data exchange that is appropriate and compliant with state and federal privacy and security regulations
- Information will be posted on the Plan website for advising providers, contractors, members, and the public how they can obtain information about the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by CalViva.
- For all members with identified complex health needs, CalViva supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. Other programs such as disease management and nurse advice line are also available to members and can help those with complex needs manage their conditions. Provider groups also support members through their coordination of care programs.

## ~~K.~~L. Delegation

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

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

The CalViva QI Program incorporates input from appropriate professionals into the designs of its corrective action plans or QI Programs. Should Corrective Action Plans (CAP) be required and implemented, CalViva utilizes physicians and registered nurse's 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 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.

## ~~L.~~M. Safety

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

- Informing and educating health care professionals on safety issues
- Identifying and evaluating strategies for reducing errors and improving member safety
- Promoting the dissemination of effective strategies and best practices throughout the health care industry
- Making performance data publicly available for members and practitioners
- Current member safety activities include but are not limited to: Conducting PCP facility site/medical record reviews and physical accessibility reviews of PCP and other high-volume provider sites.
- Conducting a rigorous credentialing and recredentialing process to ensure only qualified practitioners and organizational providers provide care in the network.
- Monitoring quality of care indicators on a quarterly basis to identify patterns and/or trends
- Conducting pharmacy system edits to assist in avoiding medication errors.
- 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 DHCS determined or nationally recommended quantity limits
- Analysis of member quality of care complaints, potential quality of care, and provider preventable conditions cases to identify patterns and trends
- Care coordination for high risk patients
- Member education
- Assuring that affected members and providers are notified of FDA and voluntary drug safety alerts and recalls
- Nurse Advice and Triage Line available 24 hours a day, 7 days a week, every day of the year

Mechanisms for communication include:

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

## ~~M.~~N. Health Plan Performance

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

CalViva adopts and maintains a broad range of key performance metrics to monitor clinical and service quality in Medical Management, Appeals & Grievances, Disease Management, Case Management, Concurrent Review and the Medical Review Unit. CalViva's QI Program also monitors key performance metrics for Pharmacy.

## ~~N.~~O. Satisfaction

CalViva Health ~~continuously~~ monitors member satisfaction throughout the year using the CAHPS survey results, member appeal~~s~~ and grievance data~~s~~, and ~~CMS complaint tracking modules (CTMs).~~ CAHPS survey results are integrated into various state and federal performance rating systems and reports including the following:

- ~~Office of the Patient Advocate Report Cards;~~
- DHCS Medi-Cal Managed Care Quality Improvement Reports.

QI activities are focused on educating CAHPS stakeholders and measure owners and implementing improvement activities. Quality Improvement staff partner~~s~~ with several business areas including Medical Management, Customer Contact Center, Appeals and Grievances, Pharmacy, Claims, Credentialing, Provider Network Management, Provider Engagement Performance Management (PEPM), Delegation Oversight, Sales, Marketing, and MHN~~S~~. ~~Annually, QI analyzes data, documents and reports to stakeholders the integrated member satisfaction reports required, to support an improved member experience.~~

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

The Quality Improvement department partners with the Customer Experience team (CXCI) to improve operational and organizational processes. The CXCI team has several initiatives underway including:

- ~~Implementation and monitoring of the Net Promoter Score (NPS).~~
- Drive to Digital: Identification of an approach for collecting and storing member contact information and preferences, and developing the capability to deliver documents electronically for key member communications.
- Member Orchestration: Creation of a holistic approach to the member experience by communicating via their preferred methods and improve common transactions.
- Value stream mapping to improve work flow and information processing in Appeals and Grievances empowerment, claims, prior authorization, and Member Services.
- Welcome Experience: Redesigning the member on-boarding process and associated collateral such as the welcome kits and ID cards.

~~QI activities focusing on access, availability, satisfaction, and service rely on multi-departmental involvement. Service activities involve CalViva and HNCS staff in the Health Care Services, Customer Contact Center, QI, Appeals & Grievances, Pharmacy, Claims, Credentialing, Provider Network Management, Delegation Oversight, and Marketing departments.~~

~~An important aspect of satisfaction and service to members is providing details of the benefit plan to prospective members and enrollees. Member materials are assessed to ensure that prospective member and enrollment information includes details on the benefit plan, how to obtain primary, specialty, and behavioral health care, how to voice complaints and appeals, and how to obtain information on translation and interpretative services. In addition, members receive various communications that highlight general medical information and other focused activities.~~

~~Information used to assess and monitor member satisfaction with service and clinical care include the following: CAHPS®, SWBHC (Satisfaction With Behavioral Health Care), grievance and appeal data, member call data, including reasons for transfers between practitioners or member disenrollment. Practitioners and providers are informed of the results of member satisfaction analyses and any opportunities for improvement that have been identified through Provider Updates and Committees with external participants. Opportunities for improvement are shared internally through quality committees.~~

# ~~O.~~P. Access and Availability

To ensure CalViva has a network that is sufficient and adequate to provide its members appropriate access to, and availability of, practitioners, providers, and health care services and to ensure CalViva's members have appropriate access to health care services within a reasonable period of time, CalViva has established access to care standards for medical services including 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® and SWBHC (Satisfaction With Behavioral Health Care) Surveys.
- Provider After-Hours Access Survey (PAHAS): Annual provider telephone survey assessing after- hours ER information and physician afterhours access.
- Provider Appointment Availability Survey (PAAS): Annual provider appointment survey to assess member access to care and service. Specific elements include preventive care, routine care, and urgent care for medical and behavioral care.
- Provider Satisfaction Survey (PSS): Annual provider survey to assess provider perspective and concerns regarding compliance with the access standards and to evaluate satisfaction with the time-elapsed standards
- Telephone Answer~~ccess~~ Survey: Quarterly provider 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, and pharmacy) providers.
- Hospital Bed Capacity: Ratio of members per hospital beds in the contracted hospital network.
- Ratio of Members to Practitioner/Provider: Assessment of the ratio of members to PCPs, SCPs, and high volume SCPs.
- Network Open Access Report: Presents the percentage of PCPs accepting new members by line of business.

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

# ~~P.~~Q. *Member Rights and Responsibilities*

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

Member rights include the right to:

- be treated with respect, dignity, and courtesy;
- privacy and confidentiality;
- receive information about your 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 you want to be cared for in case you have a life-threatening illness or injury;
- voice complaints or other feedback about the Plan or the care provided without fear of losing your benefits;
- appeal if you don't agree with a decision;
- request a State Fair Hearing;
- receive emergency or urgent services whenever and wherever you need it;
- services and information in your language;
- receive information about your rights and responsibilities; and
- 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; and
- reporting health care fraud or wrong doing.

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.

## ~~Q.~~R. Medical Records

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

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

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

CalViva monitors both medical record keeping and medical record systems to assess the quality of medical record documentation and compliance with standards through medical record audits as part of the ~~Medi-Cal Managed Care Division~~ Managed Care Quality and Monitoring Division of Department of Healthcare Services PCP Full Scope Facility Site and Medical Record Review process.

At least annually, the PCP Facility Site and Medical Record Review results are analyzed and reported to the QI/UM Committee to identify opportunities for improvement. Actions are taken when compliance issues are identified. Appropriate interventions are implemented based on compliance rates established for each standard. Interventions may include Corrective Action Plan, sending Provider Updates, revising the Provider Operations Manual, sending educational or reference materials to practitioners or providers, and creating template medical record forms. Follow up is conducted to evaluate the effectiveness of the corrective actions.

# ~~R.~~S. *Cultural and Linguistic Needs*

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

The C&L Services Department, on behalf of CalViva Health, provides resources, materials, trainings, and in-services on a wide range of C&L topics that impact health and health care. The cultural competency training program adheres and implents HHS guidelines for Section 1557 of the ACA for C&L services and requirement for ~~covers~~ non-discrimination based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. Services offered include cultural and language information for providers and their staff, as well as for Plan staff; trainings on language assistance requirements imposed by state and federal regulatory agencies; interpreter support for members and providers; culturally appropriate translation and review of member materials; and cultural responsiveness education. C&L 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.

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

To ensure compliance with applicable Medi-Cal contractual requirements, state and federal rules and regulations and other requirements of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC), the C&L Services Department:

a) Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services
b) Utilizes and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities
c) Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities
d) Collects, analyzes and reports membership language, race and ethnicity data in reports such as the Population~~Group~~ Needs Assessment (P~~G~~NA)
e) Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually
f) Maintains information links with the community through Public Policy Committee (PPC) meetings, Population~~Group~~ Needs Assessment (P~~G~~NA) and other methods
g) 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
h) Engage community-based organizations, coalitions, and collaborative in counties where CalViva Health members reside and be a resource for them on C&L issues
i) Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (ICE), America's Health Insurance Plans (AHIP), and California Association of Health Plans (CAHP)

j) Provide C&L services that support member satisfaction, retention, and growth

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

a) Provide C&L information and support for HNCS and CalViva Health staff in their efforts to provide excellent customer relations and services
b) 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
c) Support efforts of contracted providers to deliver culturally and linguistically appropriate health care services by providing informative materials, cultural competency workshops, and in-services
d) 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
e) Deliberately address health equity through collaborating to identify, develop and implement interventions at the member, community and provider levels to improve health disparities
f) Sustain efforts to address health literacy in support of CalViva Health members
g) Assess bilingual capabilities of bilingual staff and provide ongoing education and support
h) Increase cultural awareness of Plan staff through trainings, newsletter articles, annual "Heritage" activities, and other venues.

# IV.

# QI Process

# A. *Confidentiality / Conflict of Interest*

CalViva Health'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 Health's contracts require that providers and practitioners maintain the confidentiality of member's information and records. Information or copies or records may be released only to authorized individuals as permitted by state and federal law.

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

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

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

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

# B. *QI Process*

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

- Establishment of quantitative and qualitative measures to assess performance and identify and prioritize areas for improvement
- Establishment of goals or benchmarks for each measure using nationally recognized, evidence-based standards of practice if applicable
- Identification of appropriate methodology to identify the targeted population or sample and ensure the validity and reliability of the collected data
- Performance of a quantitative and qualitative (identification of barriers) analysis of the data collected for each measure
- Identification of opportunities for improvement
- Implementation of appropriate interventions to improve practitioner, provider, and plan performance
- Measurement of the effectiveness of the interventions and corrective actions
- Quality of care problems or grievances are identified and can be submitted by the member, member's family, or provider on behalf of the member and can include problems or grievances about any type of medical or behavioral health service including, without limitation, care in a physician's office, clinic, hospital, ER, outpatient facility, home health agency, rehabilitation office, retail pharmacy, 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®, and SWBHC, rates, national and regional benchmarks and goals
- Local and state required improvement projects
- Concordance with plan initiatives (e.g., disease management programs)
- QI programs identified through community collaborative activities
- Patterns of inappropriate utilization
- Cultural or linguistic makeup of membership causing gaps in care
- Health Outcome disparities

- Appeals and grievance / customer service rates
- Member and provider survey results regarding satisfaction, access and availability, and coordination of care

Selection of topics takes into account:

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

Data collected to support the CalViva QI process include:

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

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

# V.

# Program Structure and Resources

# A. *QI Committees*

## *Governing Body/RHA Commission*

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

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

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

The CalViva QI/UM Committee meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its 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 policy decisions, evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate. The Committee also ensures practitioners participate in the planning, design, implementation and review of the CalViva QI Program. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis. Membership of the CalViva QI/UM Committees includes practicing practitioners.

CalViva QI/UM Committee has the following subcommittees:

Credentialing and Peer Review Sub-Committees

## *Credentialing and Peer Review Sub-Committees*

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

The RHA Commission provides oversight of the QI/UM Committee and Credentialing and Peer Review Subcommittees, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing and Peer Review Sub-Committees. 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 Health. CalViva retains the right to request in writing any modifications to a Health Net contracted participating providers' status in the CalViva network, including, without limitation, a request to terminate a participating provider's contract.

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

# B. *QI Workgroups*

## *QI/UM Operational Workgroup*

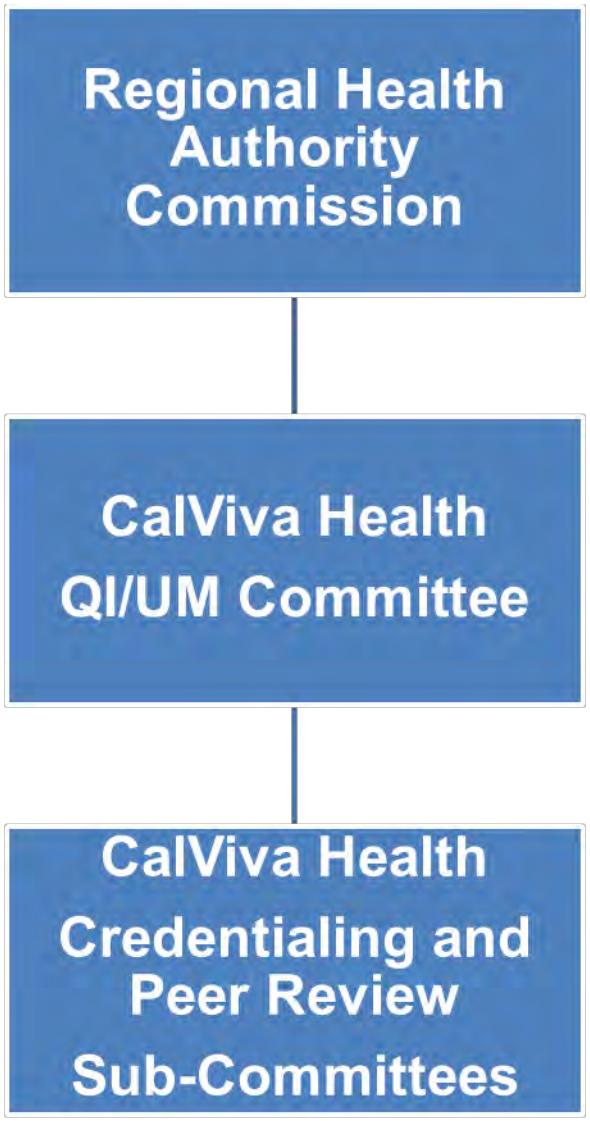
The QI/UM Operational Workgroup is designed to monitor and evaluate the adequacy and appropriateness of health and QI/UM related services on a continuous and systematic basis. The Workgroup supports the identification and pursuit of opportunities to improve health outcomes, safety, access, services and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

## *Access Workgroup*

The CalViva Access Workgroup brings together representatives from CalViva and HNCS multiple departments that have access and network adequacy related functions. The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and

evaluate implementation of activities in collaboration with HNCS representatives to improve access to care services. The Access Workgroup will report recommendations and findings to the QI/UM Workgroup.

***Committee Organizational Chart***



# C. *Staff Resources and Accountability*

### *CalViva Chief Medical Officer*

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

### *Regional Medical Director*

The Regional Medical Directors (RMDs), who are provided through HNCS, assist in the clinical focus of the QI, utilization and case 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.

### *Department Resources*

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

### *QI Team*

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

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

CalViva delegates DHCS required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per Medi-Cal Managed Care Division (MMCD) Policy Letters 14-004,12-006 and 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, 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 a registered nurse who has oversight responsibility for the PCP facility and medical record audit processes. This oversight process involves conducting initial evaluation, conducting annual review of activities, identifying areas for improvement, and collaboratively developing action plans to address areas of noncompliance. Results of the annual review are presented to the CalViva Chief Medical Officer and the CalViva QI/UM Committee.

### *Health Education*

CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services. Health education services include individual, group and community-level education, and support community needs assessments and work plans based on the results of the assessments. Based on cultural and linguistic needs of the membership, CalViva, with HNCS's assistance, implements preventive care programs, such as diabetes prevention, weight management, tobacco cessation and prenatal/postpartum education, at varying intervention levels such as individual, group and community-level.

### *Pharmacy Services*

CalViva is responsible for managing the pharmaceutical benefits of CalViva. HNCS will assist CalViva in the establishment and maintenance of the CalViva drug formularies, the education and communication of formularies and non-formulary issues throughout the CalViva practitioners and pharmacy network. 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 non-formulary drugs. Analysis includes drug utilization patterns, pharmacy service indicators and cost-effectiveness monitoring of the pharmaceutical care and services provided to CalViva members. Pharmaceutical services reports shall be made to the CalViva QI/UM Committee on a quarterly basis.

### *Grievances and Appeals*

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

### *Credentialing/Recredentialing*

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

### *Utilization Management/Medical Management*

CalViva's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and medical management programs. A systematic approach is used by CalViva, with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS Healthcare Services Department and medical management team partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CalViva's members. Utilization/Medical Management 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 Workplan.

### *Customer Contact Centers*

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

### *Provider Network Management*

CalViva delegates provider network management to HNCS. HNCS Provider Network management staff initiates and directs efforts to recruit and expand hospital, practitioner and ancillary provider networks to serve CalViva Medi-Cal members. The Provider Network Management staff liaison also collaborates with the hospitals, practitioners and other providers for the resolution of contractual, operational, service and medical issues and conducts training sessions to provide contracted practitioners and providers with current CalViva policies and operational and product changes.

### *Delegation Oversight*

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

### *HEDIS® Management and Clinical Reporting*

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

# *VI. Program Evaluation and Work Plan*

# B. *Review and Oversight*

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

# C. *Annual QI Evaluation*

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

# D. *Annual QI Work Plan*

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

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

# VII. Approval

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

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

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

Date

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

Date

# Item #6

## Attachment 6.B

Quality Improvement
2020 Work Plan


# CalViva Health
# Quality Improvement
# Work Plan 2020

03.04.20

# CalViva Health 2020 Quality Improvement Work Plan

## TABLE OF CONTENTS

Submitted by:

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

# CalViva Health 2020 Quality Improvement Work Plan

## I. Purpose

The purpose of the CalViva Health's Quality Improvement Program Work Plan is to establish objectives for the QI Program and review clinical, service and safety related outcomes against the priorities and objectives established by the Program. An assessment of critical barriers is made when objectives have not been met.

## II. CalViva Health Goals

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

## III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2020. The development of this document requires resources of multiple departments.

# CalViva Health 2020 Quality Improvement Work Plan

**Glossary of Abbreviations/Acronyms**

| | | | |
|---|---|---|---|
| **A&G:** | Appeals and Grievances | **HPL:** | High Performance Level |
| **A&I:** | Audits and Investigation | **HN:** | Health Net |
| **AH:** | After Hours | **HSAG:** | Health Services Advisory Group |
| **AWC:** | Adolescent Well-Care | **IHA:** | Initial Health Assessment |
| **BH:** | Behavioral Health | **ICE:** | Industry Collaborative Effort |
| **C&L:** | Cultural and Linguistic | **IP:** | Improvement Plan |
| **CAHPS:** | Consumer Assessment of Healthcare Providers and Systems | **IVR:** | Interactive Voice Response |
| | | **MCAS:** | **Managed Care Accountability Set** |
| **CAP:** | Corrective Action Plan | **MCL:** | Medi-Cal |
| **CCHRI:** | California Cooperative Healthcare Reporting Initiative | **MH:** | Mental Health |
| **CDC:** | Comprehensive Diabetes Care | **MMCD:** | Medi-Cal Managed Care Division |
| **CM:** | Case Management | **MPL:** | Minimum Performance Level |
| **CP:** | Clinical Pharmacist | **PCP:** | Primary Care Physician |
| **CVH:** | CalViva Health | **PIP**: | Performance Improvement Project |
| **DHCS:** | Department of Health Care Services | **PMPM:** | Per Member Per Month |
| **DM:** | Disease Management | **PMPY:** | Per Member Per Year |
| **DMHC:** | Department of Managed Health Care | **PNM:** | Provider Network Management |
| **DN:** | Direct Network | **PRR:** | Provider Relations Representative |
| **FFS:** | Fee-for-Service | **PTMPY:** | Per Thousand Members Per Year |
| **HE:** | Health Education | **QI:** | Quality Improvement |
| | | **SPD:** | Seniors and Persons with Disabilities |
| | | **UM:** | Utilization Management |

# I. ACCESS, AVAILABILITY, & SERVICE

| Section A: Description of Intervention (due Q1) | | | | |
|---|---|---|---|---|
| **1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access** | | | | |
| ☐ New Initiative ☒ Ongoing Initiative from prior year | | | | |
| **Initiative Type(s)** | ☒ Quality of Care | ☒ Quality of Service | ☐ Safety Clinical Care | |
| **Reporting Leader(s)** | **Primary:** | **CalViva Health Medical Management** | **Secondary:** | **Health Net QI Department** |

| Rationale and Aim(s) of Initiative |
|---|
| Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. Assessing practitioner compliance with access standards and surveying members allows the identification of areas for improvement. |
| **Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.** |
| Timely Appointment Access to Primary Care Physicians and Specialists is measured through eight metrics. The specific goal is 80% for all measures. Success will be evaluated at the end of the survey period. Timely Appointment Access is monitored using the DMHC PAAS Tool and the CVH PAAS Tool. |
| Timely Appointment Access to Ancillary Providers is measured through two metrics. The goal is 90% for all metrics. Timely Appointment Access is monitored using the DMHC PAAS Tool. |
| After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey. This survey is conducted to assess provider compliance with required after-hours emergency instructions for members and that members can expect to receive a call-back from a qualified health professional within 30 minutes when seeking urgent care/services by telephone. The results are made available to all applicable provider organizations through annual provider updates. When deficiencies are identified, improvement plans are requested of contracted providers and provider groups as described in CVH policy PV-100-007 Accessibility of Providers and Practitioners. These measures assess whether 90% of providers have appropriate emergency instructions whenever their offices are closed/after-hours, and if 90% of providers are available for members to contact them during after-hours for urgent issues within the 30-minute timeframe standard. |

**Planned Activities**

| Activities | Target of Intervention: Member (M) / Provider (P) | Timeframe for Completion | Responsible Party(s) |
|---|---|---|---|
| Implement Provider Appointment Access Survey (PAAS) to monitor appointment access at the provider level to comply with DMHC and continue conducting Medi-Cal Appointment Access Survey to comply with DHCS requirements | P | Q3- Q4 | CVH/HN |
| Develop and distribute provider updates, as applicable, informing providers of upcoming training webinars, | P | Q1 - Q4<br>Q2 - MY2020 Survey Prep<br>Q3 – MY2019 Survey Results | CVH/HN |

| | | | |
|---|---|---|---|
| surveys, survey results, and educational information for improvement. | | | |
| Conduct provider training webinars related to timely access standards and surveys | P | Q1-Q4 | CVH/HN |
| Conduct After Hours Telephone Answer surveys quarterly to monitor provider office answer time and member callback times. | P | Q1-Q4 | CVH/HN |
| Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval | P | Q1 | CVH/HN |
| Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability. | P | Q3-Q4 | CVH/HN |
| Complete a CAP as necessary – when CalViva providers are below standard; including additional interventions for providers not meeting standards two consecutive years. | P | Q3-Q4 | CVH/HN |
| Annual review, update and distribution of Patient Experience Toolkit, After-Hours Script, Guidelines for compliance and Monitoring and Appointment Scheduling Tip sheet | P | Q1-Q4 | CVH/HN |
| Conduct provider onsite office audits for all repeat noncompliant providers | P | Q4 | CVH/HN |

| **Section B: Mid-Year Update of Intervention Implementation (due Q3)** | **Section B: Analysis of Intervention Implementation (due end of Q4)** |
|---|---|
| | |

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)**
**Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)**
**Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)**

| Measure(s) | Specific Goal | Rate RY 2019 (MY2018) | Rate RY 2020 (MY2019) (populated mid-year) | Baseline Source | Baseline Value |
|---|---|---|---|---|---|
| Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request | 80% | Overall= 82.1%<br>Fresno=85.7 %<br>Kings=85.2 %<br>Madera=62.5 % | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 82.1%<br>Fresno=85.7 %<br>Kings=85.2 %<br>Madera=62.5 % |

| | | | | | |
|---|---|---|---|---|---|
| Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request | 80% | Overall= 68.1%<br>Fresno=72.2 %<br>Kings= 73.7%<br>Madera= 43.1 % | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 68.1%<br>Fresno=72.2 %<br>Kings= 73.7%<br>Madera= 43.1 % |
| Access to Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request | 80% | Overall= 71.4%<br>Fresno=74.2 %<br>Kings=59.3 %<br>Madera= 81.3% | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 71.4%<br>Fresno=74.2 %<br>Kings=59.3 %<br>Madera= 81.3% |
| Access to Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request | 80% | Overall= 62.8%<br>Fresno= 68.0%<br>Kings=44.4 %<br>Madera= 53.2% | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 62.8%<br>Fresno= 68.0%<br>Kings=44.4 %<br>Madera= 53.2% |
| Access to First Prenatal Visit (PCP) – Within 10 business days of request | 80% | Overall=90.3 %<br>Fresno=94.4 %<br>Kings=90.0 %<br>Madera=66.7 % | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall=90.3 %<br>Fresno=94.4 %<br>Kings=90.0 %<br>Madera=66.7 % |
| Access to First Prenatal Visit (SCP) – Within 10 business days of request | 80% | Overall=88.9 %<br>Fresno=87.5 %<br>Kings=100%<br>Madera= 100% | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall=88.9 %<br>Fresno=87.5 %<br>Kings=100%<br>Madera= 100% |
| Access to Well-Child Visit with PCP – within 10 business days of request | 80% | Overall= 73.6%<br>Fresno= 69.8 %<br>Kings= 85.2 %<br>Madera= 68.8% | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 73.6%<br>Fresno= 69.8 %<br>Kings= 85.2 %<br>Madera= 68.8% |
| Access to Physician Exams and Wellness Checks – within 30 calendar days of request | 80% | Overall= 88.5%<br>Fresno=85.2%<br>Kings= 92.6%<br>Madera=93.8 % | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 88.5%<br>Fresno=85.2%<br>Kings= 92.6%<br>Madera=93.8 % |
| Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request | 80% | Overall= 66.7%<br>Fresno= 60.0%<br>Kings=100 %<br>Madera= NR | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= | CVH Performance RY2019 | Overall= 66.7%<br>Fresno= 60.0%<br>Kings=100 %<br>Madera= NR |
| Appropriate After-Hours (AH) emergency instructions | 90% | Overall= 93.9%<br>Fresno=95.2 %<br>Kings=95.0 %<br>Madera=80.5 % | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 93.9%<br>Fresno=95.2 %<br>Kings=95.0 %<br>Madera=80.5 % |

| | | | | | |
|---|---|---|---|---|---|
| AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes (Per P&P) | 90% | Overall= 82.0%<br>Fresno=82.3 %<br>Kings=77.8 %<br>Madera=85.0 % | Overall= %<br>Fresno= %<br>Kings= %<br>Madera= % | CVH Performance RY2019 | Overall= 82.0%<br>Fresno=82.3 %<br>Kings=77.8 %<br>Madera=85.0 % |

*Denominator less than 10. Rates should be interpreted with caution due to the small denominator

↑↓ Statistically significant difference between RY2019 vs RY2018, p<0.05

NR – No reportable data

**Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered**

| | |
|---|---|
| **Analysis: Intervention Effectiveness w Barrier Analysis** | |
| **Initiative Continuation Status (Populate at year end)** | ☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Confirmed box should be checked. Continue Initiative with Modification** |

**Section A: Description of Intervention (due Q1)**

**1-2: Improve Member Satisfaction**

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

| | | | |
|---|---|---|---|
| **Initiative Type(s)** | ☒ **Quality of Care** | ☒ **Quality of Service** | ☒ **Safety Clinical Care** |

| Reporting Leader(s) | Primary: | CalViva Health Medical Management | Secondary: | Health Net QI Department |
|---|---|---|---|---|

**Rationale and Aim(s) of Initiative**

Member Experience for CalViva is monitored in two ways:

1. DHCS conducts a CAHPS survey every 3 years; results are posted the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx
2. HNCA QI CAHPS team helps to administer a scaled-back CAHPS survey to assess access areas of opportunity. This CalViva Access Survey is administered through SPH Analytics/Morpace. Final results are shared with PNM.

Member satisfaction is affected by member interaction with the providers, provider office staff, the plan, and vendor partners. Results are also impacted by member demographics and individual health status.

**Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.**

**Through the DHCS-administered CAHPS survey, the following measures are evaluated**:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Getting Needed Care (composite measure)
- Getting Care Quickly (composite measure)
- How Well Doctors Communicate (composite measure)
- Customer Service (composite measure)
- Shared Decision Making (composite measure)

Our goal for the CAHPS survey is to be at or above the Quality Compass 50$^{th}$ percentile.

**On an annual basis, the CalViva Access Survey collects information on the following measures**:

- Access to Urgent Care
- Access to Routine Care
- Access to Specialist Appointment
- Ease of Getting Care/Tests/Treatment

Our internal goal for the CalViva Access survey is to exceed previous year's performance

**Planned Activities**

| Activities | Target of Intervention: Member (M) / Provider (P) | Timeframe for Completion | Responsible Party(s) |
|---|---|---|---|
| Annually review, update, distribute and promote the 2018 Patient Experience(PE) Toolkit to providers | P | Q2 2019 | CVH/HN |
| Annually, review update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide | P | Q1-Q2 2019 | CVH/HN |
| Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the PE Toolkit to educate and empower members and improve their overall experience | P/M | Q1-Q2 2019 | CVH/HN |
| Annually, review, update and enhance materials on Interpreter services 24/7 to remind providers of the availability of these services and how to access them | P | Q1-Q2 2019 | CVH/HN |
| Create article and distribute in Member newsletter highlighting access standards and interpreter services | M | Q2 2019 | CVH/HN |
| Annually, review and update and enhance materials on the Nurse Advice Line to encourage use of this service by members | P/M | Q1-Q2 2019 | CVH/HN |
| Update and conduct scaled-back member survey to assess effectiveness of interventions implemented | M | Q3 2019 | CVH/HN |

| Section B: Mid-Year Update on Intervention Implementation (due Q3) | Section B: Analysis of Intervention Implementation (due end of Q4) |
|---|---|
| | |

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)**
**Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)**
**Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)**

| Measure(s) | Specific Goal | RY Rate 2019 | RY Rate 2020 | Baseline Source | Baseline Value |
|---|---|---|---|---|---|
| Got urgent care as soon as needed | Improve YOY | 76% | % | RY 2018 Rate | 81% |
| Got routine care as soon as needed | Improve YOY | 65% | % | RY 2018 Rate | 68% |

| | | | | | |
|---|---|---|---|---|---|
| Ease to get specialist appointment | Improve YOY | 59% | % | RY 2018 Rate | 55% |
| Ease of getting care/test/treatment | Improve YOY | 77% | % | RY 2018 Rate | 74% |
| **CAHPS Survey Measures** | **Specific Goal** | **RY 2017 Rate (MY 2016) (% always/usually)** | **RY 2020 Rate MY 2019 (% always/usually)** | **Baseline Source (RY 2020)** | **Baseline Value** |
| Getting Needed Care | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 81.11% | 69% | 69.10% | National Benchmark (50th Percentile) | 83.12% |
| Getting Care Quickly | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 80.52% | 73% | 73.31% | National Benchmark (50th Percentile) | 82.48% |
| How well doctors communicate | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 90.96% | 87% | 86.52% | National Benchmark (50th Percentile) | 91.62% |
| Customer Service | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 87.45% | NA | NA | National Benchmark (50th Percentile) | 88.52% |
| Shared Decision Making | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 79.70% | 77% | 77.00% | National Benchmark (50th Percentile) | 79.84% |
| Rating of All Health Care | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 74.06% | 63% | 63.41% | National Benchmark (50th Percentile) | 74.80% |

| | | | | | |
|---|---|---|---|---|---|
| Rating of Personal Doctor | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 80.58% | 75% | 75.46% | National Benchmark (50th Percentile) | 81.76% |
| Rating of Health Plan | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 75.70% | 73% | 73.35% | National Benchmark (50th Percentile) | 77.47% |
| Rating of Specialist | Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 80.75% | 74% | 74.44% | National Benchmark (50th Percentile) | 82.39% |
| **Analysis: Intervention Effectiveness w Barrier Analysis** | | | | | |
| **Initiative Continuation Status** | ☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification** | | | | |

| Section A: Description of Intervention (due Q1) | | | | |
|---|---|---|---|---|
| **2-1: Comprehensive Diabetes Care (CDC)** | | | | |
| ☐ **New Initiative** ☒ **Ongoing Initiative from prior year** | | | | |
| **Initiative Type(s)** | ☒ **Quality of Care** | ☐ **Quality of Service** | ☒ **Safety Clinical Care** | |
| **Reporting Leader(s)** | **Primary:** | **CalViva Health Medical Management** | **Secondary:** | Health Net QI Department and Health Net Health Education Department |

**Rationale and Aim(s) of Initiative**

**Overall Aim:** To assist members improve their compliance rate for hemoglobin A1c (HbA1c) testing as well as to lower their overall HbA1c value through education, lifestyle changes, healthy behaviors, and medication management.

**Rationale:** Diabetes occurs when the body has an inability to produce enough insulin to properly control blood sugar. When left untreated, this complex disease can increase the risk for heart disease, stroke, blindness, kidney disease and more (Comprehensive Diabetes Care, 2018). In managing chronic conditions such as diabetes, members are advised to adopt positive life style modifications which include making dietary changes and increasing physical activity for maintaining a healthy weight and managing their blood sugar, limiting alcohol intake, and engaging in smoking cessation programs (Control, 2018). A simple test to measure one's hemoglobin A1c can help identify if one has type 1 or type 2 diabetes (Mayo Clinic A1c Test) and can be the first step in managing this chronic condition. The American Diabetes Association Standards of Medical Care in Diabetes 2019 recommends the following for HbA1c Testing:

- Perform A1C test at least two times a year in patients meeting treatment goals and have stable glycemic control.
- Perform A1c test quarterly in patients whose therapy has changed or who at not meeting glycemic goals.
- Point-of-care testing for A1C providers the opportunity for more timely treatment changes (Association, 2019).

Diabetes care involves many facets and applying the multi-disciplinary approach which involves the member, provider, family members, and other health care professionals are part of the treatment plan in helping one manage their diabetes for long-term (Diabetes Care, January)

*Comprehensive Diabetes Care*. (2018). Retrieved December 30, 2018, from NCAQ - National Committee for Quality Assuarance: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
Control, C. f. (2018). *Effective Diagnosis, Treatment, and Monitoring of Hypertension in Primary Care - Participant Guide Treatment of Hypertension.*
*Diabetes Care*. ( January, 14 2018). Retrieved 30 December, 2018, from American Diabetes Association: http://care.diabetesjournals.org/content/41/Supplement_1/S28
Association, A. D. (2019). Glycemic Targets: Standards of Medical Care in Diabetes - 2019. *Diabetes Care*, 61-70.

| Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods. |
|---|
| The measure evaluates the percentage 18-75 years of age with diabetes (type 1 and type 2) who have had each of the following:<br>• Hemoglobin A1c (HbA1c) testing.<br>• HbA1c poor control (>9.0%).<br>• HbA1c control (<8.0%).<br>• HbA1c control (<7.0%) for a selected population*.<br>• Eye exam (retinal) performed.<br>• Medical attention for nephropathy.<br>• BP control (<140/90 mm Hg). |

| Planned Activities | | | |
|---|---|---|---|
| **Activities** | **Target of Intervention: Member (M) / Provider (P)** | **Timeframe for Completion** | **Responsible Party(s)** |
| Work with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) (submit PDSA). | P | Q1-Q2 | CVH/HN |
| Conduct regular meetings with Fresno County provider to improve CDC rates for HbA1c testing | P | Q1-Q2 | CVH/HN |
| Using the Planned Care Visit from the Chronic Disease Self-Management Model to assist members in completing their labs, receiving education, and scheduling an appointment with their provider for better HbA1C control. | P/M | Q1-Q2 | CVH/HN |
| Continue with in-home screening program MedXM to complete CDC HbA1C testing. | M | Q2-Q4 | CVH/HN |

| Section B: Mid-Year Update of Intervention Implementation (due Q3) | Section B: Analysis of Intervention Implementation (due end of Q4) |
|---|---|
| | |

| Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)<br>Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)<br>Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020) | | | | | |
|---|---|---|---|---|---|
| **Measure(s)** | **Specific Goal** | **Rate RY2019** | **Rate RY2020** | **Baseline Source** | **Baseline Value** |

| | | | | | |
|---|---|---|---|---|---|
| HEDIS® Comprehensive Diabetes Care – HbA1c Testing | Meet or Exceed DHCS 50th Percentile update 87.83% (RY2019) | Fresno: 84.43% | TBD% | RY 2019 CVH Results | Fresno: 83.43% |
| HEDIS® Comprehensive Diabetes Care – HbA1c Poor Control (>9%) | Meet or Exceed DHCS 50th Percentile 38.20% | Fresno: 41.61% | TBD | RY 2019 CVH Results | Fresno:41.61% |
| **Analysis: Intervention Effectiveness w Barrier Analysis** | | | | | |
| **Initiative Continuation Status** | ☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification** | | | | |

| Section A: Description of Intervention (due Q1) | | | | |
|---|---|---|---|---|
| **2-2: Addressing Breast Cancer Screening Disparities** | | | | |
| ☐ **New Initiative** ☒ **Ongoing Initiative from prior year** | | | | |
| **Initiative Type(s)** | ☒ **Quality of Care** | ☐ **Quality of Service** | | ☐ **Safety Clinical Care** |
| Reporting Leaders | **Primary** | **CalViva Health Medical Management** | **Secondary** | **Health Net QI Department** |

Rationale and Aim(s) of Initiative

**Overall Aim:** To increase and improve the survival rates of CalViva members in Fresno County who are diagnosed with breast cancer through early detection.

**Rationale**: Breast cancer is a leading cause of cancer related death among women in the U.S. The American Cancer Society estimated incidence of new breast cancer cases was 252,710 and there were 40, 610 deaths (American Cancer Society, 2017). There is strong evidence that early detection of breast cancer through screening, including mammography and clinical breast exams can effectively reduce the mortality rate from this disease (Centers for Disease Control and Prevention, 2018). The benefit of screening is finding cancer early, when it's easier to treat (Centers for Disease Control and Prevention, 2019).

Barriers to breast cancer screening included a lack of health insurance, language, and issues related to scheduling appointed. Barriers differed for younger and older women. The Hmong's belief in the spiritual etiology of cancer and attitudes toward cancer have also been identified as potential barriers to cancer screenings. In addition, for many Hmong women, mammograms are unfamiliar and regarded as invasive screening practices. Hmong women are at high-risk for health problems due to poverty, lack of education, low English Proficiency, lack of acceptance of the model of preventive care, and gender defined roles.

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**1**American Cancer Society (2017). Breast Cancer Facts & Figures 2017-2018.

https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/breast-cancer-facts-and-figures-2017-2018.pdf

2Centers for Disease Control and Prevention. (2018). Breast Cancer. What Are the Benefits and Risks of Screening? https://www.cdc.gov/cancer/breast/basic_info/benefits-risks.htm

3 Centers for Disease Control and Prevention. (2019). Women with Disabilities and Breast Cancer Screening. https://www.cdc.gov/ncbddd/disabilityandhealth/breast-cancer-screening.html

4 Kue, Zukoski, Thorburn (2014). Breast and Cervical Cancer Screening: Exploring Perceptions and Barriers with Hmong Women and Men in Oregon. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711956/

| Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods. |
|---|
| The HEDIS measure, Breast Cancer Screening (BCS) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. The baseline HEDIS result for RY 2019 was 58.08%. Increase the breast cancer screening rate among the Hmong speaking population at the targeted clinic site from a baseline of 19.2% to a goal rate of 28.8%. |

| Planned Activities | | | |
|---|---|---|---|
| **Activities** | **Target of Intervention: Member (M) / Provider (P)** | **Timeframe for Completion** | **Responsible Party(s)** |
| Continue to work with a high volume, low compliance provider in Fresno County to implement targeted BCS interventions and monitor effectiveness. | P | Q1-Q4 | CVH/HN |
| Health Education to distribute educational materials on the importance of breast cancer screening | M | Q1-Q4 | CVH/HN |
| Implement Provider Incentives to close the gaps and Improve HEDIS rates for breast cancer screening. | P | Q1-Q4 | CVH/HN |
| Implement direct member incentive for completion of breast cancer screening to improve rates | M | Q1-Q4 | CVH/HN |
| Deploy cultural and linguistic strategies at targeted convenient and culturally competent clinic site to support members in accessing their breast cancer screening services. Strategies include: on site interpreters, transportation services, etc. | M | Q1-Q4 | CVH/HN |
| Collaborating with a radiology center to improve BCS rates. | P | Q1-Q4 | CVH/HN |
| Implement and deploy community events using a video to improve BCS rates | M | Q1-Q4 | CVH/HN |

| Section B: Mid-Year Update of Intervention Implementation (due Q3) | Section B: Analysis of Intervention Implementation (due end of Q4) |
|---|---|
| | |

| Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)<br>Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)<br>Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020) | | | | | |
|---|---|---|---|---|---|
| **Measure(s)** | **Specific Goal** | **Rate RY2019** | **Rate RY2020** | **Baseline Source** | **Baseline Value** |

| | | | | | |
|---|---|---|---|---|---|
| HEDIS® Breast Cancer Screening | Meet or Exceed SMART Aim Goal of 28.8% | Fresno: 58.08% | % | RY 2020 CVH results | Fresno: 51.12% |
| **Analysis: Intervention Effectiveness w Barrier Analysis** | | | | | |
| **Initiative Continuation Status** | ☐ **Closed** ☐ **Continue Initiative Unchanged** **Continue Initiative with Modification** | | | | |

## III. PERFORMANCE IMPROVEMENT PROJECTS

| Section A: Description of Intervention (due Q1) | | | | |
|---|---|---|---|---|
| **2-3: Improving Childhood Immunizations (CIS-10)** | | | | |
| ☒ New Initiative ☐ Ongoing Initiative from prior year | | | | |
| Initiative Type(s) | ☒ Quality of Care | ☐ Quality of Service | ☒ Safety Clinical Care | |
| Reporting Leader(s) | Primary: | CalViva Health Medical Management | Secondary: | Health Net QI Department |

**Rationale and Aim(s) of Initiative**

**Overall Aim:** To improve child health in Fresno County.

**Rationale**: Childhood vaccination has proven to be one of the most effective public health strategies to control and prevent disease (Ventola, 2016).[1] In an effort to reduce childhood morbidity and mortality, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) issues annual recommendations and guidelines for childhood immunizations (Poland, Schaffner, Hopkins, 2013).[2] However, some parents decline or delay vaccinating their children or follow alternative immunization schedules because of medical, religious, philosophical, or socioeconomic reason (Ventola, 2016). Health care provider-based interventions have been suggested to overcome such vaccine noncompliance, including patient counseling; improving access to vaccinations; maximizing patient office visits; and offering combination vaccines. Community and government-based interventions to improve parent and patient adherence include public education and reminder/recall strategies, and financial incentives for vaccinations (CDC, 2017).[3]

Despite the established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. A small but increasing number of children in the United States are not getting some or all of their recommended vaccinations. The percentage of children under 2 years old who haven't received any vaccinations has quadrupled in the last 17 years, according to federal health data (Health & Science, 2018). Approximately 300 children in the United States die each year from vaccine preventable diseases (NCQA, 2019).[4] Infants also comprise the largest share of pertussis-related death. Half of the infants who contract pertussis also known as whooping cough, will be hospitalized and one in 100 will die (CDC, 2017).

With the addition of new vaccines in recent years, and more in development, there is an even greater potential to save millions of more lives. Unfortunately, continuing disease outbreaks across the U.S. remain a public health concern. Lack of access to vaccines, combined with people who are not taking full advantage of opportunities to protect themselves, their families, and their communities, leaves people susceptible to preventable diseases (State of the Immunion, 2018).[5] America's future rests in the hands of our young; here in the U.S., we have the technology to prevent suffering among our most vulnerable citizens, our newborns (State of Immunion, 2018). Through public health efforts and working together to ensure access to and delivery of vaccines, we can prevent the suffering of families who could otherwise lose their precious newborns to vaccine-preventable diseases (State of Immunion, 2018).

1 Ventola C. L. (2016). Immunization in the United States: Recommendations, Barriers, and Measures to Improve Compliance: Part 1: Childhood Vaccinations. *P & T: a peer-reviewed journal for formulary management*, *41*(7), 426–436. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927017/

2 Poland GA, Schaffner W, Hopkins RH, Jr, U.S. Department of Health and Human Services Immunization guidelines in the United States: new vaccines and new recommendations for children, adolescents, and adults. Vaccine. 2013; 31(42):4689–4693. Available at: https://www.ncbi.nlm.nih.gov/pubmed/23583896

3 Centers for Disease Control and Prevention. (2017). "How Your Child Care Program Can Support Immunization." Available at: https://www.cdc.gov/vaccines/partners/childhood/matte-articles-support-imz.html

4 NCQA National Commission Quality Assurance. (2019) Childhood Immunization Status (CIS). https://www.ncqa.org/hedis/measures/childhood-immunization-status. Accessed November 12, 2019.

5 State of the Immunion. (2018) A Report on Vaccine-Preventable Disease in the U.S. Available at: https://www.vaccinateyourfamily.org/wp-content/uploads/2018/07/FINALSOTIReport_2018-1.pdf

| **Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.** |
|---|
| The HEDIS measure, Childhood Immunization Status - Combination 10 (CIS-10), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of members who turn 2 years old who have been identified for completing the following vaccinations: four diphtheria, tetanus, and acellular pertussis (DTap); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four (pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.<br><br>The baseline rate of 32.4% was determined based on the RY 2019 HEDIS hybrid data for one high volume, low preforming clinic in Fresno County. The goal rate is 39.0%. |

| **Planned Activities** | | | |
|---|---|---|---|
| **Activities** | **Target of Intervention: Member (M) / Provider (P)** | **Timeframe for Completion** | **Responsible Party(s)** |

| | | | |
|---|---|---|---|
| Collaborate with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 2) | P | Q1-Q4 | CVH/HN |
| Improve immunization compliance rates based upon barriers identified. The clinic will implement innovative educational activities to increase immunization rates. | P/M | Q2-Q4 | CVH/HN |
| Health Education to implement educational activities on the importance of childhood immunizations. | M | Q1-Q4 | CVH/HN |
| Member newsletter article: Childhood Immunizations | M | Q1-Q4 | CVH/HN |
| Implement direct member incentive for completion of childhood immunizations series to improve rates | M | Q1-Q4 | CVH/HN |
| Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for Childhood Immunizations. | P | Q1-Q4 | CVH/HN |
| Provider Tip Sheets will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines. | P | Q1-Q4 | CVH/HN |

| **Section B: Mid-Year Update of Intervention Implementation (due Q3)** | **Section B: Analysis of Intervention Implementation (due end of Q4)** |
|---|---|
| | |

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)**
**Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)**
**Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)**

| Measure(s) | Specific Goal | Rate RY2019 | Rate RY2020 | Baseline Source | Baseline Value |
|---|---|---|---|---|---|
| Childhood Immunization Combo 10 | Meet or Exceed SMART Aim Goal of 39.0% | Fresno: 25.19 % | % | RY 2020 CVH results | Fresno: 27.74% |

| **Analysis: Intervention Effectiveness w Barrier Analysis** | |
|---|---|

| | | | |
|---|---|---|---|
| **Initiative Continuation Status** | ☐ **Closed** | ☐ **Continue Initiative Unchanged** | ☐ **Continue Initiative with Modification** |

## IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

| Activity | Activity Leader | Mid-Year Update | Year End (YE) Complete? | Year End (YE) Date | Year End (YE) YE Update or Explanation *(if not complete)* |
|---|---|---|---|---|---|
| **WELLNESS/ PREVENTIVE HEALTH** | | | | | |
| 1. Distribute Preventive Screening Guidelines (PSG) to Members | CVH/HN | | ☐ | | |
| 2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG) | CVH/HN | | ☐ | | |
| 3. Implement CalViva Pregnancy Program for high risk members. | CVH/HN | | ☐ | | |
| 4. Promote CA Smokers' Helpline to CVH members. | CVH/HN | | ☐ | | |
| 5. Diabetes Prevention Program | CVH/HN | | ☐ | | |
| **CHRONIC CARE/ DISEASE MANAGEMENT** | | | | | |
| 1. Monitor Disease Management program for appropriate member outreach | CVH/HN | | | | |
| **ACCESS, AVAILABILITY, SATISFACTION AND SERVICE** | | | | | |
| 1. C&L Report: Analyze and report Cultural and Linguistics (C&L) activities | CVH/HN | | ☐ | | |
| 2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI | CVH/HN | | ☐ | | |
| 3. Complete and submit DMHC Timely Access Reporting (TAR) by filing due date | CVH/HN | | ☐ | | |
| 4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers for follow up.. | CVH/HN | | ☐ | | |
| 5. ACCESS PROVIDER TRAINING: Conduct webinars quarterly | CVH/HN | | ☐ | | |
| 6. AFTER HOURS TELEPHONE ANSWER SURVEY: Conduct quarterly and issue CAPs to noncompliant providers. | CVH/HN | | ☐ | | |

| Activity | Activity Leader | Mid-Year Update | Year End (YE) Complete? | Date | YE Update or Explanation *(if not complete)* |
|---|---|---|---|---|---|
| 7. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances | CVH/HN | | ☐ | | |
| 8. Population Needs Assessment Update– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement Cultural & Linguistics, Health Education and Quality Improvement (QI) programs. | CVH/HN | | ☐ | | |
| 9. C & L GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement: Analyze and inform Provider Network Management areas for increased contracting with a particular provider to improve availability. (Quarterly: next report 2020) | CVH/HN | | ☐ | | |
| 10. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-Step outreach process: Quarterly IHA Compliance Monitoring Report | CVH/HN | | ☐ | | |
| **QUALITY AND SAFETY OF CARE** | | | | | |
| Integrated Case Management<br>• Utilize ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM.<br>• Evaluate the ICM Program based on the following measures:<br>o Readmission rates<br>o ED utilization<br>o Overall health care costs<br>o Member Satisfaction | CVH/HN | | ☐ | | |

| Activity | Activity Leader | Mid-Year Update | Year End (YE) Complete? | Year End (YE) Date | Year End (YE) YE Update or Explanation *(if not complete)* |
|---|---|---|---|---|---|
| **CREDENTIALING / RECREDENTIALING** | | | | | |
| 1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain 100% timely and accurate compliance. | CVH/HN | | ☐ | | |
| **BEHAVIORAL HEALTH** | | | | | |
| 1. Conduct oversight of Behavioral Health BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.) | CVH/HN | | ☐ | | |
| **QUALITY IMPROVEMENT** | | | | | |
| 1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure practitioner offices and medical records comply with DHCS contracted requirements per MMCD Policy Letter 14-004 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023 | CVH/HN | | ☐ | | |
| 2. Evaluation of the QI program: Complete QI Work Plan mid-year and annual evaluations. | CVH/HN | | ☐ | | |
| **CLINICAL DEPRESSION FOLLOW-UP** | | | | | |
| 1. Continue development and distribution of provider educational resources on screening for clinical depression and follow up (12 years and older) | CVH/HN | | | | |

# Item #7

# Attachment 7.A

## Utilization Management & Case Management
## 2020 Work Plan

# CalViva Health
# 2020
# Utilization Management (UM)/ Case Management (CM)
# Annual Work Plan



Last updated: March 13, 2020

Health Net

CalViva HEALTH

**CalViva Health**
**2020 UM/CM Plan**

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# CalViva Health
# 2020 UM/CM Plan

## Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

# 1. Compliance with Regulatory & Accreditation Requirements

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions. | ☒ Medi-Cal | Qualified licensed and trained professionals make UM decisions. | Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions.<br><br>Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software).<br><br>Credentialing maintains records of physicians' credentialing.<br><br>100% compliance with maintaining records of professional licenses and credentialing for health professionals. | Provide continuing education opportunities to staff.<br><br>Conduct Medical Management Staff new hire orientation training.<br><br>Review and revise staff orientation materials, manuals and processes.<br><br>Verification of Continuing Medical Education (CME) standing, verification of certification, participation in InterQual training and IRR testing.<br><br>Conduct training for nurses. | Monthly<br><br>As needed<br><br>Ongoing<br><br>Ongoing<br><br>Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements. | ☒ Medi-Cal | Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations.<br><br>This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance. | Review and report on legislation signed into law and regulations with potential impact on medical management.<br><br>Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate.<br><br>100% compliance of UMCM staff and processes with all legislation and regulations. | Review new legislation and regulations, either through e-mail or department presentation.<br><br>Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner.<br><br>Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology / Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.3 Separation of Medical Decisions from Fiscal Considerations | ☒ Medi-Cal | DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence. | Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates.<br><br>100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees. | All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire and annually thereafter through the Plan's online learning platform.<br><br>Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.4 Periodic audits for Compliance with regulatory standards | ☒ Medi-Cal | Ensure compliance with regulatory standards. | Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision. | Conduct File Reviews for compliance with regulatory standards.<br><br>Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process.<br><br>File Audits completed the month following each quarter. | Ongoing<br><br>Ongoing<br><br>April 2020,<br>July 2020,<br>October 2020,<br>January 2021 |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS) | ☒ Medi-Cal | Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS:<br>▪ MMCD Medical Directors Meetings<br>▪ MMCD workgroups<br>▪ Quality Improvement workgroup<br>▪ Health Education Taskforce<br><br>There are benefits to HN MD participation:<br>▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program.<br>▪ Provides HN with in-depth information regarding contractual programs.<br>▪ Provides HN with the opportunity to participate in policy determination by DHCS. | HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings.<br><br>Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD.<br><br>HN and CalViva remain a strong voice in this body with participation on key workgroups. | The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2020.<br><br>Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually. | ☒ Medi-Cal | Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements. | Core group comprised of State Health Programs Chief Medical Director (CMD), Regional Medical Directors, Director of Medical Management and Medical Management Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures. | Write and receive CalViva approval of 2020 UMCM Program Description.<br><br>Write and receive CalViva approval of 2019 UMCM Work Plan Year-End Evaluation.<br><br>Write and receive CalViva approval of 2020 UMCM Work Plan.<br><br>Write and receive CalViva approval of 2020 UMCM Work Plan Mid-Year Evaluation.<br><br>Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership.<br><br>Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements. | Q 1 2020<br><br>Q 1 2020<br><br>Q 1 2020<br><br>Q 3 2020<br><br>Ongoing<br><br>Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# 2. Monitoring the UM Process

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2018 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.1 The number of authorizations for service requests received | ☒ Medi-Cal | Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements.<br><br>Track and trend all types of prior authorization and concurrent review activities based on requirements. | Track and trend authorization requests month to month.<br>Tracking includes:<br>• Number of prior authorization requests submitted, approved, deferred, denied, or modified<br>• Turnaround times (TAT)<br>• Number of denials appealed and overturned | Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process.<br><br>Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.2 Timeliness of processing the authorization request<br><br>(Turnaround Time =TAT) | ☒ Medi-Cal | TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications).<br><br>Provide oversight, tracking, and monitoring of turnaround times for authorization requests. | Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report. | Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs.<br><br>Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies.<br><br>Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements.<br><br>Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining. | Ongoing<br><br>UM TAT summaries due monthly |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making | ☒ Medi-Cal | Consistency with which criteria are applied in UM decision-making is evaluated annually.<br><br>Opportunities to improve consistency are acted upon. | Health Net administers McKesson InterQual® IRR Tool to physician and non-physician UM reviewers annually<br><br>Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool | <u>Physician IRR</u><br>Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2020.<br><br><u>Non-Physician IRR</u><br>Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2020. | Q3-4 2020<br><br>Q3-4 2020 |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals. | ☒ Medi-Cal | Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate. | Measure UM Appeals volume as a percentage of the total authorization requests.<br><br>Measure the number upheld and overturned, as well as Turnaround Times. | Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting.<br><br>At least annually Appeals will be analyzed for trends. Opportunities for removing or modifying prior authorization requirements or criteria will be identified based upon appeals that are regularly overturned. This analysis and recommendations will be reported to CalViva Health QI/UM Committee.<br><br>Ensure appeals are processed by specialty matched physicians, which at a minimum requires pediatricians or family practitioners to evaluate all medical necessity appeals for members under age 21, and family practitioners or internists to evaluate all medical necessity appeals for members over age 21. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# 3. Monitoring Utilization Metrics

Health Net

CalViva HEALTH

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance | ☒ Medi-Cal | Health Net Central Medical Directors and Medical Management manage the non-delegated shared risk PPGs and a sizable FFS membership. | Health Net manages shared risk non-delegated PPGs and FFS inpatient UM.<br>Data reported quarterly at State Health Programs UM/QI Committee meeting<br>▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪<br>Key Metrics<br>(SPD, Non-SPD, MCE)<br>Bed days/k<br>ALOS<br>Admit /K<br>All cause readmits within 30 days<br><br>2020 Goals:<br>• 10% reduction in admissions over prior year<br>• 10% reduction in LOS overall | Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services.<br><br>Use data to identify high cost/high utilizing members to target for care management.<br><br>The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. Focus on the top 10 admitting diagnosis, and long length of stay admissions will also continue in 2020; adding a focus on 0-2 day stay admissions for appropriateness of admission.<br><br>The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. | Ongoing |

Health Net

CalViva HEALTH

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ ACTIVITY ON TARGET<br><br>☐ TOO SOON TO TELL | | | | |
| **Annual Evaluation**<br><br>☐ MET OBJECTIVES<br><br>☐ CONTINUE ACTIVITY IN 2021 | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 3.2 Over/under utilization | ☒ Medi-Cal | Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members.<br><br>Fraud, Waste and Abuse of medical services is monitored and reported.<br><br>PPG Reports are used internally and externally with medical groups to develop member and population level interventions.<br><br>Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000. | The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members.<br><br>Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include:<br>1. Admissions/K<br>2. Bed days/K<br>3. Acute care average length of stay<br>4. ER admits/K<br>5. All case readmits<br>6. % 0-2 day admits<br>In addition, PPG metrics will include:<br>7. Specialty referrals for target specialties<br>8. C-section rates.<br><br>PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. | Continue to enhance provider profile.<br><br>Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports)<br><br>Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department<br><br>Thresholds for 2020 are under evaluation.<br><br><u>Referral Rates: Specialist</u><br>PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation.<br><br>Specialties and PPG's identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated.<br><br>The Quality Improvement Plans, if applicable are reviewed at the regional team meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership at least quarterly. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 3.3 PPG Profile | ☒ Medi-Cal | PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM. | Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY.<br><br>The following metrics are tracked by Delegation oversight:<br>1. 3. Prior authorization volume & timeliness<br>2. Specialty referral volume for in network/out of network<br>3. 5. Specialty referral access timeliness<br><br>The DO Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e.<br>Utilization rate, Financial, HEDIS score etc. | CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers.<br><br>CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals.<br><br>Variance rate is calculated from previous quarter and all Variances >+- 15% are researched<br><br>Compliance rate is calculated as identified by DHCS for:<br>• Prior authorization timeliness<br><br>CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals.<br><br>CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2020** | | | | |

# 4. Monitoring Coordination with Other Programs and Vendor Oversight

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.1 Case Management (CM) Program | ☒ Medi-Cal | Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life.<br><br>Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. | Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes.<br><br>Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly<br><br>Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs<br><br>Measure program effectiveness based on the following measures:<br>o Readmission rates<br>o ED utilization<br>o Overall health care costs<br>o Member Satisfaction | Dedicated staff of RNs, LCSWs, Program Specialists, Program and Care Coordinators to perform physical health and integrated CM activities.<br><br>Continue use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM.<br><br>Review outcome measures quarterly. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

Health Net

CalViva HEALTH

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.2 Referrals to Perinatal Case Management | ☒ Medi-Cal | Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes. | Notify PCP's or PPG's of patients identified for program.<br><br>Measure program effectiveness based on the following measures:<br>o Member compliance with completing<br>• 1st prenatal visit within the 1st trimester and<br>• post-partum visit between 21 and 56 days after delivery compared to pregnant members who were not enrolled in the program | PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms.<br><br>Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities.<br><br>Implement use of Pregnancy Program materials to increase outreach to moderate and high risk member through education packets, text reminders, etc.<br><br>Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program.<br><br>Review outcome measures quarterly. | Ongoing<br><br>Ongoing<br><br>Q1<br><br>Ongoing<br><br>Quarterly |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.3 Behavioral Health (BH) Case Management Program | ☒ Medi-Cal | Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life.<br><br>Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. | Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes.<br><br>Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly<br><br>Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs<br><br>Measure program effectiveness based on the following measures:<br>o Readmission rates<br>o ED utilization<br>o Overall health care costs<br>o Member Satisfaction | Dedicated staff of LCSWs, LMFT, and Care Coordinators to perform BH CM activities.<br><br>Use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM.<br><br>Review outcome measures quarterly. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

Health Net

CalViva HEALTH

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.4 Disease Management (DM) | ☒ Medi-Cal<br><br>**Diabetes Age Groups**<br>0-21 CCS Referral (100%)<br><br>>21 Enrolled in program | The Managed Care Plan is responsible for initiating and maintaining a Disease Management program for high volume, common conditions, where guidelines and proven timely intervention have been shown to improve outcomes. | Eligibility data from sources such as: pharmacy/ encounter claims, health appraisal results, data collected through the UM or case management process, and member or provider referrals.<br><br>Evaluation of outcome data from HEDIS®-like measures.<br><br>Review/analyze DM partner annual report | Continue transition to insourced disease management programs for: asthma, diabetes, and heart failure. Transition process began Q4 2018.<br><br>Ongoing program monitoring to assure that reporting needs are met including enrollment statistics. | April 2020<br><br>Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.5 MD interactions with Pharmacy | ☒ Medi-Cal | Medi-Cal formulary is a closed formulary consisting of primarily generic medications.<br><br>State Health Program (SHP) MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the formulary and injectable guidelines to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization.<br><br>SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists.<br><br>SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data.<br><br>SHP MD's and Pharmacy continue to mirror the DHCS narcotic prescribing quantity limits. This is to prevent fraud and abuse, and prevent adverse selection to the CalViva Medi-Cal plan. | Monthly report of PA requests. | Continued active engagement with pharmacy.<br><br>Continue narcotic prior authorization requirements.<br><br>Consider implementation of opioid edits based on updated CDC guidelines for prescribing opioids. | Ongoing |

Health Net

CalViva HEALTH

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ ACTIVITY ON TARGET<br><br>☐ TOO SOON TO TELL | | | | |
| **Annual Evaluation**<br><br>☐ MET OBJECTIVES<br><br>☐ CONTINUE ACTIVITY IN 2021 | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measureable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.6 Manage care of CalViva members for Behavioral Health (BH) | ☒ Medi-Cal | CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members. | Total number of registrations and referrals. | Review data that indicates when a member was referred to the County for services to ensure that MHN staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training.<br><br>Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measureable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.7 Behavioral Health Performance Measures | ☒ Medi-Cal | CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members. | Performance Measures to be monitored:<br><br>Appointment Accessibility by Risk Rating<br><br>Authorization Decision Timelines<br><br>Potential Quality Issues<br><br>Provider Disputes<br><br>Network Availability<br><br>Network Adequacy: Member Ratios<br><br>Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder. | Participate in cross functional team to improve quality of behavioral health care. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ ACTIVITY ON TARGET<br><br>☐ TOO SOON TO TELL | | | | |
| **Annual Evaluation**<br><br>☐ MET OBJECTIVES<br><br>☐ CONTINUE ACTIVITY IN 2021 | | | | |

# 5. Monitoring Activities for Special Populations

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 5.1 Monitor of California Children's Services (CCS) identification rate. | ☒ Medi-Cal | Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD. | All HN SHP staff will work with Public Programs Coordinators and UM staff to identify potential CCS cases and refer to county for approval.<br><br>Based on the standardized formula, monthly report indicates CCS %.<br>Goal: Health Net identifies 5% of total population for likely CCS eligibility. | CCS identification and reporting continues to be a major area of focus. Work in CY 2018 to further develop internal systems and handoffs are expected to yield improvements in 2019.<br><br>Continue current CCS policies and procedures.<br><br>Continue to refine CCS member identification and referral through concurrent review, prior authorization, case management, pharmacy, claims review and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool).<br><br>Continue to improve and refine coordination with CCS between specialists and primary care services. Continue to distribute quarterly provider letters based upon DHCS Corrective Action Plans. | Ongoing |

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2021** | | | | |

# CalViva Health
# 2020 UM/CM Plan

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objectives | 2020 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements | ☒ Medi-Cal | California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management. | All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program.<br><br>Monitor HRA outreach | Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Case Management, the Pharmacy Program, the Pregnancy Program, or a Disease Management Program.<br><br>Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Disease Management and Care Coordination. | Ongoing |

Health Net

CalViva HEALTH

# CalViva Health
# 2020 UM/CM Plan

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ ACTIVITY ON TARGET<br><br>☐ TOO SOON TO TELL | | | | |
| **Annual Evaluation**<br><br>☐ MET OBJECTIVES<br><br>☐ CONTINUE ACTIVITY IN 2021 | | | | |

# Item #8

## Attachment 8.A

Financials as of February 29, 2020

# Fresno-Kings-Madera Regional Health Authority dba CalViva Health

## Balance Sheet

## As of February 29, 2020

| | | Total |
|---|---|---|
| 1 | ASSETS | |
| 2 | Current Assets | |
| 3 | Bank Accounts | |
| 4 | Cash & Cash Equivalents | 140,186,317.32 |
| 5 | Wells Fargo Money Market Mutual Funds | 5,262,379.83 |
| 6 | Total Bank Accounts | $ 145,448,697.15 |
| 7 | Accounts Receivable | |
| 8 | Accounts Receivable | 155,055,869.08 |
| 9 | Total Accounts Receivable | $ 155,055,869.08 |
| 10 | Other Current Assets | |
| 11 | Interest Receivable | 6,568.63 |
| 12 | Investments - CDs | 0.00 |
| 13 | Prepaid Expenses | 454,334.82 |
| 14 | Security Deposit | 0.00 |
| 15 | Total Other Current Assets | $ 460,903.45 |
| 16 | Total Current Assets | $ 300,965,469.68 |
| 17 | Fixed Assets | |
| 18 | Buildings | 6,791,387.17 |
| 19 | Computers & Software | 0.00 |
| 20 | Land | 3,161,419.10 |
| 21 | Office Furniture & Equipment | 128,293.50 |
| 22 | Total Fixed Assets | $ 10,081,099.77 |
| 23 | Other Assets | |
| 24 | Investment -Restricted | 315,533.83 |
| 25 | Total Other Assets | $ 315,533.83 |
| 26 | TOTAL ASSETS | $ 311,362,103.28 |
| 27 | LIABILITIES AND EQUITY | |
| 28 | Liabilities | |
| 29 | Current Liabilities | |
| 30 | Accounts Payable | |
| 31 | Accounts Payable | 42,168.55 |
| 32 | Accrued Admin Service Fee | 3,864,069.00 |
| 33 | Capitation Payable | 161,184,219.48 |
| 34 | Claims Payable | 61,678.96 |
| 35 | Directed Payment Payable | 62,024,496.30 |
| 36 | Total Accounts Payable | $ 227,176,632.29 |
| 37 | Other Current Liabilities | |
| 38 | Accrued Expenses | 554,147.03 |
| 39 | Accrued Payroll | 52,717.97 |
| 40 | Accrued Vacation Pay | 305,450.30 |
| 41 | Amt Due to DHCS | 0.00 |
| 42 | IBNR | 164,886.99 |
| 43 | Loan Payable-Current | 0.00 |
| 44 | Premium Tax Payable | 0.00 |
| 45 | Premium Tax Payable to BOE | 5,959,951.98 |
| 46 | Premium Tax Payable to DHCS | 0.00 |
| 47 | Total Other Current Liabilities | $ 7,037,154.27 |
| 48 | Total Current Liabilities | $ 234,213,786.56 |
| 49 | Long-Term Liabilities | |
| 50 | Renters' Security Deposit | 0.00 |
| 51 | Subordinated Loan Payable | 0.00 |
| 52 | Total Long-Term Liabilities | $ 0.00 |
| 53 | Total Liabilities | $ 234,213,786.56 |
| 54 | Equity | |
| 55 | Retained Earnings | 70,284,248.46 |
| 56 | Net Income | 6,864,068.26 |
| 57 | Total Equity | $ 77,148,316.72 |
| 58 | TOTAL LIABILITIES AND EQUITY | $ 311,362,103.28 |

# Fresno-Kings-Madera Regional Health Authority dba CalViva Health

## Budget vs. Actuals: Income Statement

## July 2019 - February 2020 (FY 2020)

| | | Total | | |
|---|---|---|---|---|
| | | Actual | Budget | Over/(Under) Budget |
| 1 | Income | | | |
| 2 | Investment Income | 892,421.18 | 532,000.00 | 360,421.18 |
| 3 | Premium/Capitation Income | 688,869,541.05 | 754,026,016.00 | (65,156,474.95) |
| 4 | **Total Income** | **689,761,962.23** | **754,558,016.00** | **(64,796,053.77)** |
| 5 | Cost of Medical Care | | | |
| 6 | Capitation - Medical Costs | 644,951,670.79 | 627,129,680.00 | 17,821,990.79 |
| 7 | Medical Claim Costs | 2,188,226.98 | 1,933,336.00 | 254,890.98 |
| 8 | **Total Cost of Medical Care** | **647,139,897.77** | **629,063,016.00** | **18,076,881.77** |
| 9 | **Gross Margin** | **42,622,064.46** | **125,495,000.00** | **(82,872,935.54)** |
| 10 | Expenses | | | |
| 11 | Admin Service Agreement Fees | 31,176,475.00 | 31,548,000.00 | (371,525.00) |
| 12 | Bank Charges | 40.31 | 4,400.00 | (4,359.69) |
| 13 | Computer/IT Services | 81,030.89 | 104,800.00 | (23,769.11) |
| 14 | Consulting Fees | 1,575.00 | 70,000.00 | (68,425.00) |
| 15 | Depreciation Expense | 193,524.82 | 196,800.00 | (3,275.18) |
| 16 | Dues & Subscriptions | 109,119.50 | 120,128.00 | (11,008.50) |
| 17 | Grants | 1,015,395.77 | 1,166,664.00 | (151,268.23) |
| 18 | Insurance | 121,295.42 | 141,481.00 | (20,185.58) |
| 19 | Labor | 2,085,566.93 | 2,267,356.00 | (181,789.07) |
| 20 | Legal & Professional Fees | 69,069.30 | 127,200.00 | (58,130.70) |
| 21 | License Expense | 508,737.94 | 462,800.00 | 45,937.94 |
| 22 | Marketing | 722,722.15 | 701,000.00 | 21,722.15 |
| 23 | Meals and Entertainment | 14,080.33 | 14,900.00 | (819.67) |
| 24 | Office Expenses | 36,849.79 | 54,400.00 | (17,550.21) |
| 25 | Parking | 1,068.14 | 1,000.00 | 68.14 |
| 26 | Postage & Delivery | 2,250.86 | 2,160.00 | 90.86 |
| 27 | Printing & Reproduction | 2,242.70 | 3,200.00 | (957.30) |
| 28 | Recruitment Expense | 1,837.92 | 24,000.00 | (22,162.08) |
| 29 | Rent | 2,400.00 | 8,000.00 | (5,600.00) |
| 30 | Seminars and Training | 6,060.11 | 16,000.00 | (9,939.89) |
| 31 | Supplies | 6,986.70 | 6,800.00 | 186.70 |
| 32 | Taxes | (1,258.22) | 83,914,704.00 | (83,915,962.22) |
| 33 | Telephone | 22,931.31 | 22,400.00 | 531.31 |
| 34 | Travel | 16,587.54 | 20,130.00 | (3,542.46) |
| 35 | **Total Expenses** | **36,196,590.21** | **120,998,323.00** | **(84,801,732.79)** |
| 36 | **Net Operating Income** | **6,425,474.25** | **4,496,677.00** | **1,928,797.25** |
| 37 | Other Income | | | |
| 38 | Other Income | 438,594.01 | 440,000.00 | (1,405.99) |
| 39 | **Total Other Income** | **438,594.01** | **440,000.00** | **(1,405.99)** |
| 40 | **Net Other Income** | **438,594.01** | **440,000.00** | **(1,405.99)** |
| 41 | **Net Income** | **6,864,068.26** | **4,936,677.00** | **1,927,391.26** |

# Fresno-Kings-Madera Regional Health Authority dba CalViva Health

## Income Statement: CY vs PY

## FY 2020 vs FY 2019

| | | Total | |
|---|---|---|---|
| | | July 2019 - Feb 2020 | July 2018 - Feb 2019 (PY) |
| 1 | Income | | |
| 2 | Investment Income | 892,421.18 | 662,931.08 |
| 3 | Premium/Capitation Income | 688,869,541.05 | 776,404,663.01 |
| 4 | Total Income | **689,761,962.23** | **777,067,594.09** |
| 5 | Cost of Medical Care | | |
| 6 | Capitation - Medical Costs | 644,951,670.79 | 649,070,145.69 |
| 7 | Medical Claim Costs | 2,188,226.98 | 1,708,455.89 |
| 8 | Total Cost of Medical Care | **647,139,897.77** | **650,778,601.58** |
| 9 | Gross Margin | **42,622,064.46** | **126,288,992.51** |
| 10 | Expenses | | |
| 11 | Admin Service Agreement Fees | 31,176,475.00 | 31,751,467.00 |
| 12 | Bank Charges | 40.31 | 1,374.10 |
| 13 | Computer/IT Services | 81,030.89 | 84,806.21 |
| 14 | Consulting Fees | 1,575.00 | 4,200.00 |
| 15 | Depreciation Expense | 193,524.82 | 193,525.04 |
| 16 | Dues & Subscriptions | 109,119.50 | 114,185.27 |
| 17 | Grants | 1,015,395.77 | 1,342,535.64 |
| 18 | Insurance | 121,295.42 | 133,191.66 |
| 19 | Labor | 2,085,566.93 | 2,036,283.62 |
| 20 | Legal & Professional Fees | 69,069.30 | 81,258.95 |
| 21 | License Expense | 508,737.94 | 449,695.52 |
| 22 | Marketing | 722,722.15 | 555,820.93 |
| 23 | Meals and Entertainment | 14,080.33 | 12,912.67 |
| 24 | Office Expenses | 36,849.79 | 37,412.02 |
| 25 | Parking | 1,068.14 | 1,001.11 |
| 26 | Postage & Delivery | 2,250.86 | 1,996.18 |
| 27 | Printing & Reproduction | 2,242.70 | 1,543.98 |
| 28 | Recruitment Expense | 1,837.92 | 1,206.13 |
| 29 | Rent | 2,400.00 | 1,200.00 |
| 30 | Seminars and Training | 6,060.11 | 4,835.34 |
| 31 | Supplies | 6,986.70 | 6,247.55 |
| 32 | Taxes | (1,258.22) | 83,914,720.69 |
| 33 | Telephone | 22,931.31 | 22,296.38 |
| 34 | Travel | 16,587.54 | 15,347.13 |
| 35 | Total Expenses | **36,196,590.21** | **120,769,063.12** |
| 36 | Net Operating Income | **6,425,474.25** | **5,519,929.39** |
| 37 | Other Income | | |
| 38 | Other Income | 438,594.01 | 461,359.95 |
| 39 | Total Other Income | **438,594.01** | **461,359.95** |
| 40 | Net Other Income | **438,594.01** | **461,359.95** |
| 41 | Net Income | **6,864,068.26** | **5,981,289.34** |

# Item #8

## Attachment 8.B

Compliance Report

| Regulatory Filings | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2020 YTD Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **# of DHCS Filings** | | | | | | | | | | | | | |
| **Administrative/ Operational** | 9 | 15 | 12 | 4 | | | | | | | | | 40 |
| **Member & Provider Materials** | 2 | 1 | 7 | 4 | | | | | | | | | 14 |
| **# of DMHC Filings** | 5 | 8 | 7 | 3 | | | | | | | | | 23 |

**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.

| Fraud, Waste, & Abuse Activity | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2020 YTD Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **# of New MC609 Cases Submitted to DHCS** | 2 | 1 | 3 | 0 | | | | | | | | | 6 |
| **# of Cases Open for Investigation (Active Number)** | 16 | 16 | 16 | 14 | | | | | | | | | |

**Summary of Potential Fraud, Waste & Abuse (FWA) cases**

For 2020 year to date, the Plan identified six (6) cases which were determined to reflect potential FWA and six (6) MC609 reports were filed with the DHCS. All cases were provider-related.

In January, one provider reported was identified for billing certain procedures on an excessive basis above recommended medical guidelines and potential up coding of Evaluation and Management Services (E/Ms). Another provider was referred to DHCS based on suspected abuse for billing excessive units per visit for multiple procedure codes. In February one case was filed after a participating provider was identified for unexpected utilization of diagnosis codes by the SIU Unit's Suspect Diagnosis Model algorithm. In March, three new cases were filed: all cases involved participating providers identified as inappropriately billing more than expected diagnoses in certain categories, for potential unbundling or billing inappropriate codes.

There were no cases that needed to be referred to other law enforcement agencies by the Plan.

Report Date 04/16/20

| Compliance Oversight & Monitoring Activities | Description |
|---|---|
| **CalViva Health Oversight Activities** | **Health Net**<br>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. Health Net is providing more detailed reports of vendor oversight audits and comprehensive reports of participating provider groups (PPG) activity – additional reporting enhancements will be implemented in 2020. 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: Appeals & Grievances, Marketing, Provider Network, Utilization Management & Case Management, Provider Dispute Resolutions and Claims.<br><br>The following audit has been completed since the last Commission report: Q2 2019 Provider Dispute Resolutions (No CAP). |
| **Regulatory Reviews/Audits and CAPS** | **Status** |
| **Department of Health Care Services ("DHCS") 2020 Medical Audit** | DHCS was onsite at CalViva Health the week of February 3, 2020 to conduct their annual Medical Audit. The Plan has responded to all current post-onsite requests for documents. DHCS will issue a Preliminary Report of their findings later in 2020. |
| **Department of Health Care Services ("DHCS") 2019 Medical Audit** | DHCS issued its Final Report to the Plan on October 29, 2019 citing three deficiencies. The Plan submitted its CAP on December 3, 2019. The Plan is currently submitting monthly progress reports to DHCS regarding the status of CAP implementation. |
| **Department of Managed Health Care ("DMHC") 2019 Medical Survey** | The DMHC issued their Final Report on February 5, 2020 citing two deficiencies as corrected and two deficiencies uncorrected. CalViva's supplemental CAP response was submitted 4/5/20. DMHC will also conduct an 18-month follow-up audit to validate corrective actions have been implemented. |
| **Department of Managed Health Care ("DMHC") MY2019 Timely Access Report** | Due to the COVID-19 emergency, DMHC has extended the filing due date for this annual major filing to 5/1/20. It is normally due March 31 of every year. |
| **Department of Health Care Services ("DHCS") Annual Network Certification** | On 2/27/20, DHCS published All Plan Letter (APL 20-003) specifying new requirements for annual network certification (ANC). The most significant change relates to provider availability standards. Plans must now meet **both** time **and** distance standards (no longer time **or** distance). This change will result in a significant number of zip codes and specialty categories falling out of compliance and requiring CalViva to file Alternative Access Standards (AAS) requests with DHCS. For each AAS request, plans are now required to provide the names/addresses of two of the nearest out-of-network providers along with their times and distances and a description of the Plan's contracting efforts with them. Due to the |

| | |
|---|---|
| | COVID-19 emergency, DHCS has extended the filing due date for this annual major filing to 4/20/20. It is normally due about March 18 of every year. |
| **New Regulations / Contractual Requirements** | |
| **California Advancing and Innovating Medi-Cal (CalAIM) (fmr "Medi-Cal Healthier California for All")** | **Note:** due to COVID-19, CalAIM and other proposed health care related initiatives are being reviewed and recalibrated at by the state due to the budgetary and economic crisis that is developing. Since DHCS has not yet issued official notice of specific CalAIM delays, changes or cancellations, the following status remains but will likely be changed by the next Commission meeting.<br><br>DHCS changed the name of this program back to CalAIM. CalAIM has three primary goals:<br>1. Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health;<br>2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and<br>3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.<br><br>CalAIM contains 20+ initiatives that will be phased in over several years. See Table 1 below for a list of current areas of focus and updated information. Updates are in bolded italics. |
| **Behavioral Health Integration (BHI) Incentive Program** | The Trailer Bill implementing the 2019 Budget Act authorized DHCS to develop the Behavioral Health Integration (BHI) Incentive Program as part of its Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care. CalViva Health received three (3) applications with one application covering two programs. All three (3) applications met the minimum qualifying criteria and the application packets have been submitted to DHCS for review. Due to the COVID-19 emergency, DHCS has deferred the start date of the BHI Incentive program to July 1, 2020. |
| **Preventive Care Outreach Project** | In the last report, it was noted that DHCS is implementing a Preventive Care Outreach project in two phases. In phase 1, DHCS will use targeted outreach (via mail and a call campaign) to contact members. DHCS has started mailing the letters and the managed care plans were to start the call campaign by 3/16/20. However, due to the coronavirus emergency, DHCS has directed plans to put the call campaign on hold. |
| **COVID-19<br>Novel Coronavirus** | The Plan has received numerous All Plan Letters and other regulatory guidance from DMHC and DHCS during the last month. DHCS requires MCPs to report provider site closures, positive COVID-19 tests and hospitalizations on a daily basis, including weekends. Both agencies have provided guidance to plans on ensuring access to testing, screening and treatment services, promoting telehealth services, ensuring members are not liable for COVID-19 balance bills from providers, etc.<br>CalViva Health staff and our administrator's staff are carrying out operations on a remote basis. We are assessing the remote working situation on a weekly basis. |
| **Committee Report** | |
| **Public Policy Committee** | The Public Policy Committee (PPC) met in Fresno County on March 4, 2020. The following reports were presented: the Q4 2019 Grievance & Appeal report, the Annual 2019 Compliance Report, the Q3 and Q4 2019 Member Incentive Programs Report. There were no recommendations for referral to the Commission. The next meeting will be held on June 10, 2020, 11:30 a.m. in Kings County, 1400 Lacey Blvd., Hanford, CA. |

**Table 1**

| CalAIM CORE INITIATIVE | TIMELINE |
|---|---|
| NCQA Accreditation for Plans and Delegates | By 2025 |
| Population Health Management | Incorporated into plan contracts by ***2022***. ***DHCS has determined that plans should have additional time to design and implement their Population Health Management Strategies, delaying the effective date to January 1, 2022*** |
| Enhanced Care Management + In Lieu of Services (Incentive payments to shared savings) | ECM benefit by 1/2021 for mandated populations and 1/2023 for individuals transitioning from incarceration. ***DHCS will offer a phased approach to give plans without Whole Person Care and Health Homes Programs experience additional time to prepare for the transition to enhanced care management. The implementation date for plans in counties with Whole Person Care pilots and/or Health Homes Programs is January 1, 2021; plans in counties without WPC or HHP will have until July 1, 2021 to implement, but may implement earlier.*** |
| LTC Integration + Duals + D-SNPs<br>Organ Transplants | LTC & organ transplants for all plans by 1/2021; duals mandatory 1/2023; mandate D-SNPs ***1/2026 (new D-SNP date – formerly 1/1/2023)*** |
| Regional Rates | Phase I for targeted counties and MCPs by 1/1/2021. Statewide regional rates no sooner than 1/1/2023 |
| Behavioral Health (Payment Reform, Revising Medical Necessity Criteria, Administrative Integration of SMI and SUD, County Regional Contracting) | January 1, 2021 or later depending on county readiness |
| Mandatory Managed Care Populations | Non-dual and pregnancy related aid code group, and population-based transitions by 1/1/2021; dual aid code group by 1/1/2023. |

# 2020 New California Health Care Laws

| Bill | Name | Description | Applies to CalViva | Effective Date | Plan Action/Notes |
|---|---|---|---|---|---|
| **AB 115** | Committee on Budget | This bill renewed a tax on managed care organizations that expired in July and brings in $1.7 billion in federal Medicaid funding. CMS subsequently rejected California's MCO Tax on 1/30/20 claiming that it violates the federal rules regarding a "hold harmless" for plans paying the taxes. DHCS submitted an updated waiver request with a modified tax model for CMS review on 2/10/20. | Yes | 9/27/2019 | Awaiting CMS review and approval of DHCS updated waiver request. |
| **AB 290** | Wood | This bill would prohibit a chronic dialysis clinic from steering, directing, or advising a patient regarding any specific coverage program option or health care service plan contract. This bill was intended to restrict the ability of financially interested medical providers from using donations to charitable organizations as a means to increase their reimbursement rates at the expense of the commercial coverage risk pool. The bill mandates specific requirements on financially interested entities that pay premiums in order to remove the financial incentive of providing premium assistance and to ensure consumers are properly notified of their rights and coverage options. | Yes | 1/1/2020 & 1/1/2022 | A federal judge has issued a preliminary injunction on AB 290 and this is currently on hold pending resolution of a lawsuit by the nonprofit American Kidney Fund.<br><br>If the lawsuit fails and the bill is enacted, then plans may have to review and update claims policies, review contract payment rates, revise EOCs and likely have to provide periodic reporting to DMHC. |
| **AB 577** | Eggman | This bill expands continuity of care requirements to include a maternal mental health condition and mandates that health plans provide completion of covered services for pregnant women for up to 12 months from the diagnosis or from the end of pregnancy, whichever occurs later, if the woman presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider.<br><br>Defines "a maternal mental health condition" as "a mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery." | Yes | 1/1/2020 | CalViva Health updated its continuity of care policies and the Member Handbook/EOC. Additionally, the Plan has revised its template block transfer/enrollee transfer notices (ETNs) to add "a maternal mental health condition" to the list of conditions for which a plan shall provide completion of covered services by a terminated or nonparticipating provider. |
| **AB 651** | Grayson | This bill requires a health plan to limit the enrollee payment for covered services provided by a noncontracted air ambulance service provider to no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracted air ambulance provider. Refers to this as the in-network cost-sharing amount. | Yes | 1/1/2020 | The Plan's Medi-Cal managed care product does not have any enrollee cost sharing requirements. |

| Bill | Name | Description | Applies to CalViva | Effective Date | Plan Action/Notes |
|---|---|---|---|---|---|
| **AB 678** | Flora | Prohibits prior authorization requirements for podiatrists rendering podiatric services in either an outpatient or inpatient setting if a physician or surgeon providing the same service would not be required to submit a prior authorization to DHCS.<br>Specifies that a podiatrist working within their scope of practice is subject to the same Medi-Cal billing and services policies as required for a physician and surgeon. | Yes | 1/1/2020 | CalViva to work with HN to determine if Plan policies or EOC need revision. |
| **AB 1004** | McCarty | This bill requires plans to ensure that developmental screening services provided for members as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit comply with the AAP/Bright Futures periodicity schedule and guidelines.<br>DHCS APL 19-016 released on 12/26/19 provides details on requirements. Supplemental Prop 56 payments will be made to plans and plans in turn will issue supplemental payments to eligible contracted providers providing covered developmental screening services for dates of service starting 1/1/20.<br>Until 7/1/23, an external quality review organization (EQRO) must review and report annually on plan metrics for developmental screenings, and would require DHCS to use the EQRO's technical report to monitor plans' compliance with providing enrollees access to developmental screenings. | Yes | 1/1/2020 | CalViva is working with our administrator to review and revise policies as needed and to develop the supplemental payment processes needed. |
| **AB 1088** | Wood | Requires DHCS to seek a State Plan Amendment or waiver to implement an income disregard to allow aged, blind, or disabled individuals who become ineligible for Medi-Cal as a result of the State paying for their Medicare Part B premiums to remain eligible for Medi-Cal if their income and resources otherwise meet eligibility requirements.<br>Existing law allows the payment of Medicare premiums, deductibles, and coinsurance for elderly and disabled persons whose income does not exceed the federal poverty level or 200% of a specified Supplemental Security Income program standard. | Maybe | 7/1/2021 | Implementation contingent on obtaining any necessary federal approvals and availability of federal financial participation. CalViva could potentially see increased enrollment of aged, blind and disabled populations currently ineligible for Medi-Cal. |

| Bill | Name | Description | Applies to CalViva | Effective Date | Plan Action/Notes |
|---|---|---|---|---|---|
| **AB 1494** | Aguiar-Curry | States that neither face-to-face contact nor a patient's physical presence on the premises is required for services delivered to Medi-Cal beneficiaries during or immediately following a state of emergency.<br>• Defines "immediately following" to mean up to 90 calendar days following the termination of the proclaimed state of emergency. This period of time may be extended at DHCS discretion.<br>• Defines "premises" to mean within the four walls of an enrolled community clinic. | Yes | 7/1/2020 | Implementation subject to obtaining any necessary federal approvals and availability of federal financial participation.<br>• Requires DHCS to provide guidance by 7/1/20, including direction to plans regarding prompt payment of claims that may require a temporary waiver of documentation requirements and streamlined billing or appeal processes.<br>• May need to update Plan policies after DHCS direction. |
| **AB 1642** | Wood | Establishes additional requirements for alternative access requests submitted by plans to DHCS. The bill requires Medi-Cal plans that receive approval for alternative access to assist enrollees by arranging for covered transportation, and to inform members of the approved alternative access standards. The bill also requires information compiled by an external quality review organization (EQRO) to include the extent to which each Medi-Cal managed care plan uses clinically appropriate telecommunication technology to meet established T&D standards.<br>This bill also increases the maximum civil penalty amounts in existing law for plans, broadens the bases for DHCS to levy sanctions against plans, and broadens DHCS authority to find noncompliance beyond medical audits. | Yes | 1/1/2020 | CalViva will need to revise policies and procedures, implement new activities and provide additional information related to annual network certification filings, update member communications and more. |
| **AB 1705** | Bonta | Establishes a new Medi-Cal Public Provider Intergovernmental Transfer (IGT) Program for public ground emergency medical transportation (GEMT) providers.<br>Subject to federal approval, requires additional payments to these providers in Medi-Cal FFS and managed care.<br>Exempts public ambulance providers from the current Quality Assurance Fee and resulting add-on payment. | Yes | 7/1/2021 | DHCS will likely issue an APL specific to the new IGT program and revisions to the existing GEMT APL. CalViva will assess need for policy and procedure changes and modified supplemental payment processes. |
| **AB 1802** | Committee on Health | Changes the DMHC's internet website from http://www.hmohelp.ca.gov to http://www.dmhc.ca.gov, and toll-free telephone number from 1-888-HMO-2219 to 1-888-466-2219, in all plan documents required under Sections 1358.20, 1368.015, 1368.02, and 1373.65. | Yes | 1/1/2020 | CalViva is in the process to of updating all applicable member communications to reflect the DMHC's updated contact information. |

| Bill | Name | Description | Applies to CalViva | Effective Date | Plan Action/Notes |
|---|---|---|---|---|---|
| **SB 129** | Pan | Amends existing plan enrollment reporting requirements to include individual and small group products sold inside and outside Covered California, and multiple employer welfare arrangements (MEWAs), in addition to large group products, administrative services only business lines, and any other business lines. Requires DMHC to make the reported data for the previous year available no later than April 15 of each year on the department's Web site. | Yes | 3/1/2020 | The Plan must complete a new annual enrollment report but since CalViva only offers a Medi-Cal product the report will not include individual and small group products sold inside or outside Covered California, MEWAs and other business lines. |
| **SB 159** | Wiener | The intent of the bill is to increase access to HIV medications by allowing pharmacists to furnish two HIV preventative medications, PrEP and PEP without a physician's prescription. Authorizes a pharmacist to provide preexposure/postexposure prophylaxis (PrEP) for the prevention of AIDS/HIV, if the enrollee meets certain clinical criteria, and the pharmacist completes a training program approved by the California State Board of Pharmacy.<br>• Expands Medi-Cal benefits to include PrEP.<br>• Prohibits plans from requiring prior authorization/step therapy for antiretroviral drugs including PrEP, unless there are FDA approved therapeutic equivalents to prevent AIDS/HIV. If so, the plan must cover at least one therapeutic equivalent without prior authorization/step therapy.<br>• Prohibits plans and PBMs from not covering PrEP. | Yes | 1/1/2021 | Under the terms of the Medi-Cal managed care program, AIDS/HIV drugs are carved out and are covered under the Medi-Cal Fee-for-Service program. Therefore, DHCS is responsible for coverage related to antiretroviral drugs for the prevention of AIDS/HIV, including PrEP. Although AIDS/HIV PrEP is carved out, Health Net has affirmed to the Plan that if any provider contracts, administrative services agreements with pharmacy providers, pharmacy provider groups and/or PBM or policies and procedures conflict with SB 159, Health Net will amend these documents to comply with SB 159 and file the documents as applicable with DMHC/DHCS. |
| **SB 583** | Jackson | This bill would expand required coverage for clinical trials under a plan contract to include a clinical trial relating to the prevention, detection, or treatment of a life-threatening disease or condition as defined in the law. The bill would prohibit a plan contract from, among other things, discriminating against an enrollee or insured for participating in an approved clinical trial. The bill would authorize a plan or insurer to require a qualified enrollee or insured to participate in a clinical trial. | Yes | 1/1/2020 | The Plan's clinical trial coverage is consistent with DHCS contract requirements and supported by DHCS Member Handbook/EOC model language |
| **AB 824** | Wood | AB 824, prevents harmful "pay-for-delay" deals occur when brand name pharmaceutical companies pay generic drug makers to slow down or stop lower-cost alternative medications from entering the marketplace. While this drives up profits for drug companies, consumers were being left to pay artificially high prescription drug costs. | No | 1/1/2020 | Information Only |

# Item #8

## Attachment 8.C

Appeals & Grievances Report

# CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2020

Current as of End of the Month: January
Revised Date: 2/14/2020

| CalViva - 2020 | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Grievances** | **Jan** | **Feb** | **Mar** | **Q1** | **Apr** | **May** | **Jun** | **Q2** | **Jul** | **Aug** | **Sep** | **Q3** | **Oct** | **Nov** | **Dec** | **Q4** | **2020 YTD** | **2019** |
| Expedited Grievances Received | 10 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 189 |
| Standard Grievances Received | 104 | 0 | 0 | 104 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 104 | 1118 |
| **Total Grievances Received** | **114** | **0** | **0** | **114** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **114** | **1307** |
| | | | | | | | | | | | | | | | | | | |
| Grievance Ack Letters Sent Noncompliant | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| **Grievance Ack Letter Compliance Rate** | **100.0%** | **0.0%** | **0.0%** | **100.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **100.00%** | **98.9%** |
| | | | | | | | | | | | | | | | | | | |
| 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 | 10 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 189 |
| **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 | 110 | 0 | 0 | 110 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 110 | 1100 |
| **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** | **120** | **0** | **0** | **120** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **120** | **1290** |
| | | | | | | | | | | | | | | | | | | |
| **Grievance Descriptions - Resolved Cases** | | | | | | | | | | | | | | | | | | |
| **Quality of Service Grievances** | **96** | **0** | **0** | **96** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **96** | **983** |
| Access - Other - DMHC | 7 | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 58 |
| Access - PCP - DHCS | 10 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 166 |
| Access - Physical/OON - DHCS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Access - Spec - DHCS | 10 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 59 |
| Administrative | 13 | 0 | 0 | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 | 211 |
| Continuity of Care | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 10 |
| Interpersonal | 8 | 0 | 0 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 106 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 11 | 0 | 0 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 87 |
| Pharmacy | 7 | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 50 |
| Transportation - Access | 17 | 0 | 0 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 160 |
| Transportation - Behaviour | 7 | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 56 |
| Transportation - Other | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 20 |
| | | | | | | | | | | | | | | | | | | |
| **Quality Of Care Grievances** | **24** | **0** | **0** | **24** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **24** | **307** |
| Access - Other - DMHC | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 11 |
| Access - PCP - DHCS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| 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 | 2 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 51 |
| PCP Care | 11 | 0 | 0 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 108 |
| PCP Delay | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 50 |
| Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Specialist Care | 8 | 0 | 0 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 65 |
| Specialist Delay | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Exempt Grievances Received** | 324 | 0 | 0 | **324** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **324** | NA |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

# CalViva Health Appeals and Grievances Dashboard 2020

| Appeals | Jan | Feb | Mar | Q1 | Apr | May | June | Q2 | Jul | Aug | Sep | Q3 | Oct | Nov | Dec | Q4 | YTD | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Expedited Appeals Received | 11 | 0 | 0 | 11 | 0 | 0 | 0 | 0 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 158 |
| Standard Appeals Received | 78 | 0 | 0 | 78 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 78 | 744 |
| **Total Appeals Received** | **89** | **0** | **0** | **89** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | 89 | **902** |
| | | | | | | | | | | | | | | | | | | |
| Appeals Ack Letters Sent Noncompliant | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 3 |
| **Appeals Ack Letter Compliance Rate** | **100.0%** | **0.0%** | **0.0%** | **100.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **100.00%** | **99.6%** |
| | | | | | | | | | | | | | | | | | | |
| Expedited Appeals Resolved Noncompliant | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Expedited Appeals Resolved Compliant | 11 | 0 | 0 | **11** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 11 | 158 |
| **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 | 3 |
| Standard Appeals Resolved Compliant | 65 | 0 | 0 | 65 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 65 | 726 |
| **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%** | **99.6%** |
| | | | | | | | | | | | | | | | | | | |
| **Total Appeals Resolved** | **76** | **0** | **0** | **76** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **76** | **887** |
| | | | | | | | | | | | | | | | | | | |
| **Appeals Descriptions - Resolved Cases** | | | | | | | | | | | | | | | | | | |
| **Pre-Service Appeals** | **76** | **0** | **0** | **76** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **76** | 883 |
| Continuity of Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Consultation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| DME | 5 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 51 |
| Experimental/Investigational | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| Advanced Imaging | 34 | 0 | 0 | 34 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 | 412 |
| Other | 5 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 71 |
| Pharmacy | 31 | 0 | 0 | 31 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 | 274 |
| Surgery | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 50 |
| 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** | 4 |
| Consultation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DME | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Experimental/Investigational | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 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 | 33 | 0 | 0 | **33** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 | 463 |
| **Uphold Rate** | **43.4%** | **0.0%** | **0.0%** | **43.4%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **43.4%** | **52.2%** |
| Overturns - Full | 40 | 0 | 0 | **40** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 40 | 399 |
| **Overturn Rate - Full** | **52.6%** | **0.0%** | **0.0%** | **52.6%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **52.6%** | **45.0%** |
| Overturns - Partials | 3 | 0 | 0 | **3** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 3 | 19 |
| **Overturn Rate - Partial** | **3.9%** | **0.0%** | **0.0%** | **3.9%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.00%** | **3.9%** | **2.1%** |
| Withdrawal | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | **0** | 6 |
| **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%** | **0.00%** | **0.0%** | **0.7%** |
| | | | | | | | | | | | | | | | | | | |
| **Membership** | 348,034 | - | - | | - | - | - | | - | - | - | | - | - | - | | | 4,246,376 |
| Appeals - PTMPM | 0.22 | - | - | 0.22 | - | - | - | - | - | - | - | - | - | - | - | - | 0.22 | 0.21 |
| Grievances - PTMPM | 0.34 | - | - | 0.34 | - | - | - | - | - | - | - | - | - | - | - | - | 0.34 | 0.30 |
| | | | | | | | | | | | | | | | | | | |

| Affected Month | Date of Entry | Outlier | Explanation |
|---|---|---|---|
| January | 2/14/2020 | There were 14 Exempt Grievances related to ID Card-Not Received in January. | We have shown an increase for Exempt Grievances pertaining to ID Cards with 14 in January, 8 in December ,and 20 in November . These Exempt Grievances involved the member grieving about not having received ID cards. Issue was resolved by confirming/changing the member's address and mailing out an ID Card. |
| January | 2/14/2020 | There were 24 Exempt Grievances related to Attitude/Service in January. | Effective 2020, Exempt Grievances for this category include service issues against the plan. Exempt grievances for this category had a slight increase with 28 in December as compared to 24 in December, and 21 in November. 24 Issues were against the provider/staff was unprofessional towards the member, issue is resolved by changing the PCP, 4 service issues were against the plan. There were 7 complaints for Sante Community Physicians providers, all other medical groups had 3 or less incidents. |
| January | 2/14/2020 | There were 147 Exempt Grievances related to PCP assignment in January. | We have shown an increase in this category with 147 in January as compared to 101 in December, and 84 in November. Members stated they were not assigned to the PCP requested. Trends were identified with Sante FFS having 37 members stating they were assigned the incorrect PCP. |
| January | 2/14/2020 | There were 31 Exempt Grievances related to Pharmacy in January. | We have shown an increase in this category with 31 in January as compared to 20 in December, and 18 in November. These Exempt Grievances involved members not being able to get medications due to eligibility(26) or issues with the Pharmacy (5). The issues were resolved by contacting the pharmacy service department for assistance with the necessary updates. The Pharmacy Service department is working on a permanent fix for the eligibility issue. |
| January | 2/14/2020 | There were 18 Exempt Grievances related to Availability of Appointment with PCP in January. | We have shown an increase in this category with 18 in January as compared to 11 in December, and 3 in November. These Exempt Grievances involved members unable to obtain medical appointments within a reasonable timeframe, based upon the plan's appointment standards. The issues were resolved by contacting providers on members' behalf to assist scheduling appointments, changing the authorized specialist, or changing the primary care provider. |
| January | 2/14/2020 | There were 18 Exempt Grievances related to member billing in January. | We have shown a decrease in this category with 18 in January as compared to 21 in December, and 8 in November. These cases are related to balance billing issues from either hospitals or ancillary provider. Issues were resolved by contacting the billers and providing the correct billing process for the claims. |
| January | 2/14/2020 | There were 53 Logisticare Exempt Grievances related to Transportation in January. | We have shown a decrease for Exempt Grievances pertaining to transportation with 53 in January , as compared to 70 in December , and 117 in November. These issues included 24 access incidents in which the provider arrived late for pick up or was a no shows, 27 behavior issues involved the transportation provider's behavior during pick up or customer service at Logisticare, and 2 miscellaneous issues. Trends were identified with Lyft having 9 issues all others have 4 or less. |

# Item #8

## Attachment 8.D

Key Indicator Report

# *Healthcare Solutions Reporting*

## Key Indicator Report

*Auth Based PPG Utilization Metrics for CALVIVA California SHP*

*Report from 1/01/2019 to 1/31/2020*

*Report created 2/17/2020*

***Purpose of Report:*** Summary report on Inpatient and Outpatient Utilization Metrics by Region, County, PPG entity
Reports show inpatient Rates with and without maternity, readmission, TAT Compliance, Care Management Programs

**Exhibits:**



### Contact Information

| Sections | Contact Person |
|---|---|
| Concurrent Inpatient TAT Metric | |
| TAT Metric | Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM> |
| CCS Metric | Azra S. Aslam <Azra.S.Aslam@healthnet.com> |
| Case Management Metrics | Kenneth Hartley <KHARTLEY@cahealthwellness.com |
| Authorization Metrics | John Gonzalez |

**Key Indicator Report**
**Auth Based PPG Utilization Metrics for CALVIVA California SHP**
**Report from 1/01/2019 to 1/31/2020**
Report created 2/17/2020

| ER utilization based on Claims data | 2019-01 | 2019-02 | 2019-03 | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2019-Trend | 2020-01 | 2020-Trend | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 | Qtr Trend | CY- 2019 | YTD-2020 | YTD-Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | Quarterly Averages | | | | | Annual Averages | | |
| Expansion Mbr Months | 85,804 | 85,536 | 85,443 | 85,401 | 85,311 | 85,605 | 85,497 | 85,474 | 85,363 | 85,043 | 84,589 | 83,876 | | 82,799 | | 85,594 | 85,439 | 85,445 | 84,503 | | 85,245 | 82,799 | |
| Family/Adult/Other Mbr Mos | 245,982 | 242,445 | 243,360 | 243,118 | 242,793 | 241,477 | 240,923 | 240,126 | 238,798 | 237,820 | 237,081 | 235,924 | | 233,429 | | 243,929 | 242,463 | 239,949 | 236,942 | | 240,821 | 233,429 | |
| SPD Mbr Months | 32,803 | 32,772 | 32,798 | 32,817 | 32,896 | 32,976 | 32,956 | 32,947 | 32,944 | 32,960 | 32,935 | 32,875 | | 32,683 | | 32,791 | 32,896 | 32,949 | 32,923 | | 32,890 | 32,683 | |
| Admits - Count | 2,319 | 2,103 | 2,254 | 2,150 | 2,314 | 2,182 | 2,339 | 2,317 | 2,110 | 2,236 | 2,155 | 2,180 | | 2,237 | | 2,225 | 2,215 | 2,255 | 2,190 | | 2,222 | 2,237 | |
| Expansion | 654 | 602 | 614 | 620 | 719 | 677 | 752 | 730 | 653 | 649 | 650 | 631 | | 684 | | 623 | 672 | 712 | 643 | | 663 | 684 | |
| Family/Adult/Other | 1,109 | 1,036 | 1,070 | 1,003 | 1,058 | 1,005 | 1,057 | 1,090 | 980 | 1,086 | 1,030 | 1,069 | | 1,054 | | 1,072 | 1,022 | 1,042 | 1,062 | | 1,049 | 1,054 | |
| SPD | 545 | 458 | 562 | 516 | 525 | 486 | 515 | 485 | 468 | 492 | 466 | 471 | | 489 | | 522 | 509 | 489 | 476 | | 499 | 489 | |
| Admits Acute - Count | 1,591 | 1,479 | 1,576 | 1,481 | 1,581 | 1,482 | 1,526 | 1,484 | 1,412 | 1,456 | 1,443 | 1,455 | | 1,536 | | 1,549 | 1,515 | 1,474 | 1,451 | | 1,497 | 1,536 | |
| Expansion | 466 | 453 | 472 | 466 | 553 | 510 | 560 | 534 | 478 | 484 | 479 | 476 | | 495 | | 464 | 510 | 524 | 480 | | 494 | 495 | |
| Family/Adult/Other | 618 | 597 | 588 | 532 | 541 | 518 | 491 | 516 | 499 | 525 | 541 | 545 | | 583 | | 601 | 530 | 502 | 537 | | 543 | 583 | |
| SPD | 500 | 423 | 510 | 476 | 481 | 444 | 470 | 429 | 429 | 443 | 419 | 428 | | 456 | | 478 | 467 | 443 | 430 | | 454 | 456 | |
| Readmit 30 Day - Count | 320 | 274 | 297 | 270 | 309 | 303 | 293 | 284 | 300 | 309 | 297 | 301 | | 299 | | 297 | 294 | 292 | 302 | | 296 | 299 | |
| Expansion | 90 | 78 | 82 | 68 | 100 | 105 | 95 | 109 | 105 | 99 | 93 | 80 | | 87 | | 83 | 91 | 103 | 91 | | 92 | 87 | |
| Family/Adult/Other | 91 | 76 | 90 | 89 | 76 | 82 | 90 | 85 | 95 | 92 | 96 | 91 | | 96 | | 86 | 82 | 90 | 93 | | 88 | 96 | |
| SPD | 135 | 119 | 125 | 112 | 132 | 115 | 107 | 89 | 99 | 116 | 107 | 129 | | 116 | | 126 | 120 | 98 | 117 | | 115 | 116 | |
| Readmit 14 Day - Count | 38 | 23 | 17 | 32 | 30 | 34 | 31 | 25 | 20 | 23 | 27 | 21 | | 29 | | 26 | 32 | 25 | 24 | | 27 | 29 | |
| Expansion | 12 | 9 | 5 | 7 | 16 | 12 | 9 | 10 | 5 | 7 | 10 | 6 | | 8 | | 9 | 12 | 8 | 8 | | 9 | 8 | |
| Family/Adult/Other | 10 | 7 | 3 | 7 | 4 | 11 | 8 | 6 | 6 | 7 | 2 | 8 | | 10 | | 7 | 7 | 7 | 6 | | 7 | 10 | |
| SPD | 15 | 7 | 9 | 18 | 10 | 11 | 14 | 9 | 9 | 9 | 15 | 7 | | 11 | | 10 | 13 | 11 | 10 | | 11 | 11 | |
| **ER Visits - Count | 16,111 | 15,562 | 18,197 | 15,956 | 15,393 | 14,889 | 14,883 | 15,058 | 15,128 | 14,493 | 14,466 | 14,650 | | 9,950 | | 16,623 | 15,413 | 15,023 | 14,536 | | 15,399 | 9,950 | |
| Expansion | 3,811 | 3,294 | 3,903 | 3,833 | 3,802 | 3,833 | 4,112 | 3,989 | 3,744 | 3,487 | 3,394 | 3,449 | | 2,109 | | 3,669 | 3,823 | 3,948 | 3,443 | | 3,721 | 2,109 | |
| Family/Adult/Other | 10,617 | 10,676 | 12,477 | 10,418 | 9,926 | 9,329 | 8,949 | 9,394 | 9,676 | 9,431 | 9,540 | 9,699 | | 6,903 | | 11,257 | 9,891 | 9,340 | 9,557 | | 10,011 | 6,903 | |
| SPD | 1,663 | 1,573 | 1,791 | 1,670 | 1,624 | 1,673 | 1,768 | 1,636 | 1,663 | 1,525 | 1,506 | 1,469 | | 905 | | 1,676 | 1,656 | 1,689 | 1,500 | | 1,630 | 905 | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| Admits Acute - PTMPY | 52.3 | 49.2 | 52.3 | 49.1 | 52.5 | 49.3 | 50.9 | 49.6 | 47.4 | 49.0 | 48.8 | 49.4 | | 52.7 | | 51.3 | 50.3 | 49.3 | 49.1 | | 50.0 | 52.7 | |
| Expansion | 65.2 | 63.6 | 66.3 | 65.5 | 77.8 | 71.5 | 78.6 | 75.0 | 67.2 | 68.3 | 68.0 | 68.1 | | 71.7 | | 65.0 | 71.6 | 73.6 | 68.1 | | 69.6 | 71.7 | |
| Family/Adult/Other | 30.1 | 29.5 | 29.0 | 26.3 | 26.7 | 25.7 | 24.5 | 25.8 | 25.1 | 26.5 | 27.4 | 27.7 | | 30.0 | | 29.6 | 26.2 | 25.1 | 27.2 | | 27.0 | 30.0 | |
| SPD | 182.9 | 154.9 | 186.6 | 174.1 | 175.5 | 161.6 | 171.1 | 156.3 | 156.3 | 161.3 | 152.7 | 156.2 | | 167.4 | | 174.8 | 170.4 | 161.2 | 156.7 | | 165.8 | 167.4 | |
| Bed Days Acute - PTMPY | 253.7 | 254.9 | 271.3 | 243.2 | 250.8 | 242.1 | 249.9 | 242.5 | 226.0 | 246.5 | 244.6 | 241.1 | | 242.5 | | 260.0 | 245.4 | 239.5 | 244.1 | | 247.3 | 242.5 | |
| Expansion | 327.0 | 352.8 | 326.3 | 312.2 | 377.8 | 352.3 | 401.3 | 418.1 | 346.0 | 320.0 | 361.3 | 353.2 | | 355.5 | | 335.3 | 347.4 | 388.5 | 344.8 | | 354.0 | 355.5 | |
| Family/Adult/Other | 107.2 | 124.3 | 107.6 | 102.8 | 96.6 | 101.2 | 88.8 | 90.4 | 93.7 | 111.2 | 110.4 | 112.0 | | 108.4 | | 113.0 | 100.2 | 91.0 | 111.2 | | 103.8 | 108.4 | |
| SPD | 1,152.0 | 933.0 | 1,331.8 | 1,081.6 | 1,053.5 | 975.3 | 1,033.0 | 889.8 | 865.5 | 1,010.3 | 909.1 | 876.0 | | 915.0 | | 1,139.0 | 1,036.7 | 929.4 | 931.9 | | 1,009.1 | 915.0 | |
| ALOS Acute | 4.8 | 5.2 | 5.2 | 4.9 | 4.8 | 4.9 | 4.9 | 4.9 | 4.8 | 5.0 | 5.0 | 4.9 | | 4.6 | | 5.1 | 4.9 | 4.9 | 5.0 | | 4.9 | 4.6 | |
| Expansion | 5.0 | 5.6 | 4.9 | 4.8 | 4.9 | 4.9 | 5.1 | 5.6 | 5.1 | 4.7 | 5.3 | 5.2 | | 5.0 | | 5.2 | 4.9 | 5.3 | 5.1 | | 5.1 | 5.0 | |
| Family/Adult/Other | 3.6 | 4.2 | 3.7 | 3.9 | 3.6 | 3.9 | 3.6 | 3.5 | 3.7 | 4.2 | 4.0 | 4.0 | | 3.6 | | 3.8 | 3.8 | 3.6 | 4.1 | | 3.8 | 3.6 | |
| SPD | 6.3 | 6.0 | 7.1 | 6.2 | 6.0 | 6.0 | 6.0 | 5.7 | 5.5 | 6.3 | 6.0 | 5.6 | | 5.5 | | 6.5 | 6.1 | 5.8 | 5.9 | | 6.1 | 5.5 | |
| Readmit % 30 Day | 13.8% | 13.0% | 13.2% | 12.6% | 13.4% | 13.9% | 12.5% | 12.3% | 14.2% | 13.8% | 13.8% | 13.8% | | 13.4% | | 13.3% | 13.3% | 13.0% | 13.8% | | 13.3% | 13.4% | |
| Expansion | 13.8% | 13.0% | 13.4% | 11.0% | 13.9% | 15.5% | 12.6% | 14.9% | 16.1% | 15.3% | 14.3% | 12.7% | | 12.7% | | 13.4% | 13.5% | 14.5% | 14.1% | | 13.9% | 12.7% | |
| Family/Adult/Other | 8.2% | 7.3% | 8.4% | 8.9% | 7.2% | 8.2% | 8.5% | 7.8% | 9.7% | 8.5% | 9.3% | 8.5% | | 9.1% | | 8.0% | 8.1% | 8.6% | 8.8% | | 8.4% | 9.1% | |
| SPD | 24.8% | 26.0% | 22.2% | 21.7% | 25.1% | 23.7% | 20.8% | 18.4% | 21.2% | 23.6% | 23.0% | 27.4% | | 23.7% | | 24.2% | 23.5% | 20.1% | 24.6% | | 23.1% | 23.7% | |
| Readmit % 14 Day | 2.4% | 1.6% | 1.1% | 2.2% | 1.9% | 2.3% | 2.0% | 1.7% | 1.4% | 1.6% | 1.9% | 1.4% | | 1.9% | | 1.7% | 2.1% | 1.7% | 1.6% | | 1.8% | 1.9% | |
| Expansion | 2.6% | 2.0% | 1.1% | 1.5% | 2.9% | 2.4% | 1.6% | 1.9% | 1.0% | 1.4% | 2.1% | 1.3% | | 1.6% | | 1.9% | 2.3% | 1.5% | 1.6% | | 1.8% | 1.6% | |
| Family/Adult/Other | 1.6% | 1.2% | 0.5% | 1.3% | 0.7% | 2.1% | 1.6% | 1.2% | 1.2% | 1.3% | 0.4% | 1.5% | | 1.7% | | 1.1% | 1.4% | 1.3% | 1.1% | | 1.2% | 1.7% | |
| SPD | 3.0% | 1.7% | 1.8% | 3.8% | 2.1% | 2.5% | 3.0% | 2.1% | 2.1% | 2.0% | 3.6% | 1.6% | | 2.4% | | 2.2% | 2.8% | 2.4% | 2.4% | | 2.4% | 2.4% | |
| **ER Visits - PTMPY | 598.8 | 599.8 | 600.8 | 601.8 | 602.8 | 603.8 | 604.8 | 605.8 | 606.8 | 607.8 | 608.8 | 609.8 | | 598.8 | | 550.3 | 512.0 | 502.3 | 491.4 | | 514.2 | 341.6 | |
| Expansion | 533.0 | 462.1 | 548.2 | 538.6 | 534.8 | 537.3 | 577.1 | 560.0 | 526.3 | 492.0 | 481.5 | 493.4 | | 305.7 | | 514.4 | 536.9 | 554.5 | 489.0 | | 523.8 | 305.7 | |
| Family/Adult/Other | 517.9 | 528.4 | 615.2 | 514.2 | 490.6 | 463.6 | 445.7 | 469.5 | 486.2 | 475.9 | 482.9 | 493.3 | | 354.9 | | 553.8 | 489.5 | 467.1 | 484.0 | | 498.8 | 354.9 | |
| SPD | 608.4 | 576.0 | 655.3 | 610.7 | 592.4 | 608.8 | 643.8 | 595.9 | 605.8 | 555.2 | 548.7 | 536.2 | | 332.3 | | 613.2 | 604.0 | 615.1 | 546.7 | | 594.7 | 332.3 | |
| Services | TAT Compliance Goal: 100% | | | | | | | | | | | | | T Compliance Goal: 10 | | TAT Compliance Goal: 100% | | | | | TAT Compliance Goal: 100% | | |
| Preservice Routine | 100.0% | 100.0% | 96.7% | 96.7% | 40.0% | 60.0% | 90.0% | 86.0% | 86.0% | 74.0% | 100.0% | 92.0% | | 100.0% | | 98.9% | 65.6% | 87.3% | 88.7% | | | | |
| Preservice Urgent | 100.0% | 96.7% | 100.0% | 96.7% | 90.0% | 83.3% | 96.7% | 86.7% | 92.0% | 76.0% | 100.0% | 92.0% | | 100.0% | | 98.9% | 90.0% | 91.8% | 89.3% | | | | |
| Postservice | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 96.7% | 86.7% | 92.0% | 100.0% | 94.0% | 94.0% | 94.0% | | 100.0% | | 100.0% | 98.9% | 92.9% | 94.0% | | | | |
| Concurrent (inpatient only) | 96.7% | 80.0% | 100.0% | 93.3% | 100.0% | 96.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | | 92.2% | 96.7% | 100.0% | 100.0% | | | | |
| Deferrals - Routine | 100.0% | 100.0% | 100.0% | 88.9% | 100.0% | 88.2% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | | 100.0% | 92.4% | 100.0% | 100.0% | | | | |
| Deferrals - Urgent | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | N/A | 100.0% | NA | null | 100.0% | NA | | N/A | | 100.0% | 100.0% | 100.0% | 100.0% | | | | |
| Deferrals - Post Service | null | null | null | NA | NA | NA | NA | NA | NA | NA | NA | NA | | null | | null | null | null | null | | | | |

**Key Indicator Report**
**Auth Based PPG Utilization Metrics for CALVIVA California SHP**
**Report from 1/01/2019 to 1/31/2020**
Report created 2/17/2020

| ER utilization based on Claims data | 2019-01 | 2019-02 | 2019-03 | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2019-Trend | 2020-01 | 2020-Trend | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 | Qtr Trend | CY- 2019 | YTD-2020 | YTD-Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | CCS ID RATE | | | | | | | | | | | | | CCS ID RATE | | CCS ID RATE | | | | | CCS ID RATE | | |
| CCS % | 8.07% | 8.07% | 8.06% | 8.07% | 8.14% | 8.11% | 8.13% | 8.15% | 8.29% | 8.25% | 8.29% | 8.31% | | 8.36% | | 8.07% | 8.10% | 8.19% | 8.28% | | 8.16% | 8.36% | |
| | Perinatal Case Management | | | | | | | | | | | | | rinatal Case Manage | | Perinatal Case Management | | | | | Perinatal Case Management | | |
| Total Number Of Referrals | 43 | 40 | 53 | 64 | 183 | 250 | 267 | 249 | 139 | 116 | 96 | 184 | | 282 | | 135 | 507 | 655 | 396 | | 1,693 | 282 | |
| Pending | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 4 | 0 | 2 | 6 | | 6 | | 0 | 1 | 5 | 8 | | 14 | 6 | |
| Ineligible | 3 | 1 | 6 | 6 | 10 | 24 | 17 | 13 | 5 | 1 | 1 | 3 | | 3 | | 10 | 40 | 35 | 5 | | 90 | 3 | |
| Total Outreached | 40 | 38 | 47 | 58 | 172 | 236 | 250 | 235 | 130 | 115 | 93 | 175 | | 273 | | 125 | 466 | 615 | 383 | | 1,589 | 273 | |
| Engaged | 10 | 13 | 8 | 23 | 43 | 55 | 55 | 57 | 37 | 43 | 33 | 64 | | 81 | | 31 | 121 | 149 | 140 | | 441 | 81 | |
| Engagement Rate | 25% | 34% | 17% | 40% | 25% | 23% | 22% | 24% | 28% | 37% | 35% | 37% | | 30% | | 25% | 26% | 24% | 37% | | 28% | 30% | |
| New Cases Opened | 10 | 13 | 8 | 23 | 43 | 55 | 55 | 57 | 37 | 43 | 33 | 64 | | 81 | | 31 | 121 | 149 | 140 | | 444 | 81 | |
| Total Cases Managed | 79 | 71 | 66 | 80 | 108 | 150 | 188 | 216 | 227 | 245 | 242 | 283 | | 324 | | 99 | 177 | 273 | 316 | | 503 | 324 | |
| Total Cases Closed | 21 | 14 | 9 | 15 | 10 | 12 | 30 | 25 | 25 | 34 | 25 | 40 | | 44 | | 44 | 37 | 80 | 99 | | 260 | 44 | |
| Cases Remained Open | 56 | 51 | 52 | 56 | 92 | 125 | 154 | 180 | 197 | 206 | 214 | 228 | | 266 | | 52 | 125 | 197 | 228 | | 228 | 266 | |
| | Integrated Case Management | | | | | | | | | | | | | egrated Case Managem | | Integrated Case Management | | | | | Integrated Case Management | | |
| Total Number Of Referrals | 45 | 31 | 76 | 62 | 70 | 126 | 101 | 109 | 80 | 111 | 78 | 112 | | 107 | | 152 | 258 | 290 | 301 | | 1,001 | 107 | |
| Pending | 0 | 0 | 0 | 3 | 1 | 0 | 1 | 3 | 2 | 2 | 1 | 7 | | 8 | | 0 | 4 | 6 | 10 | | 20 | 8 | |
| Ineligible | 3 | 1 | 6 | 11 | 4 | 16 | 16 | 13 | 5 | 11 | 9 | 10 | | 8 | | 10 | 31 | 34 | 30 | | 105 | 8 | |
| Total Outreached | 42 | 30 | 70 | 48 | 65 | 110 | 84 | 93 | 73 | 98 | 68 | 95 | | 91 | | 142 | 223 | 250 | 261 | | 876 | 91 | |
| Engaged | 15 | 8 | 35 | 19 | 27 | 27 | 34 | 34 | 30 | 38 | 32 | 49 | | 45 | | 58 | 73 | 98 | 119 | | 348 | 45 | |
| Engagement Rate | 36% | 27% | 50% | 40% | 42% | 25% | 40% | 37% | 41% | 39% | 47% | 52% | | 49% | | 41% | 33% | 39% | 46% | | 40% | 49% | |
| Total Screened and Refused/Decline | 8 | 4 | 16 | 14 | 15 | 29 | 20 | 21 | 24 | 25 | 26 | 14 | | 15 | | 28 | 58 | 65 | 65 | | 216 | 15 | |
| Unable to Reach | 22 | 21 | 24 | 25 | 37 | 69 | 46 | 49 | 32 | 53 | 27 | 42 | | 40 | | 67 | 131 | 127 | 122 | | 447 | 40 | |
| New Cases Opened | 15 | 8 | 35 | 19 | 27 | 27 | 34 | 34 | 30 | 38 | 32 | 49 | | 45 | | 58 | 73 | 98 | 113 | | 342 | 45 | |
| Total Cases Closed | 15 | 28 | 20 | 19 | 17 | 34 | 40 | 34 | 28 | 41 | 40 | 30 | | 19 | | 63 | 70 | 102 | 111 | | 346 | 19 | |
| Cases Remained Open | 109 | 134 | 116 | 134 | 147 | 137 | 151 | 142 | 130 | 126 | 102 | 125 | | 141 | | 116 | 137 | 130 | 125 | | 125 | 141 | |
| Total Cases Managed | 125 | 129 | 136 | 135 | 143 | 150 | 150 | 141 | 137 | 144 | 130 | 139 | | 151 | | 164 | 189 | 192 | 202 | | 444 | 151 | |
| Critical-Complex Acuity | 23 | 24 | 22 | 23 | 27 | 26 | 24 | 23 | 22 | 24 | 24 | 31 | | 36 | | 26 | 32 | 31 | 39 | | 65 | 36 | |
| High/Moderate/Low Acuity | 102 | 105 | 114 | 112 | 116 | 124 | 126 | 118 | 115 | 120 | 106 | 108 | | 115 | | 138 | 157 | 159 | 163 | | 379 | 115 | |
| | Transitional Case Management | | | | | | | | | | | | | sitional Case Managen | | Transitional Case Management | | | | | Transitional Case Management | | |
| Total Number Of Referrals | 41 | 49 | 64 | 60 | 45 | 32 | 111 | 152 | 114 | 162 | 129 | 132 | | 132 | | 152 | 137 | 377 | 414 | | 1,080 | 132 | |
| Pending | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 18 | 3 | 2 | 29 | | 19 | | 0 | 3 | 18 | 34 | | 55 | 19 | |
| Ineligible | 10 | 11 | 8 | 18 | 12 | 15 | 24 | 28 | 9 | 17 | 9 | 15 | | 7 | | 29 | 45 | 61 | 41 | | 176 | 7 | |
| Total Outreached | 29 | 38 | 56 | 40 | 32 | 17 | 87 | 124 | 87 | 138 | 113 | 88 | | 106 | | 123 | 89 | 298 | 339 | | 849 | 106 | |
| Engaged | 9 | 14 | 27 | 14 | 8 | 3 | 32 | 52 | 41 | 64 | 55 | 48 | | 75 | | 50 | 25 | 125 | 167 | | 367 | 75 | |
| Engagement Rate | 31% | 38% | 47% | 38% | 24% | 18% | 37% | 42% | 47% | 46% | 49% | 55% | | 71% | | 41% | 28% | 42% | 49% | | 43% | 71% | |
| Total Screened and Refused/Decline | 13 | 15 | 16 | 16 | 2 | 7 | 22 | 24 | 20 | 38 | 33 | 14 | | 14 | | 44 | 25 | 66 | 85 | | 220 | 14 | |
| Unable to Reach | 8 | 12 | 16 | 15 | 25 | 8 | 42 | 51 | 31 | 44 | 28 | 29 | | 21 | | 36 | 48 | 124 | 101 | | 309 | 21 | |
| New Cases Opened | 9 | 15 | 27 | 13 | 8 | 3 | 32 | 52 | 41 | 64 | 55 | 48 | | 75 | | 51 | 24 | 125 | 167 | | 367 | 75 | |
| Total Cases Closed | 5 | 11 | 13 | 11 | 24 | 8 | 12 | 33 | 34 | 56 | 56 | 55 | | 54 | | 29 | 43 | 79 | 167 | | 318 | 54 | |
| Cases Remained Open | 15 | 20 | 18 | 20 | 14 | 13 | 26 | 42 | 45 | 67 | 54 | 55 | | 74 | | 18 | 13 | 45 | 55 | | 55 | 74 | |
| Total Cases Managed | 19 | 28 | 44 | 46 | 43 | 21 | 46 | 88 | 94 | 129 | 125 | 117 | | 138 | | 52 | 55 | 128 | 167 | | 378 | 138 | |
| High/Moderate/Low Acuity | 19 | 28 | 44 | 46 | 43 | 21 | 46 | 88 | 94 | 129 | 125 | 117 | | 138 | | 52 | 55 | 128 | 167 | | 378 | 138 | |
| | Palliative Care | | | | | | | | | | | | | alliative Ca | | Palliative Care | | | | | Palliative Care | | |
| Total Number Of Referrals | | | | | | | | | | | | 21 | | 20 | | | | | 21 | | 21 | 20 | |
| Pending | | | | | | | | | | | | 3 | | 4 | | | | | 3 | | 3 | 4 | |
| Ineligible | | | | | | | | | | | | 0 | | 5 | | | | | 0 | | 0 | 5 | |
| Total Outreached | | | | | | | | | | | | 18 | | 11 | | | | | 18 | | 18 | 11 | |
| Engaged | | | | | | | | | | | | 14 | | 8 | | | | | 14 | | 14 | 8 | |
| Engagement Rate | | | | | | | | | | | | 78% | | 73% | | | | | 78% | | 78% | 73% | |
| Total Screened and Refused/Decline | | | | | | | | | | | | 2 | | 3 | | | | | 2 | | 2 | 3 | |
| Unable to Reach | | | | | | | | | | | | 2 | | 0 | | | | | 2 | | 2 | 0 | |
| New Cases Opened | | | | | | | | | | | | 13 | | 13 | | | | | 13 | | 13 | 13 | |
| Total Cases Closed | | | | | | | | | | | | 9 | | 5 | | | | | 9 | | 9 | 5 | |
| Cases Remained Open | | | | | | | | | | | | 84 | | 85 | | | | | 84 | | 84 | 85 | |
| Total Cases Managed | | | | | | | | | | | | 109 | | 90 | | | | | 109 | | 109 | 90 | |
| | Behavioral Health Case Management | | | | | | | | | | | | | oral Health Case Mana | | Behavioral Health Case Management | | | | | ehavioral Health Case Managemen | | |

**Key Indicator Report**
**Auth Based PPG Utilization Metrics for CALVIVA California SHP**
**Report from 1/01/2019 to 1/31/2020**
Report created 2/17/2020

| ER utilization based on Claims data | 2019-01 | 2019-02 | 2019-03 | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2019-Trend | 2020-01 | 2020-Trend | Q1 2019 | Q2 2019 | Q3 2019 | Q4 2019 | Qtr Trend | CY- 2019 | YTD-2020 | YTD-Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Number Of Referrals | 12 | 27 | 40 | 29 | 30 | 45 | 54 | 75 | 45 | 51 | 24 | 24 | | 25 | | 80 | 104 | 174 | 97 | | 455 | 25 | |
| Pending | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 7 | 1 | 0 | 2 | | 0 | | 0 | 1 | 8 | 3 | | 12 | 0 | |
| Ineligible | 1 | 2 | 6 | 2 | 6 | 1 | 8 | 13 | 2 | 2 | 1 | 2 | | 2 | | 9 | 9 | 23 | 5 | | 46 | 2 | |
| Total Outreached | 12 | 25 | 34 | 27 | 23 | 44 | 46 | 61 | 36 | 47 | 22 | 20 | | 23 | | 71 | 94 | 143 | 89 | | 397 | 23 | |
| Engaged | 6 | 9 | 14 | 14 | 14 | 12 | 27 | 16 | 11 | 17 | 13 | 10 | | 12 | | 29 | 40 | 54 | 40 | | 163 | 12 | |
| Engagement Rate | 50% | 36% | 41% | 52% | 61% | 27% | 59% | 26% | 31% | 36% | 59% | 50% | | 52.0% | | 41% | 43% | 38% | 45% | | 41% | 52% | |
| Total Screened and Refused/Decline | 0 | 2 | 0 | 0 | 1 | 1 | 3 | 3 | 1 | 2 | 1 | 2 | | 1 | | 2 | 2 | 7 | 5 | | 16 | 1 | |
| Unable to Reach | 6 | 16 | 22 | 13 | 11 | 34 | 24 | 49 | 26 | 32 | 10 | 11 | | 14 | | 44 | 58 | 99 | 53 | | 254 | 14 | |
| New Cases Opened | 6 | 9 | 14 | 14 | 14 | 12 | 27 | 15 | 11 | 17 | 13 | 10 | | 12 | | 29 | 40 | 53 | 40 | | 163 | 12 | |
| Total Cases Closed | 6 | 7 | 8 | 3 | 12 | 11 | 18 | 20 | 22 | 15 | 19 | 11 | | 20 | | 21 | 26 | 60 | 45 | | 152 | 20 | |
| Cases Remained Open | 13 | 35 | 21 | 35 | 36 | 34 | 43 | 36 | 25 | 25 | 20 | 25 | | 18 | | 21 | 34 | 25 | 25 | | 25 | 18 | |
| Total Cases Managed | 23 | 27 | 34 | 40 | 51 | 50 | 67 | 64 | 54 | 50 | 48 | 39 | | 39 | | 47 | 63 | 76 | 63 | | 181 | 39 | |
| Critical-Complex Acuity | 3 | 2 | 1 | 4 | 5 | 3 | 6 | 7 | 8 | 9 | 7 | 4 | | 5 | | 4 | 6 | 9 | 10 | | 14 | 5 | |
| High/Moderate/Low Acuity | 20 | 25 | 33 | 36 | 46 | 47 | 61 | 57 | 46 | 41 | 41 | 35 | | 34 | | 43 | 57 | 67 | 53 | | 167 | 34 | |
| | Record Processing | | | | | | | | | | | | | Record Processing | | Record Processing | | | | | | Record Processing | |
| Total Records | 7,479 | 7,327 | 7,723 | 7,256 | 9,524 | 7,696 | 7,900 | 7,867 | 7,518 | 8,761 | 7,380 | 7,418 | | 8,341 | | 22,529 | 24,476 | 23,285 | 23,559 | | 93,849 | 8,341 | |
| Total Admissions | 2,249 | 2,058 | 2,183 | 2,087 | 2,242 | 2,111 | 2,277 | 2,260 | 2,067 | 2,188 | 2,116 | 2,155 | | 2,244 | | 6,490 | 6,440 | 6,604 | 6,459 | | 25,993 | 2,244 | |

# Item #8

## Attachment 8.E

Credentialing Sub-Committee
Quarterly Report

# REPORT SUMMARY TO COMMITTEE

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

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

**COMMITTEE DATE:** March 19th, 2020

**SUBJECT:** CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2020

**Purpose of Activity:**
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2020 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 28th, 2020. At the February 28th meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the third quarter for 2019 were reviewed for delegated entities and the fourth quarter 2019 reports were reviewed for both Health Net and MHN. A summary of the third quarter data is included in the table below.

III. Table 1. Third Quarter 2019 Credentialing/Recredentialing

| | Sante | ChildNet | MHN | Health Net | La Salle | ASH | Envolve Vision | IMG | CVMP | Adventist | **Totals** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Initial credentialing | 76 | 22 | 17 | 33 | 28 | 0 | 2 | 20 | 25 | 42 | **265** |
| Recredentialing | 122 | 47 | 20 | 10 | 24 | 2 | 2 | 5 | 30 | 0 | **262** |
| Suspensions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Resignations (for quality of care only) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Totals** | **198** | **69** | **37** | **43** | **52** | **2** | **4** | **25** | **55** | **42** | **527** |

IV. There were two (2) cases to report on the Quarter 4 2019 Credentialing Report from Health Net. The first case was a Fair Hearing for Fresno County, an uphold of denial. The second case was for Madera County, an administrative denial with exclusion of practitioner for 5 years.

# Item #8

## Attachment 8.F

Peer Review Sub-Committee
Quarterly Report

# REPORT SUMMARY TO COMMITTEE

| | |
|---|---|
| **TO:** | Fresno-Kings-Madera Regional Health Authority Commissioners<br>CalViva QI/UM Committee |
| **FROM:** | Patrick C. Marabella, MD<br>Amy R. Schneider, RN |
| **COMMITTEE DATE:** | March 19th, 2020 |
| **SUBJECT:** | CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2020 |

**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 28th 2020. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2019 were reviewed for approval. There were no significant cases to report.

II. The Quarter 4, 2019 Peer Count Report was presented at the meeting with a total of 16 cases reviewed. The outcomes for these cases are as follows:
   - There were six (6) cases closed and cleared. There were two (2) cases pending closure for Corrective Action Plan compliance. There were eight (8) more cases pended for further information and no (0) cases with an outstanding CAP.

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

# Item #8

## Attachment 8.G

Operations Report

| | | | |
|---|---|---|---|
| **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. |
| **Message From The COO** | At present time, there are no issues, items of significance to report at this time as it relates to the Plan's IT Communications and Systems. | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Privacy and Security** | **Risk Analysis (Last Completed mm/yy: 6/19)** | **Risk Rating: Medium** | Description: Conducting an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held in the Health Plans IT and Communication Systems. A Rating is assigned: "No Risk", "Low Risk", "Medium Risk", "High Risk", "Critical Risk". | | | | | |
| | **Eff. Date & Last Annual Mail Date of NPP (mm/yy)** | **4/18 & 2/20** | Description: Notice of Privacy Practices (NPP) describes how PHI may be used and disclosed. The NPP is review and updated when appropriate. The NPP is distributed upon enrollment and annually thereafter | | | | | |
| | **Active Business Associate Agreements** | **6** | Description: A signed agreement is required of any person/entity who is not a member of CalViva Health's workforce who will create or receive PHI of behalf of CalViva Health. | | | | | |
| | **# Of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)** | | | | | | | |
| | **Year** | **2019** | **2019** | **2019** | **2019** | **2020** | **2020** | **2020** |
| | **Month** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| | **No/Low Risk** | **2** | **1** | **1** | **3** | **4** | **3** | **1** |
| | **High Risk** | **0** | **0** | **0** | **1** | **0** | **0** | **0** |
| | **Total Cases By Month** | **2** | **1** | **1** | **4** | **4** | **3** | **1** |
| | **Year** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** |
| | **No/Low Risk** | **48** | **54** | **36** | **28** | **38** | **23** | **8** |
| | **High Risk** | **6** | **3** | **5** | **1** | **1** | **2** | **0** |
| | **Total Cases By Year** | **54** | **57** | **41** | **29** | **39** | **25** | **8** |
| **Message from the COO** | At present time, there are no issues, items of significance to report at this time as it relates to the Plan's Privacy and Security activities. | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Member Call Center CalViva Health Website** | | **Year** | **2018** | **2018** | **2019** | **2019** | **2019** | **2019** |
| | | **Quarter** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **(Main) Member Call Center** | **# of Calls Received** | **31,095** | **28,135** | **30,380** | **28,902** | **30,232** | **27,416** |
| | | **# of Calls Answered** | **30,937** | **27,948** | **30,174** | **28,762** | **30,031** | **27,140** |
| | | **Abandonment Level (Goal < 5%)** | **0.50%** | **0.70%** | **0.70%** | **0.50%** | **0.70%** | **1.00%** |
| | | **Service Level (Goal 80%)** | **93%** | **91%** | **93%** | **94%** | **92%** | **86%** |
| | **Behavioral Health Member Call Center** | **# of Calls Received** | **1,121** | **1,034** | **1,297** | **1,204** | **1,132** | **1,040** |
| | | **# of Calls Answered** | **1,101** | **1,011** | **1,277** | **1,188** | **1,124** | **1,026** |
| | | **Abandonment Level (Goal < 5%)** | **1.80%** | **2.20%** | **1.50%** | **1.30%** | **0.70%** | **1.30%** |
| | | **Service Level (Goal 80%)** | **88%** | **83%** | **84%** | **88%** | **87%** | **88%** |
| | **Transportation Call Center** | **# of Calls Received** | **13,854** | **13,776** | **14,470** | **14,281** | **16,285** | **16,264** |
| | | **# of Calls Answered** | **13,770** | **13,583** | **14,383** | **14,224** | **15,943** | **16,085** |
| | | **Abandonment Level (Goal < 5%)** | **0.60%** | **1.40%** | **0.60%** | **0.40%** | **2.10%** | **1.10%** |
| | | **Service Level (Goal 80%)** | **86%** | **84%** | **82%** | **92%** | **67%** | **83%** |
| | **CalViva Health Website** | **# of Users** | **18,000** | **17,000** | **20,000** | **19,000** | **20,000** | **20,000** |
| | | **Top Page** | **Main Page** | **Main Page** | **Main Page** | **Find a Provider** | **Find a Provider** | **Find a Provider** |
| | | **Top Device** | **Mobile (57%)** | **Mobile (58%)** | **Mobile (60%)** | **Mobile (59%)** | **Mobile (57%)** | **Mobile (57%)** |
| | | **Session Duration** | **~ 3 minutes** | **~ 3 minutes** | **~ 2 minutes** | **~ 2 minutes** | **~ 2 minutes** | **~ 2 minutes** |
| **Message from the COO** | At present time, there are no issues, items of significance to report at this time as it relates to the Plan's Call Center and Website activities. | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Provider Network Activities & Provider Relations** | **Year** | **2019** | **2019** | **2019** | **2019** | **2019** | **2019** | **2020** |
| | **Month** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** |
| | **Hospitals** | **10** | **10** | **10** | **10** | **10** | **10** | **10** |
| | **Clinics** | **122** | **121** | **121** | **122** | **121** | **121** | **125** |
| | **PCP** | **356** | **367** | **370** | **379** | **375** | **374** | **374** |
| | **Specialist** | **1305** | **1326** | **1367** | **1353** | **1367** | **1369** | **1383** |
| | **Ancillary** | **190** | **190** | **189** | **188** | **188** | **189** | **191** |
| | | | | | | | | |
| | **Year** | **2018** | **2018** | **2018** | **2019** | **2019** | **2019** | **2019** |
| | **Quarter** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **Pharmacy** | **165** | **167** | **164** | **161** | **151** | **151** | **152** |
| | **Behavioral Health** | **261** | **226** | **336** | **342** | **343** | **342** | **368** |
| | **Vision** | **77** | **71** | **77** | **31** | **39** | **42** | **41** |
| | **Urgent Care** | **10** | **10** | **11** | **12** | **14** | **13** | **12** |
| | **Acupuncture** | **6** | **11** | **5** | **7** | **6** | **6** | **5** |
| | | | | | | | | |
| | **Year** | **2018** | **2018** | **2018** | **2018** | **2019** | **2019** | **2019** |
| | **Quarter** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** |
| | **% of PCPs Accepting New Patients - Goal (85%)** | **88%** | **89%** | **91%** | **91%** | **94%** | **93%** | **90%** |
| | **% Of Specialists Accepting New Patients - Goal (85%)** | **97%** | **97%** | **98%** | **97%** | **95%** | **95%** | **95%** |
| | **% Of Behavioral Health Providers Accepting New Patients - Goal (85%)** | | | | | | | **72%** |
| | | | | | | | | |
| | **Year** | **2019** | **2019** | **2019** | **2019** | **2019** | **2019** | **2020** |
| | **Month** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** |
| | **In-Person Visits by Provider Relations** | **151** | **140** | **95** | **185** | **104** | **132** | **137** |
| | **Provider Trainings by Provider Relations** | **143** | **97** | **127** | **125** | **114** | **87** | **78** |
| | **Year** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** |
| | **Total In Person Visits** | **1,790** | **2,003** | **2,604** | **2,786** | **2,552** | **1,932** | **137** |
| | **Total Trainings Conducted** | **148** | **550** | **530** | **762** | **808** | **1,353** | **78** |
| **Message From the COO** | At present time, there are no issues, items of significance to report at this time as it relates to the Provider Network & Provider Relations activities. The Plan is preparing to represent its network to Regulators. | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Claims Processing** | **Year** | **2018** | **2018** | **2018** | **2019** | **2019** | **2019** | **2019** |
| | **Quarter** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure** | 98% / 99%<br>YES | 97%/99%<br>NO | 90% / 99%<br>NO | 90% / 99%<br>YES | 94% / 99%<br>YES | 99% / 99%<br>NO | 99% / 99%<br>NO |
| | **Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure** | 96% / 99%<br>YES | 97%/99%<br>YES | 98% / 99%<br>N/A | 98% / 99%<br>N/A | 97% / 99%<br>N/A | 97%/98%<br>N/A | 98% / 99%<br>N/A |
| | **Pharmacy Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% /100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% /100%<br>NO | 100% /100%<br>NO | 99% /100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | | 99% / 99%<br>NO | 98% / 99%<br>NO | 95% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 84% / 100%<br>NO | 99% / 100 %<br>NO | 100% /100%<br>NO | | | | |
| | **PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 83% / 97%<br>YES | 78% / 88%<br>YES | 98% / 99%<br>NO | 99% / 100%<br>NO | 97% / 98%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 94% / 98%<br>NO | 95% / 100%<br>NO | 99% / 100 %<br>NO | 92% / 100 %<br>NO | 99% / 100 %<br>NO | 93% / 99%<br>NO | 93% / 100%<br>NO |
| | **PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 95% / 100%<br>NO | 99% / 100%<br>NO | 99% / 100%<br>NO |
| | **PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 89% / 100%<br>NO | 98% / 100%<br>NO | 93% / 98%<br>NO | 97% / 100%<br>NO | 90% / 99%<br>NO | 89% / 100%<br>YES | 88% / 98%<br>YES |
| | **PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 86% / 100%<br>NO | 95% / 100%<br>NO | 95% / 100%<br>NO | 94% / 100%<br>NO | 92% / 99%<br>NO | 99% / 100%<br>YES | 100% / 100%<br>YES |
| | **PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | | 95% / 100%<br>NO | 99% / 100%<br>NO | 96% / 100%<br>NO | 96% / 99%<br>NO | 99% / 100%<br>YES | 98% / 98%<br>YES |
| | **PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | | | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 99% / 100%<br>NO |
| | **PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | | | | 100% / 100%<br>NO | 99% / 100%<br>NO | 100% / 100%<br>NO | 99% / 100%<br>NO |
| **Message from the COO** | Claims processing metrics met goal for most areas. CalViva Health is continuing to monitor the activities of PPG 5, 6, and 7. | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Provider Disputes** | **Year** | **2018** | **2018** | **2018** | **2019** | **2019** | **2019** | **2019** |
| | **Quarter** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **Medical Provider Disputes Timeliness (45 days) Goal ( 95%)** | 88% | 97% | 98% | 99% | 99% | 96% | 95% |
| | **Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)** | 100% | 99% | 100% | 85% | 89% | 100% | 90% |
| | **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%)** | N/A | N/A | 100% | 100% | N/A | 100% | 100% |
| | **Transportation Provider Dispute Timeliness (45 Days) Goal (95%)** | | N/A | N/A | N/A | N/A | N/A | N/A |
| | **PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | 100% | 100% | | | | |
| | **PPG 2 Provider Dispute Timeliness ( 45 Days) Goal (95%)** | 54% | 17% | 67% | 98% | 100% | 89% | 64% |
| | **PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)** | 94% | 100% | 100% | 100% | 100% | 100% | 100% |
| | **PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | **PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | N/A | 73% | 100% | 99% | 95% | 99% |
| | **PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | N/A | 96% | 96% | 100% | 93% | 100% |
| | **PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)** | | N/A | 95% | 97% | N/A | 67% | 100% |
| | **PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)** | | | N/A | 100% | 100% | 100% | 100% |
| | **PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)** | | | | N/A | N/A | N/A | N/A |
| **Message from the COO** | Provider disputes met metrics in most areas. CalViva Health is continuing to monitor the activities of Behavioral Health and PPG 2 due to the missed metric. | | | | | | | |

# Item #8

## Attachment 8.H

Executive Dashboard

| | 2019 | 2019 | 2019 | 2019 | 2019 | 2019 | 2019 | 2019 | 2019 | 2019 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Month** | **February** | **March** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** |
| **CVH Members** | | | | | | | | | | | | |
| Fresno | 291,607 | 291,254 | 290,257 | 291,340 | 291,316 | 290,728 | 289,852 | 288,082 | 287,519 | 285,402 | 284,285 | 281,473 |
| Kings | 29,201 | 29,165 | 29,385 | 29,399 | 29,326 | 29,305 | 29,338 | 29,383 | 29,410 | 29,448 | 29,514 | 29,392 |
| Madera | 36,749 | 36,769 | 36,788 | 36,842 | 37,002 | 37,031 | 37,112 | 37,068 | 37,181 | 37,266 | 37,264 | 37,169 |
| **Total** | 357,557 | 357,188 | 356,430 | 357,581 | 357,644 | 357,064 | 356,302 | 354,533 | 354,110 | 352,116 | 351,063 | 348,034 |
| SPD | 31,665 | 31,773 | 31,834 | 32,054 | 32,236 | 32,382 | 32,441 | 32,582 | 32,591 | 32,753 | 32,836 | 32,797 |
| **CVH Mrkt Share** | 71.04% | 71.06% | 71.06% | 71.16% | 71.20% | 71.23% | 71.28% | 71.28% | 71.29% | 71.32% | 71.36% | 71.34% |
| **ABC Members** | | | | | | | | | | | | |
| Fresno | 106,674 | 106,311 | 106,066 | 106,032 | 105,901 | 105,546 | 104,884 | 104,326 | 104,083 | 103,079 | 102,524 | 101,664 |
| Kings | 19,567 | 19,556 | 19,464 | 19,346 | 19,257 | 19,203 | 19,200 | 19,103 | 19,102 | 19,112 | 19,057 | 18,926 |
| Madera | 19,525 | 19,611 | 19,602 | 19,513 | 19,502 | 19,505 | 19,451 | 19,398 | 19,450 | 19,402 | 19,289 | 19,246 |
| **Total** | 145,766 | 145,478 | 145,132 | 144,891 | 144,660 | 144,254 | 143,535 | 142,827 | 142,635 | 141,593 | 140,870 | 139,836 |
| **Default** | | | | | | | | | | | | |
| Fresno | 1,142 | 1,242 | 1,484 | 1,160 | 1,519 | 1,080 | 1,053 | 1,080 | 928 | 1,364 | 1,038 | 945 |
| Kings | 174 | 171 | 211 | 165 | 247 | 146 | 177 | 159 | 148 | 240 | 173 | 181 |
| Madera | 138 | 175 | 177 | 133 | 185 | 145 | 160 | 132 | 131 | 187 | 104 | 98 |
| **County Share of Choice as %** | | | | | | | | | | | | |
| Fresno | 62.60% | 69.00% | 66.50% | 67.40% | 67.80% | 68.10% | 65.60% | 67.30% | 65.10% | 66.10% | 65.60% | 62.50% |
| Kings | 69.00% | 61.10% | 68.80% | 60.10% | 58.50% | 57.30% | 64.70% | 63.90% | 62.20% | 58.80% | 63.60% | 65.20% |
| Madera | 61.20% | 55.20% | 62.20% | 65.20% | 62.20% | 57.70% | 63.30% | 60.10% | 63.00% | 68.10% | 67.60% | 60.80% |
| **Voluntary Disenrollment's** | | | | | | | | | | | | |
| Fresno | 422 | 503 | 520 | 449 | 393 | 394 | 418 | 486 | 421 | 413 | 300 | 336 |
| Kings | 36 | 67 | 58 | 35 | 61 | 43 | 38 | 48 | 52 | 43 | 55 | 48 |
| Madera | 64 | 81 | 95 | 51 | 69 | 68 | 86 | 67 | 71 | 62 | 81 | 73 |

# Item #10

## Attachment 10.A

Community Support Funding
Grant Recommendations

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY



Gregory Hund
Chief Executive Officer

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

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

DATE: April 16, 2020

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Greg Hund, CEO

RE: CalViva Health Community Support Program

BL #: 20-003
Agenda Item 7
Attachment 7.A

In May 2017, the Fresno-Kings-Madera Regional Health Authority established a process to review and consider funding for Community Support programs/initiatives in excess of twenty thousand dollars ($20,000) per fiscal year. Guidelines and review process were established and approved during this time. As a reminder, the Commission has approved funds over the past three years to support our community programs.

The current fund request is intended for specialty and physician recruitment, physician incentives, education scholarships and community based organization support.

The Ad-hoc committee reviewed the funding recommendations (attachment 6.A) on March 4, 2020 and voted to bring them to the full commission.

**Community Support Grant Recommendations 2020-2021**

| | Counties | | | | | |
|---|---|---|---|---|---|---|
| | Fresno | Madera | Kings | Ad Hoc Recmd | Addl Funding | Total |
| **Training** | | | | | | |
| Parlier FP Residency UHC | x | | | $150,000 | $0 | $150,000 |
| **Providers** | | | | | | |
| Funding for 12 PCPs/Extenders/Specialist | x | x | x | $1,200,000 | $0 | $1,200,000 |
| Year End Provider Incentives | x | x | x | $1,200,000 | $0 | $1,200,000 |
| **Education Scholarships** | | | | | | |
| California State University Fresno | x | x | x | $200,000 | $0 | $200,000 |
| Community Colleges | x | x | x | $100,000 | $0 | $100,000 |
| **Community Based Organizations** | | | | | | |
| Big Brother Big Sisters Fresno and Madera Counties | x | x | x | $100,000 | $0 | $100,000 |
| CASA Fresno and Madera Counties | x | x | x | $50,000 | $0 | $50,000 |
| Every Neighborhood Partnership | x | | | $100,000 | $0 | $100,000 |
| Exceptional Parents Unlimited | x | x | x | $100,000 | $50,000 | $150,000 |
| Habitat for Humanity Acts of Kindness Madera County | x | x | | $100,000 | $0 | $100,000 |
| Kings County Action Organization (Women's Shelter) | | | x | $50,000 | $0 | $50,000 |
| Madera Rescue Mission | | x | | $50,000 | $0 | $50,000 |
| Marjaree Mason Center | x | | | $100,000 | $0 | $100,000 |
| Poverello House | x | | | $100,000 | $150,000 | $250,000 |
| Tzu Chi-See 2 Succeed Vision Program | x | | | $100,000 | $0 | $100,000 |
| **Other** | | | | | | |
| Embrace (Formerly Fresno Glow Group Prenatal Care) | x | x | x | $50,000 | $0 | $50,000 |
| Fresno Cradle 2 Career | x | | | $100,000 | $0 | $100,000 |
| Help Me Grow Fresno County | x | | | $25,000 | $0 | $25,000 |
| Outdoor Play and Green Space | x | x | x | $250,000 | $0 | $250,000 |
| Food Bank Funding | x | x | x | $75,000 | $100,000 | $175,000 |
| County Health Department Covid 19 Cost offset *** See Dist. Below** | x | x | x | | $800,000 | $800,000 |

**Total**

| | | | | | | |
|---|---|---|---|---|---|---|
| 2019-2020 Budgeted Amount | | | | $4,200,000 | $1,100,000 | $5,300,000 |

* Fresno $500,000, Kings $150,000, Madera $150,000