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

Phone: 559-540-7840
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DATE: March 15, 2019

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

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

Thursday, March 21, 2019
1:30 pm to 3:30 pm

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

Meeting materials have been emailed to you.

Currently, there are **11** 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

March 21, 2019
1:30pm - 3:30pm

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

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	J. Neves, Vice-Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment A Attachment B Attachment C Attachment D	**Consent Agenda** • Commission Minutes dated 2/21/19 • Finance Committee Minutes dated 10/18/18 • QI/UM Committee Minutes dated 11/15/2018 • Public Policy Committee Minutes dates 12/5/2018 *Action: Approve Consent Agenda*	J. Neves, Vice-Chair
	Handouts will be available at meeting	*PowerPoint Presentations will be used for item 4 thru 6* ***One vote will be taken for combined items 4-6***	
4 Action	Attachment A Attachment B	**2019 Quality Improvement** • 2019 Program Description • 2019 Work Plan	P. Marabella, MD, CMO
5 Action	Attachment A Attachment B	**2019 Utilization Management** • 2019 Program Description • 2019 Work Plan	P. Marabella, MD, CMO
6 Action	Attachment A	**2019 Case Management** • 2019 Program Description *Action: Approve the 2019 QI Program Description and Work Plan; the 2019 UM Program Description and Work Plan; and the 2019 Case Management Program Description*	P. Marabella, MD, CMO

7 Action		**Standing Reports**	
	Attachment A	**Operations** • Operations Report	J. Nkansah, COO
	Attachment B	**Finance Report** • Financials as of January 31, 2019	D. Maychen, CFO
	Attachment C	**Compliance** • Compliance Report	M.B. Corrado, CCO
	Attachment D Attachment E Attachment F Attachment G Attachment H	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • QIUM Quarterly Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment I *No attachment* *No attachment*	**Executive Report** • Executive Dashboard • Telehealth • Governor's Report	G. Hund, CEO
		Action: Accept Standing Reports	
8		**Final Comments from Commission Members and Staff**	
9		**Announcements**	
10		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
11		**Adjourn**	J. Neves, Vice-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 16, 2019 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

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

Item #3

Attachment 3.A

Commission Minutes dated 02/21/19

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
February 21, 2019

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 1:30 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 Information 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.	
#4 Valley Children's Hospital Appointment Action David Hodge, MD, Chairman	Brian Smullin was appointed as Commission representative from Valley Children's Hospital for a three-year term, ending in January 2022.	**Motion:** *Approve Valley Children's Hospital Appointment* 9 – 0 – 1 – 7 (Nikoghosian / Soares)
#5 Fresno County At-Large Seat Nomination Action David Hodge, MD, Chairman	John Frye was re-appointed as the Fresno County At-Large representative for a three-year term, ending in January 2022.	**Motion:** *Approve Fresno County At-Large Reappointment* 9 – 0 – 1 – 7 (Soares / Griffin)
#6 Kings County At-Large Seat Nomination Action David Hodge, MD, Chairman	Derrick Gruen was re-appointed as the Kings County At-Large representative for a three-year term, ending in January 2022.	**Motion:** *Approve Kings County At-Large Reappointment* 10 – 0 – 0 – 7 (Frye / Neves)
#7 Closed Session A. **Government Code section 59454.5 – Report Involving Trade**	Jason Epperson, General Counsel, reported out of Closed Session. Commissioners discussed those items agendized for closed session. Regarding 7.A direction was given to staff. Regarding 7.B, report was accepted by Commission.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Secret – Discussion of service, program, or facility B. **Government Code 54957(b)(1) – Public Employee Appointment, Employment, Evaluation, or Discipline –** General Counsel Review	Closed Session concluded at 1:40 pm.	
#8 Consent Agenda a) Commission Minutes 10/18/18 b) Finance Committee Minutes 9/20/18 c) QI/UM Committee Minutes 9/20/18 d) QI/UM Committee Minutes 10/18/18 e) Public Policy Committee Minutes 9/5/18 f) Compliance Report Action David Hodge, MD, Chairman	All consent items were presented and accepted as read.	***Motion**: Approve Consent Agenda* *10 – 0 – 0 – 7* *(Neves / Naz)*
#9 Reappoint Moss Adams as Independent Auditors Action David Hodge, MD, Chairman	The acceptance of Moss Adams, independent auditors, was approved for an additional term through fiscal year end 2021.	***Motion**: Approve Reappointment of Moss Adams* *10 – 0 – 0 –7* *(Naz / Nikoghosian)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#10 Annual Administration Information 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 as well.	
#11 FPPC Approved Biennial Conflict of Interest Code Information David Hodge, MD, Chairman	The biennial Conflict of Interest code was approved by the FPPC effective 12/15/2018.	
#12 CEO Annual Review Ad-Hoc Committee Selection Action 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.	***Motion:*** *Approve Ad-Hoc Committee members* *10 – 0 – 0 –7* *(Neves / Hill)*
#13 2018 Annual Quality Improvement Work Plan Evaluation Action David Hodge, MD, Chairman	Dr. Marabella presented the 2018 Annual Quality Improvement Work Plan Evaluation. The planned activities and Quality Improvement focus for 2018 included the following: • Access, Availability and Service: o Improve Access to Care: ▪ Three measures did not meet compliance for Provider Appointment Availability: o Urgent care appointments with Specialists that require prior authorizations within 96 hours	*See #14 for Action Taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Non-urgent appointment with Specialists within 15 days ○ After Hours Urgent Care to contact on-call provider within 30 minutes. ▪ Corrective Action Plans were issued to all non-compliant PPGs and directly contracted providers. Telephone audits were conducted for providers noncompliant for two consecutive years. ▪ Provider Office Wait Time met overall goal for 30 minutes or less for all three counties in Q2. • Quality and Safety of Care: All three counties exceeded the DHCS Minimum Performance Level (MPL) in five of the six Default Enrollment Measures; Fresno County fell below in HbA1c testing: ○ Childhood Immunization Combo 3 ○ Well Child Visits 3-6 years ○ Prenatal Care ○ HbA1c Testing ○ Controlling High Blood Pressure ○ Cervical Cancer Screening • Performance Improvement Projects (PIPs): The two PIPs for 2018 were: ○ Childhood Immunizations (CIS-3) ○ Postpartum Care Disparity Project (PPC) 2 • Ongoing Workplan Activity. These projects will close out on June 30th, 2019	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#14 2018 Annual Utilization Management Case Management Work Plan Evaluation Action David Hodge, MD, Chairman	Dr. Marabella presented the Annual Utilization Management Case Management Work Plan Evaluation. Utilization Management & Case Management focused on the following areas for 2018: • Compliance with Regulatory & Accreditation Requirements: o Licensure and credentialing requirements maintained. o Program documents and policies were updated to incorporate new regulatory requirements into practice. o DHCS Medi-Cal Managed Care Division Medical Director meetings attended by Medical Directors and CVH CMO. • Monitoring the UM Process: o Turn-around times for prior authorizations were monitored with a goal of 100%; the average for 2018 was 97.2%. o Annual trends for Appeal rates were reviewed including: Overturns, Partial Upholds, Upholds, and Withdrawals. In addition, the turn-around-time compliance rate was reviewed. Compliance rates have been consistent year to year. • Monitoring Utilization Metrics: o All UM metrics for Monitoring Utilization met the objectives except "Improve shared risk and FFSUM acute inpatient performance". Goals were not met for: ▪ Expansion population Bed days, admits/K and 30-day readmits ▪ SPD Avg Length of Stay ▪ TANF admits/K	**Motion:** Approve the 2018 Annual Quality Improvement Work Plan Evaluation and 2018 Annual Utilization Management Case Management Work Plan Evaluation. *10-0-0-7 (Naz / Neves)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ These goals were not met primarily due to fragmented aftercare and inadequate placement options for patients with multiple social determinants of health. • Monitoring Coordination with Other Programs and Vendor Oversight: ○ All metrics for Behavioral Health met goal with the exception of Network Availability and Adequacy for Q3 related to autism providers. ○ Complex Case Management initiated for behavioral health in Q2 2018. Referrals continue to increase. • Monitoring Activities for Special Populations: ○ CCS, SPD, CBAS, and Mental Health tracking and monitoring is ongoing. ○ All monitoring activities met goals except Provide UMCM Programs to support SPD Mandatory Managed Care Requirements. ○ Health Risk Assessments were not meeting expectations as IT migration prevented data exchange. ○ A Corrective Action Plan was initiated in Q3 and completed by 12/31/18.	
#15 - #19 • **15**. 2018 Annual Compliance Evaluation • **16**. 2019 Compliance Program Description • **17**. 2019 Code of Conduct • **18**. 2019 Anti-Fraud 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. **<u>2018 Annual Compliance Evaluation</u>** Regulatory Audits & Performance Evaluations for 2018 include:	**Motion:** Approve 2018 Annual Compliance Evaluation, 2019 Compliance Program Description, 2019 Code of Conduct, 2019 Anti-Fraud Plan, and 2019 Privacy & Security Plan. *10-0-0-7 (Hill / Frye)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **19**. 2019 Privacy and Security Plan Action David Hodge, MD, Chairman	• 2016 DMHC Full-Service Survey – Results of 18 month follow-up review • 2017 DHCS Audit – Closure and acceptance of CAP • 2018 DHCS Annual Audit – Preliminary report • 2016-2017 DHCS Performance Evaluation report • 2018 HEDIS® Compliance Audit • DHCS 2018 Encounter Data Validation Study • 2018 DHCS Annual Network Certification The DMHC Undertaking relating to the Kaiser transition was completed on 9/1/2018. All members that remained with Kaiser due to continuity of care have been transitioned back to CalViva Health. DMHC has closed the Undertaking in December subject to the submission of a Material Modification for Alternative Access Standards and a Significant Network Change Amendment. Health Net's SIU identified and investigated on behalf of CVH a number of potential cases. Four potential provider fraud/abuse cases were reported to the DHCS, and two were open with DOJ. In relation to Oversight Audits; several functions delegated to Health Net were audited in 2018 which includes: Appeals & Grievances, Call Center/Member Services, Claims, Privacy & Security, Provider Dispute Resolution, Provider Relations/Network, and Utilization Management. Results were favorable with minor corrective actions. Ongoing oversight of Health Net will continue. CalViva Health employees participated in and passed all annual mandatory trainings. Two new hires completed trainings.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Sixty-nine member communications were reviewed and approved. The 2018 Member Handbook Annual Mailing was sent out. Updated printed provider directories began issuance on a monthly basis in 2018; the searchable on-line provider directory is updated daily. 122 Provider updates were sent to contracted providers. The total number of regulatory cases decreased in 2018 from 2017. Looking ahead into 2019 regulatory audit and performance monitoring activity will increase. **2018 Compliance Program Description** Annual review; no changes needed. **2018 Code of Conduct** Annual review; no changes needed. **2018 Anti-Fraud Plan** Added DHCS PIO email address; no other changes needed. **2018 Privacy and Security** Annual review; no changes needed.	
#20 Standing Reports • **Finance Report** Daniel Maychen, CFO	**Finance** **Financial Statements as of December 31, 2018:**	**Motion:** *Approve Standing Reports* *10 – 0 – 0 – 7 (Naz / Soares)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Total current assets were approximately $273M; total current liabilities were approximately $219M. Current ratio is 1.24. TNE as of December 31, 2018 was approximately $64.4M, which is approximately 484% of the minimum DMHC required TNE amount. Total revenue reported for first six months of fiscal year was approximately $590M which is $19.1M above budgeted amounts primarily due to rates being higher than projected and enrollment being higher than projected. For those same reasons, capitation medical costs and admin service fees expense are higher than budgeted. All other expense line items are either below or in line with budget. Total net income for the first six months of the fiscal year is approximately $4.6M which is approximately $1.2M more than budgeted.	
• **Medical Management** P. Marabella, MD, CMO	**<u>Medical Management</u>** **Key Indicator Report** Dr. Marabella presented the Key Indicator Report with a year-end comparison against goals for Q4 2017 through Q4 2018. • TANF rates for Q4 2018 were at or below goals in all categories (lower number is better). • SPD rates for Q4 2018 were challenging with Acute Average Length of Stay and Readmission rates above goals.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Medi-Cal Expansion rates were at or slightly above goal in all categories. • Early in 2018 (Q1 & Q2) some measures were well above goal for particular measures in the MCE and TANF populations due to a particularly virulent influenza strain, however these rates came down in the second half of the year. **Appeals and Grievances Dashboard** Dr. Marabella presented the Appeals & Grievances Dashboard through December 2018. **Grievance Data:** • The total number of grievances received in 2018 remained relatively stable when compared to 2017 data. • The total number of Quality of Service Grievances in 2018 also remained stable when compared to the previous year. Although the new category of Transportation Related grievances was added. The number of Quality of Care Grievances resolved in 2018 decreased compared to the prior year. • A significant increase was noted in Exempt grievances for 2018. • A theme noted throughout the year for all grievances is a shift in grievance type associated with the EHS transition. The increase in volume for Exempt grievances is also attributable to the EHS transition and the addition of the Transportation benefit and subsequent grievance tracking and monitoring. • An increase in the total number of Appeals Received/Resolved is noted in 2018. This increase is attributable primarily to advanced	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	imaging (CTs, MRI and cardiac imaging), allergy shots, and pharmacy denials. Practitioner education regarding prior authorization criteria has been ongoing and these numbers are expected to decline. Overall, an evaluation of the per thousand member per month rates for grievances and appeals when comparing 2017 to 2018, the rate for grievances remained the same at 0.23 and appeals increased from 0.05 to 0.12. **Credentialing Sub-Committee Quarterly Report** In Quarter 4 the Credentialing Sub-Committee met on October 18, 2018. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q2 2018 were reviewed for delegated entities, Q3 2018 reports were reviewed for Health Net. The 2019 Credentialing Sub-Committee draft meeting schedule was reviewed and accepted. The Q3 2018 Credentialing report was reviewed with one case cleared and closed to normal track and trend, one case was postponed and one case approved for network re-entry with monitoring and subsequently administratively terminated. Other County-specific Credentialing Sub-Committee reports were reviewed and approved. No significant cases were identified on these reports. **Peer Review Sub-Committee Quarterly Report** The Peer Review Sub-Committee met on October 18, 2018. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2018 were reviewed for approval. There were no significant cases to	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Operations** J. Nkansah, COO	report. The 2019 Peer Review Sub-Committee draft meeting schedule was reviewed and accepted. The Q3 2018 Peer Count Report was presented and there were no cases closed and cleared. There was one case pending closure for Corrective Action Plan compliance. There was one case pended for further information. Follow up will be initiated to obtain additional information on tabled case and ongoing monitoring and reporting will continue. **<u>Operations Report</u>** Jeff Nkansah presented the Operations Report. All IT communications and systems are well. A draft of an updated Risk Analysis for CVH will be put through the Plan's Compliance Committee for vetting. Any new risk rating as a result of the vetting will be communicated in a future Operations Report. It is anticipated this will take place in 2019. The Notice of Privacy Practices mailing is contingent upon the model handbook receipt from DHCS. The Active Business Associate Agreements increased from six to seven. There are no concerns surrounding call center activity. Updated provider network numbers for 2018 were provided. The Plan continues to monitor the new requirement that requires providers to be screened and enrolled. There have been challenges with this process and the Plan is monitoring to make sure there is no adverse impact to the members and Plan network.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** G. Hund, CEO	A Corrective Action Plan is in place to improve the claims timeliness and provider disputes for a provider group which is performing below goal. Transportation is a new addition to the report so that this service can be tracked and monitored. Additional provider groups are entering the CVH service area and will be monitored. **<u>Executive Report</u>** Membership for January 2019 increased from December 2018 due to a change in accounting and reporting for membership. The Plan is now aligning reporting with the standards used by LHPC plans and Anthem Blue Cross. An update was given on the Valley Health Team Primary Care Residency program. The 2018 Annual Report was mailed to all Commissioners in January.	
#21 Final Comments from Commission Members and Staff	CVH CEO will be attending the LHPC Legislative Day on 2/26/19. Harout Torosian, Sr. Director of Account Management, liaison from Health Net was introduced to Commission. Sherrie Bakke, Director of Business Development for Madera Community Hospital was introduced by Dr. Naz.	
#22 Announcements	None.	
#23 Public Comment	Jim Richardson from Free Denti-Cal Youth Services thanked CVH for the assistance in launching the new program and gave a brief overview of the program.	
#24 Adjourn	The meeting was adjourned at 3:13 pm	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The next Commission meeting is scheduled for March 21, 2019 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #3

Attachment 3.B

Finance Committee Minutes
dated 10/18/18

CalViva Health
Finance
Committee Meeting Minutes

February 21, 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
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:30 am, a quorum was present.	
#2 New Finance Committee Member Information D. Maychen, Chair	New Finance Committee member, John Frye, was announced.	
#3 Finance Committee Minutes dated October 18, 2018 Attachment 3.A Action	The minutes from the October 18, 2018 Finance meeting were approved as read.	Motion: *Minutes were approved* *5 – 0 – 0 – 2* *(Neves / Nikoghosian)*

D. Maychen, Chair		
#4 Financial Statements as of December 31, 2018 Attachment 4.A Action D. Maychen, Chair	Total current assets were approximately $273M; total current liabilities were approximately $219M. Current ratio is 1.24. TNE as of December 31, 2018 was approximately $64.4M, which is approximately 484% of the minimum DMHC required TNE amount. Total revenue reported for first six months of fiscal year was approximately $590M which is $19.1M above budgeted amounts primarily due to rates being higher than projected and enrollment being higher than projected. For those same reasons, capitation medical costs and admin service fees expense are higher than budgeted. All other expense line items are either below or in line with budget. Total net income for the first six months of the fiscal year is approximately $4.6M which is approximately $1.2M more than budgeted. *John Frye arrived @ 11:31*	Motion*: Approve Financial Statements as of December 31, 2018* *6 – 0 – 0 – 1* *(Nikoghosian / Soares)*
#5 Fiscal Year 2020 – Review and Discuss Budget Attachment 5.A Action D. Maychen, Chair	A formalized budget is planned for presentation at the March meeting with intent to accept and adopt. Any changes as a result of the March meeting will carry on to an April meeting. The formal budget will be presented at the May Commission meeting. Basic assumptions are consistent with prior years with the exception of an increase in Knox Keene licensing fee, marketing expense, interest income, net income, and staffing increase to 18. In addition, enrollment is projected to be relatively flat for FY 2020. An overall rate decrease of approximately 1.3% is also projected. The current MCO tax is set to expire June 30, 2019 and an extension was not included in Gov. Newsom's initial state fiscal year 2020 budget proposal. As such, MCO	Motion*: Approve Budget Assumptions* *6 – 0 – 0 – 1* *(Nikoghosian / Neves)*

	taxes were not included in CalViva's fiscal year 2020 preliminary budget. A recommendation was made by John Frye to create a secondary budget adding MCO tax.	
#6 Announcements	A brief discussion on the Community Support program and the Marketing plan took place.	
#7 Adjourn	Meeting was adjourned at 11:49 am	

Submitted by: _____
Cheryl Hurley, Clerk to the Commission

Dated: _____

Approved by Committee: _____
Daniel Maychen, Committee Chairperson

Dated: _____

Item #3

Attachment 3.C

QIUM Committee Minutes
dated 11/15/18

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
November 15, 2018

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**, Medical Management Specialist
✓	**John Zweifler, MD.,** At-large Appointee, Kings County	✓	**Kari Willis**, Administrative Coordinator, Temporary
✓	**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
#1 **Call to Order** Patrick Marabella, M.D, Chair	The meeting was called to order at 10:38 am. A quorum was present.	
#2 **Approve Consent Agenda** - Committee Minutes: October 18, 2018 - Standing Referrals Report (Q3) - Concurrent Review IRR Audit Report (Q3) - Provider Preventable Conditions (Q3) - A&G Inter-Rater Reliability Report (IRR). - A & G Classification	The October QI/UM minutes were reviewed and highlights from the consent agenda items were discussed and approved. The full October Formulary (RDL) was available for review at the meeting.	Motion: Approve Consent Agenda (Ramirez/Zweifler) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Audit Report - A&G Daily Letter Review Logs & CAP Summary Report - Pharmacy Provider Update (Q4) - PM 160 Report (Q3) - California Children's Service Report (CCS) (Q3) - Pharmacy Formulary Drug List (October) (Attachments A-K) Action Patrick Marabella, M.D Chair		
#3 **QI Business** Appeals & Grievances: - Dashboard and Turnaround Time Report (September) - Executive Summary (Q3) - Quarterly Member Report (Q3) (Attachments L-N) Action Patrick Marabella, M.D, Chair	The A & G Dashboard provides monthly data to facilitate monitoring for trends in the number and types of cases over time. The Dashboard included data through the end of September 2018. <u>Grievances:</u> ➢ There was a total of 88 grievances resolved in September with 67 Quality of Service grievances and 21 Quality of Care grievances. ➢ Number of grievances received in September slightly decreased compared to recent months. ➢ An increase is noted in Exempt grievances in September due to PPG related administrative issues. <u>Appeals:</u> ➢ Total number of Appeals Resolved decreased in September compared to recent months. The Appeals and Grievances Executive Summary and Quarterly Member Report for Q3 were presented and reviewed. ➢ The total number of appeals decreased in Q3 compared to Q2 2018. o All Q3 appeals were pre-service. ➢ The total number of grievances increased moderately in Q3 compared to Q2. o 211 Quality of Service (QOS) o 58 Quality of Care (QOC)	Motion: Approve Appeals & Grievances - Dashboard and Turnaround Time Report (September) Executive Summary Q3 Quarterly Member Report Q3 (Lee/Zweifler) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Access Grievances ➢ The top Access grievance classifications for Quarter 3 2018 are: o Availability of PCP o PCP Referral for Services grievances o Access to Care- Availability of Appointment with Specialist Transportation Grievances 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. Exempt Grievances ➢ The highest volume of exempt grievances in Q3 were: PCP Assignment, Transportation and Interpersonal Clinic/Provider staff. ➢ The number of exempt grievances reported in Q3 remained consistent with Q2. Inter-rater Reliability Report ➢ The Inter-rater Reliability audit evaluates clinical and non-clinical A&G staff adherence to regulatory requirements and internal policies and procedures established for the handling of appeals and grievances. ➢ For the audit period of July 1, 2018 through September 30, 2018, results for the appeals and grievances case reviews averaged an overall score of 99.90%. The audit score threshold is 95%. ➢ Feedback is provided to A&G staff on all audit findings.	
#3 **QI Business** -Potential Quality Issues (Q3) (Attachment O) Action Patrick Marabella, M.D., Chair	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 activity. Peer review activities include cases with a severity code level of III or IV or any case the CalViva Health Chief Medical Officer (CMO) requests to be forwarded to Peer Review. ➢ There were no Non-member Source of PQIs resolved in Q3. ➢ Member Source of PQI's remained consistent in Q3. ➢ Peer Review PQI cases were lower in Q3 compared to previous quarters. Data was reviewed for all case types including the follow-up actions taken when indicated.	Motion: Approve Potential Quality Issues Q3 (Ramirez/Lee) 4-0-0-3
#3 **QI Business** - MHN Performance Indicator Report (Q3)	The MHN Performance Indicator Report for Quarter 3 2018 was presented. ➢ For Quarter 3 2018, 17 of the 18 metrics met or exceeded their targets. ➢ Performance was below target for Network Adequacy for Member Ratios of	Motion: Approve MHN Performance Indicator Report Q3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachment P) Action Patrick Marabella, M.D, Chair	BCaBA/paraprofessional. This was the first time this metric has fallen below target in the last 12 months. ➢ Barriers and challenges identified include: ABA groups have been resistant to provide DHCS required data on paraprofessionals and there are a limited number of ABA groups in the CalViva Health tri-county area. ➢ MHN Provider Relations will re-contact all CalViva Health contracted groups to obtain updated rosters containing all DMHC required elements.	(Ramirez/Lee) 4-0-0-3
#3 **QI Business** - Facility Site & Medical Record & PARS Review Report (Q1 & Q2) (Attachment Q) Action Patrick Marabella, M.D, Chair	This report displays completed activity and results of the DHCS required Facility Site Review (FSR), Medical Records Review (MRR), and Physical Accessibility Review Survey (PARS) for the tri-county area. ➢ There were 25 FSRs completed in the first and second quarters of 2018. ➢ There were 21 MRRs completed in the first and second quarters of 2018. ➢ The CE CAP submission compliance rate within 10 business days was 100% in the first and second quarters of 2018. FSR and MRR CAPs were also closed at a 100% rate within 45 days of the audit. ➢ 8 FSRs and 3 MRRs required CAPs to verify corrections during this time period in 2018. ➢ There were 25 PARS completed in the first and second quarters 2018, of which 48% had basic access.	Motion: Approve Facility Site & Medical Record & PARS Review Report Q1 & Q2 (Zweifler/Lee) 4-0-0-3
#3 **QI Business** - Initial Health Assessment Quarterly Audit (Q3) (Attachment R) Action Patrick Marabella, M.D, Chair	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-pronged approach to monitoring is performed and includes the following: ➢ Medical Record Review (MRR) via onsite provider audits ➢ Monitoring of claims and encounters ➢ Member outreach following a three step methodology <u>FSR/MRR Data:</u> ➢ Data from Quarter 3 FSR/MRRs reviewed. ➢ Combined IHA/IHEBA completion and compliance rates were noted to be higher for pediatric patients compared to adult patients. ➢ Non-compliant sites received a follow-up educational letter advising of the DHCS requirements for timely completion of the IHA.	Motion: Approve Initial Health Assessment Quarterly Audit Q3 (Zweifler/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Claims Data: ➢ Pediatric completion within 120 days increased from 77.99% (1st half of 2017) to 85.68% (1st half of 2018). ➢ Adult IHA completion also increased from 73.37% to 81.11%. when comparing 1st half of 2017 to the 1st half of 2018. Outreach Attempts: ➢ Three Step outreach includes: Welcome Packet, Welcome Call and Welcome Postcard. ➢ Outreach attempts for Quarter 3 remained consistently above 95%.	
#4 **UM Business** - Key Indicator Report & Turn-around Time Report (September) - Utilization Management Turn-around Time Report (Attachments S) Action Patrick Marabella, M.D, Chair	The Key Indicator Report reflects data as of 9/30/2018. This report includes key metrics for tracking utilization and case management activities. ➢ The number of ER visits and Inpatient admissions have normalized compared to quarters 1 and 2. ➢ Average Length of Stay and Readmission rates have remained consistent. ➢ There is an increase in the engagement rate for CalViva's Pregnancy Program, although the number of referrals has slightly decreased. ➢ Turn-around Times for Utilization Management are all above 95 % with 5 of 6 metrics at 100%. Continue to monitor all cases that do not meet standard through the Turn-around Time Report. ➢ Integrated Case Management and Transitional Case Management continue to demonstrate good engagement rates. These two teams work together to provide smooth care transitions. ➢ Outreach and engagement efforts for Behavioral Health Case Management continue to improve in September.	Motion: Approve Key Indicator Report & Turn-around time report (September) (Lee/Zweifler) 4-0-0-3
#4 **UM Business** - Utilization Management Concurrent Review Report (Q3) (Attachments T) Action Patrick Marabella, M.D, Chair	The 2018 Utilization Management/Medical Management Concurrent Review Report presents inpatient utilization data and clinical concurrent review activities for Quarter 3 2018. Focus is on improving member healthcare outcomes, minimizing readmission risk, and reducing post-acute gaps in care delivery via proactive discharge planning and expeditious linkages to medically necessary health and support services. ➢ An increase in utilization across all populations (TANF, Expansion, and SPD) for admissions and Emergency visits noted in Q1 and Q2 but has moved towards normalization in Q3. ➢ An analysis of admission types and emergency room visits for Q3 reveal Sepsis and Pneumonia to be the most common diagnoses with Diabetes the most common co-morbidity. ➢ The average length of stay for both the TANF and Expansion populations have continued to move	Motion: Approve Utilization Management Concurrent Review Report Q3 (Lee/Zweifler) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	downward as the Concurrent Review team continues to focus on enhanced discharge planning and a close scrutiny of levels of care. ➢ Homelessness continues to be a major barrier to safe, appropriate discharge for CalViva members in all populations as the homeless rate continues to rise for the tri-county area. (Average homeless rate increased by 12% over 2017 based on report from Fresno/Kings/Madera County Point in Time Study conducted in January 2018). The Utilization Management team continues to explore new ways to mitigate the impact of homelessness on readmissions.	
#4 **UM Business** -Case Management Report (Q3) (Attachment U) Action Patrick Marabella, M.D., Chair	This report provides a summary of Case Management, Transitional Care Management, and Palliative Care activities for Quarter 3 2018. The goal of these programs is to identify members who would benefit from the services offered and to engage them in the appropriate program. The effectiveness of the case management program is based upon: • Readmission rates • ED utilization • Overall health care costs • Member Satisfaction Positive results continue for these measures in Quarter 3 2018. Effectiveness of the other program types are established and evaluated and included in the quarterly report.	Motion: Approve Case Management Report Q3 (Lee/Zweifler) 4-0-0-3
#4 **UM Business** - Specialty Referrals Reports: HN, La Salle, IMG, Adventist (Q3) - Specialty Referral Report: First Choice (Q2) (Attachments V-W) Action Patrick Marabella, M.D, Chair	These reports provide a summary of Specialty Referral Services in Quarters 2 & 3 2018 that required prior authorization in the tri-county area for Health Net, La Salle, IMG, Adventist and First Choice Medical Group. As parameters for these reports have recently been clarified with Delegation Oversight staff, there may be some edits or updates. These reports provide evidence of the tracking process in place to ensure appropriate access to specialty care for CalViva Health members. Results will continue to be monitored and reported over time.	Motion: Approve Specialty Referrals Reports: HN, La Salle, IMG, Adventist Q3 Specialty Referral Report: First Choice Q2 (Ramirez/Zweifler) 4-0-0-3
#5 **Pharmacy Business** -Executive Summary (Q3) -Operations Metrics Report (Q3) -Top 30 Prior Authorizations (Q3)	Pharmacy reports for Q3 2018 include Executive Summary, Operations Metrics, Top 30 Medication Prior Authorizations, and quarterly formulary changes. These reports are provided 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. ➢ Pharmacy Prior Authorizations (PA) metrics were within 5% of standard for third quarter 2018. ➢ Third quarter 2018 top medication PA requests varied minimally from second quarter 2018. ➢ An All Plan Letter (APL 18-013) was released on 8/15/2018 providing updated guidance on the	Motion: Approve Executive Summary Q3 Operations Metrics Report Q3 Top 30 Authorizations Q3 (Zweifler/Lee) 4-0-0–3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments X-Z) Action Patrick Marabella, M.D., Chair	treatment of Hepatitis C. ➢ Effective 11/1/18, Admelog is the preferred Rapid Acting Insulin (Humalog removed from RDL).	
#6 **Credentialing and Peer Review Subcommittee Business** -Credentialing Subcommittee Report (Q4) (Attachment AA) Action Patrick Marabella, M.D., Chair	This report provides the QI/UM Committee and RHA Commission with a summary of the CalViva Health Credentialing activities. <u>Credentialing Subcommittee Report</u> The Credentialing Sub-Committee met on October 18, 2018. Routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated entities. Reports covering Q2 2018 were reviewed for delegated entities and Q3 2018 was reviewed for Health Net. The 2019 Credentialing Sub-Committee draft meeting schedule was reviewed and accepted. The Q3 2018 Credentialing report was reviewed with one case cleared and closed to normal track and trend, one case was postponed, and one case was approved for network re-entry with monitoring and subsequently administratively terminated. Other county-specific Credentialing subcommittee reports were reviewed and approved. No significant cases were identified on these reports.	Motion: Approve Credentialing Subcommittee Report Q4 (Ramirez/Lee) 4-0-0-3
#6 **Credentialing and Peer Review Subcommittee Business** -Peer Review Subcommittee Report (Q4) (Attachment BB) Action Patrick Marabella, M.D., Chair	This report provides the QI/UM Committee and RHA Commission with a summary of the CalViva Health Peer Review activities. <u>Peer Review Subcommittee Report</u> The Peer Review Subcommittee met on October 18, 2018. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2018 were reviewed for approval. There were no significant cases to report. The 2019 Peer Review Sub-Committee draft meeting schedule was reviewed and accepted. The Q3 2018 Peer Count Report was presented and there were no cases closed and cleared. There was one case pending closure for Corrective Action Plan compliance. There was one case pended for further information. Follow up will be initiated to obtain additional information for the tabled case and ongoing monitoring and reporting will continue.	Motion: Approve Peer Review Subcommittee Report Q4 (Lee/Zweifler) 4-0-0-3
#7 **Policy Review** -Public Health Policy Review (Attachment CC) Action Patrick Marabella, M.D.,	Public Health Policy & Procedure Annual Review grid was presented to the committee. The majority of policies were updated without changes or had minor edits. Five policies that required more extensive review were included in the meeting packet: ➢ PH-008 Early Start Program ➢ PH-013 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services ➢ PH-019 Minor Consent Services	Motion: Approve Public Health Policy Review (Lee/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Chair	➢ PH-022 Alcohol and Drug Treatment Services ➢ PH-105 Pregnancy Termination The policy edits were discussed and the Public Health policies were approved.	
#8 **Compliance Update** (Attachment DD)	Mary Beth Corrado presented the Compliance report. ➢ 2018 DHCS Medical Audit – An exit conference has been scheduled for 11/16/18 to review the DHCS' Preliminary Findings Report. ➢ On 9/25/18 received written DHCS notification of a Quality Improvement Corrective Action Plan (CAP); Medical Management responded to the CAP and has a meeting with DHCS on 11/16/18 to discuss the CAP. ➢ The Plan will have a DMHC survey consisting of a pre-audit review of documentation and onsite interviews, file audits, and document review during the week of February 25, 2019. Over 800 pre-audit documents were submitted on 10/29/18. ➢ Public Policy Committee has appointed CalViva member, Kristi Hernandez to the "At-Large" seat. There is a new vacancy for the Madera County Seat. The Plan is actively seeking a replacement. ➢ Pediatric Palliative Care has been provided by DHCS under a waiver agreement with CMS. DHCS will end the PPC waiver on December 31, 2018 due to the inability to come to consensus with CMS on an alternate workable structure for the waiver. Children enrolled in the waiver program will receive their palliative care services through managed care plans effective January 1, 2019. DHCS is working directly with plans, the current PPC waiver providers, and county PPC waiver staff to facilitate the transition process. To date, CalViva has been notified that one member will be affected by this transition. Impacted members received a 60-day notice of this transition and a 30-day notice will be sent by December 1, 2018. ➢ The next Public Policy Committee meeting is scheduled for December 5, 2018 11:30 a.m. in Fresno County at the CalViva office on Palm Ave.	
#9 **Old Business**	None.	
#10 **Announcements**	None.	
#11 **Public Comment**	None.	
#12 **Adjourn** Patrick Marabella, M.D, Chair	Meeting was adjourned at 12:12 pm.	

NEXT MEETING: February 21, 2019

Submitted this Day: February 21st, 2019

Submitted by: Amy B Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #3

Attachment 3.D

Public Policy Committee Minutes
dated 12/5/18

Public Policy Committee
Meeting Minutes
December 5, 2018

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	✓	Mary Beth Corrado, Chief Compliance Officer
✓	Kristi Hernandez, At-Large Representative	✓	Mary Lourdes Leone, Director of Compliance
	Seng Moua, Fresno County Representative	✓	Cheryl Hurley, Commission Clerk
		✓	Courtney Shapiro, Community Relations Director
		✓	Pat Marabella, M.D., Chief Medical Officer
		*	= late arrival

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:35 am. A quorum was present.	
#2 Meeting Minutes from September 5, 2018 **Action** Joe Neves, Chair	The September 5, 2018 meeting minutes were reviewed. There were no discrepancies.	**Motion:** Approve September 5, 2018 Minutes 4-0-1-2 (R. Garcia / D. Phillips)
#3 Committee Membership Update **Information** Joe Neves, Chair	Kristi Hernandez was introduced as the newest member to join the Public Policy Committee. She has filled the At-Large position. The Madera County position is vacant; to date, one application has been received. An update will be presented at the March 2019 meeting.	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#4 Approved 2019 Calendar **Information** Joe Neves, Chair	The approved calendar for 2019 meeting schedule was presented; no questions or comments were brought forth.	**No motion**
#5 Enrollment Dashboard **Information** Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the enrollment dashboard through October 2018. Membership as of the end of October was 356,360.	**No motion**
#6 Health Education *2018 Work Plan Mid-Year Evaluation Summary and 2018 Work Plan Mid-Year Evaluation* **Information** Justina Felix	Justina Felix presented the 2018 Work Plan mid-year evaluation and summary. Eleven of the 14 initiatives met or exceeded 50% of the year-end goal; those initiatives include: • Chronic Disease Education • Community Partnerships • Digital Health Education Programs • Healthy Equity Projects • HEDIS Improvement Incentive Programs • Immunization Initiative • Member Engagement • Member Newsletter • Promotores Health Network • Compliance: Oversight and Reporting • Health Education Department Promotion, Materials Update, Development, Utilization and Inventory The remaining three initiatives did not meet 50% of the year-end goal: • Obesity Prevention, • Perinatal Education • Tobacco Cessation	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	These three initiatives experienced low enrollment and will require an increased focus on promotional/engagement efforts in Q3 and Q4.	
#7 Cultural and Linguistics **Information** Lali Witrago	Lali Witrago presented the Cultural and Linguistics 2018 Work Plan Mid-Year Evaluation and Summary, and the 2018 Language Assistance Program Mid-Year report. A summary of Work Plan activities presented include: • Language Assistance Services • Compliance Monitoring • Communication, Training and Education • Health Literacy, Cultural Competency and Health Equity. All activities are on target to be completed by the end of the year with a few already completed. A summary of the mid-year Language Assistance Program was presented. During January 1 to June 30, 2018, the total number of calls handled by Member Services Department representatives accounted for 75,034 across all languages. Of these, 11,302 (15%) were handled in Spanish and Hmong languages. Additionally, 2,718 interpreter requests were fulfilled for CalViva Health members. A total of 2,526 (93%) of these requests were fulfilled utilizing telephonic interpreter services with 117 (4%) for in-person and 75 (3%) for sign language interpretation. MHN Member Services Department representatives handled a total of 2,420 across all languages and fulfilled a total of 49 interpreter requests.	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Of the 49 requests, 48 (98%) were fulfilled for in-person and 1 (2%) for sign language interpretation.	
#8 Medical Management *RY 2018 HEDIS® Data Results* **Information** Patrick Marabella, MD, CMO	Dr. Marabella reported on the RY 2018 HEDIS® data results. In 2018 Managed Care Plans (MCPs) reported on a total of 17 measures (16 HEDIS® measures and the All-Cause Readmission measure, a non HEDIS measure). DHCS uses certain External Accountability Set (EAS) measures to assign members to a health plan in each county; this is called default enrollment. The Default Enrollment Measures are: • CIS-3: Childhood Immunizations – Combo 3 • W34: Well Child Visits in 3-6th Years of Life • PPC-Pre: Prenatal Care • CDC-HT: HbA1c Testing • CBP: Controlling High Blood Pressure • CCS: Cervical Cancer Screening All default enrollment measures were met in all three counties with the exception of CDC-HT – HbA1c Testing, which did not meet in Fresno county. Managed Care Plans (MCPs) are required to meet Minimum Performance Levels (MPLs) and if performance levels are below MPLs (25%) an improvement plan must be developed and implemented. For RY 2018 HEDIS® Improvement Plans, results below the MPL include the following:	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• Monitoring Persistent Meds – ACE/ARB – Madera County • Monitoring Persistent Meds – Diuretics – Madera County • Avoidance of ABX Adults with Bronchitis – Madera County • Breast Cancer Screening – Fresno County • HbA1c Testing – Fresno County • Nephropathy – Fresno County	
#9 Appeals, Grievances, and Complaints **Information** Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the appeals, grievances and complaints report for Q3 2018. Total appeals and grievances for Q3 2018 were 406. Total appeals for Q3 2018 were 106. Total grievances for Q3 2018 were 297. Turnaround time compliance standard for Grievances was met at 100%. Turnaround time compliance standard for Standard Appeals met at 100%; however, the standard for Expedited Appeals met at 83.3%. The majority of appeals and grievances were from members in Fresno County which has the largest CalViva Health enrollment.	**No motion**
#10 2018 DHCS Audit Exit Conference; 2019 DMHC Pre-Onsite Audit Request **Information** Mary Beth Corrado, CCO	Mary Beth Corrado reported on the 2018 DHCS Audit Exit Conference. CalViva Health participated in the exit conference with DHCS to discuss the onsite audit from 2018. Audit results presented only two findings. For one finding CVH provided supplemental information and a response from DHCS is pending receipt of final report. The findings were related to Provider training and documenting new Providers are trained within ten days of becoming	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	active with the Plan. The second finding had to do with Individual Behavioral Health Assessment as it relates to documentation, monitoring, and tracking. CVH advised DHCS about the tracking and monitoring that was completed and response is pending final report. There are two upcoming onsite audits for 2019; one from Department of Managed Health Care (DMHC), and the other from Department of Health Care Services (DHCS). Both entities will be onsite the last week of February 2019.	
#11 Final Comments from Committee Members and Staff	Roberto Garcia, with Self-Help Enterprises, announced they are venturing into Senior Living. David Phillips, with United Health Centers, announced the grant they received from CVH to assist with adding Residents to their Residency Program. Leann Floyd shared positive feedback received from CVH members with regard to Family Health Care Network's new location. Members have commented they have been treated better. Jeff Garner, with KCAO, announced they will be working with both public agencies and non-profit agencies to launch a needs assessment in Kings county during the first quarter of 2019.	
#12 Announcements	None.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#13 Public Comment	None.	
#14 Adjourn	Meeting adjourned at 12:59 pm.	

NEXT MEETING **March 6, 2019 in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: March 6, 2019

Submitted By: _____
Courtney Shapiro, Director Community Relations

Approval Date: March 6, 2019

Approved By: _____
Joe Neves, Chairman

Item #4

Attachment 4.A

Quality Improvement
2019 Program Description

CalViva Health
Quality Improvement (QI) Program Description

2019

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 ensure~~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.

~~CalViva offers a variety of health education programs, services and resources that are free to CalViva members. Examples include:~~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~~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~~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.
- ~~Healthy~~CalViva~~-~~ Pregnancy Program – Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. 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 year long 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 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, substance use, pain management, and insomnia.
- 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.
- 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.

- ~~The Health Education Information Line – The Health Education Information Line (1-800-804-6074) allows members to request health education materials and find out about health education programs available.~~
- ~~Weight Management Programs – Members have access to a comprehensive Fit Families for Life *Be In Charge!*℠ 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. Overweight children and adult can also access telephonic coaching through Raising Well and Adult Weight Management programs respectively.

- Disease Management Program – At risk members with asthma, diabetes, and chronic heart failure are offered enrollment into the *Be In Charge!*[sm] Disease Management program to help them control their condition. Members receive educational resources and have unlimited 24 hour access to a nurse to address their medical concerns
- Healthy Pregnancy Program – Pregnant members receive educational resources including telephonic case management for high risk pregnancies to help them achieve a successful pregnancy and healthy baby. .
- California Smokers' Helpline – The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service operated by the University of California San Diego Moore's Cancer Center. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking.
- Nurse Advice Line – Members may speak to a nurse 24 hours a day, 7 days a week in the member's preferred language about any health related concerns. Pre-recorded information about a variety of diseases and health issues is also available via the Nurse Advice Line as part of the Audio Health Library.
- Healthy Hearts, Healthy Lives – Members have access to a heart health prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to community classes to learn how to maintain a healthy heart.
- Electronic Health Education – Teens from 13 years old and adults may participate in electronic 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 participants in learning how to access credible health education information and seek preventive health care services.
- Community and Telephonic 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.
- Member Newsletters – Newsletters are mailed to members on a quarterly basis and covers various health topics and the most up-to-date information on health education programs and services.
- Health Education Materials – Members have access to culturally appropriate health education brochures, flyers, newsletter, and screening guidelines on 25 health topics and up to 3 threshold languages.

MemberConnections® Program

MemberConnections is a special educational and outreach 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*

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!* SM 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!* SM Program is to improve member knowledge and self-management of these diseases leading to improved quality of life, and better functional status. ~~and decreased absenteeism.~~ 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 ~~Integrated~~ 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 85th percentile are eligible for the program. Participants, including their parents or guardians, are given personalized, telephonic support from health coaches who specialize in weight management. Coaches include registered dietitians, 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 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.

The TCM 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.

G. ~~Integrated~~ Case Management (~~I~~CM) Program

CalViva partners with HNCS to provide ~~Integrated~~ Case Management (~~I~~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 ~~I~~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 hospitals
- 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 ~~Integrated~~ 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~~Members may also be directly referred by sources including:

- Health information 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

~~management.~~

ICM 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. *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, 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. *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:

- ~~Integrated~~ 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. *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. *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. *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. *Satisfaction*

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. *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.
- Telephone Access 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. *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,~~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. *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 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. *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 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.

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 Group Needs Assessment (GNA)
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, Group Needs Assessment (GNA) 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 ~~an organizational and~~ member, community and provider levels ~~strategic plan~~ 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" ~~events~~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 ~~Workplan~~Work plan and QI ~~Workplan~~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*

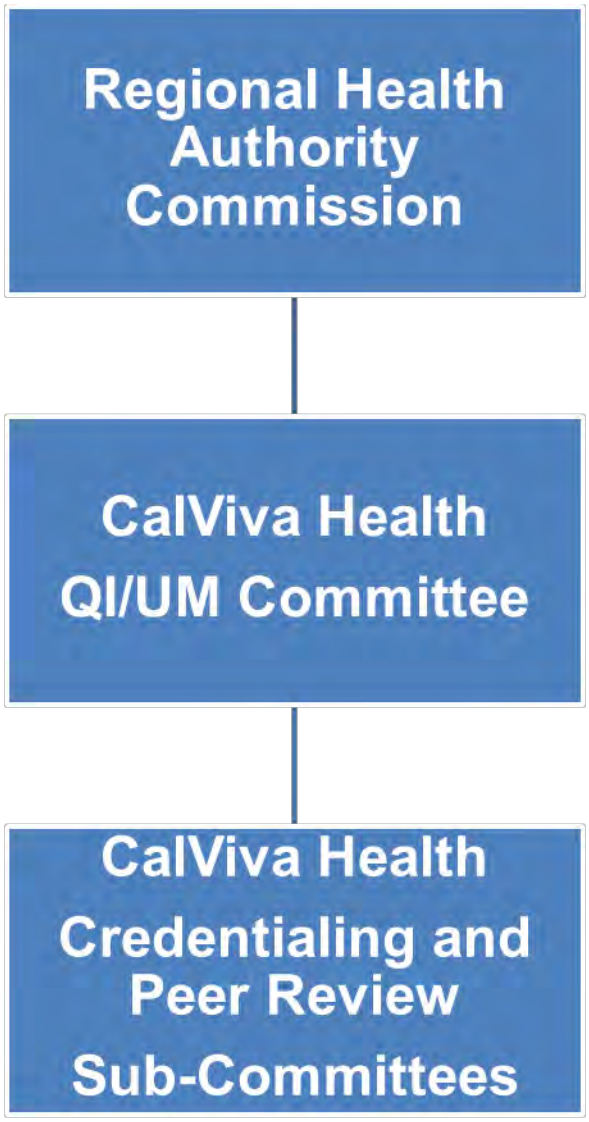
QI/UM Operational Workgroup

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



Staff Resources and Accountability

Staff Resources and Accountability

C. Staff Resources and Accountability

~~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

~~March 15th, 2018~~

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

Date

~~March 15th, 2018~~

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

Date

Item #4

Attachment 4.B

Quality Improvement
2019 Work Plan

CalViva Health Quality Improvement Work Plan 2019

3.13.19

Attachment I

CalViva Health 2019 Quality Improvement Work Plan

TABLE OF CONTENTS

Submitted by:

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

CalViva Health 2019 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 2019. The development of this document requires resources of multiple departments.

CalViva Health 2019 Quality Improvement Work Plan

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances
A&I:	Audits and Investigation
AH:	After Hours
AWC:	Adolescent Well-Care
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CDC:	Comprehensive Diabetes Care
CM:	Case Management
CP:	Clinical Pharmacist
CVH:	CalViva Health
DHCS:	Department of Health Care Services
DM:	Disease Management
DMHC:	Department of Managed Health Care
DN:	Direct Network
FFS:	Fee-for-Service
HE:	Health Education
HPL:	High Performance Level
HN:	Health Net
HSAG:	Health Services Advisory Group
IHA:	Initial Health Assessment
ICE:	Industry Collaborative Effort
IP:	Improvement Plan
IVR:	Interactive Voice Response
MCL:	Medi-Cal
MH:	Mental Health
MMCD:	Medi-Cal Managed Care Division
MPL:	Minimum Performance Level
PCP:	Primary Care Physician
PIP:	Performance Improvement Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
PNM:	Provider Network Management
PRR:	Provider Relations Representative
PTMPY:	Per Thousand Members Per Year
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 80% for all metrics. Timely Appointment Access is monitored using the ICE-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 surveys, survey results, and educational information for improvement.	P	Q1 - Q4 Q2 - MY2019 Survey Prep Q3 – MY2018 Survey Results	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)**

- MY2019 PAAS Survey: Survey being conducted by Sutherland Global beginning in August 2019.
- Provider Updates: MY2018 Appoint Access and After-Hours Survey Results scheduled to go out August 2019. MY2019 PAAS and After-Hours Survey Prep distributed June 2019.
- P&P PV-100 Accessibility of Providers and Practitioners: Update required for TAR filing in Q1 2019. Updates approved at May Access WG meeting.
- MY2019 PAHAS Survey - After-Hours survey being conducted by SPH Analytics beginning in September 2019.
- MY2018 CAP packets to be distributed to noncompliant provider's in August 2019.
- 2019 Review of Patient Experience Toolkit – major overhaul of this piece to take place in 2019. Provider Onsite Audits – to take place in September/October 2019. Noncompliant providers subject to audit will be notified in August with their CAP packets.

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 2018	Rate RY 2019 (populated mid-year)	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall= 90.1% Fresno= 87.7% Kings= 97.7% Madera= 94.9%	Q2 2019	CVH Performance RY2018	Overall= 90.1% Fresno= 87.7% Kings= 97.7% Madera= 94.9%

Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	80%	Overall= 64.0^% Fresno= 68.8^% Kings= 65.2^% Madera= 55.5^%	Q2 2019	CVH Performance RY2018	Overall= 64.0^% Fresno= 68.8^% Kings= 65.2^% Madera= 55.5^%
Access to Urgent Care Services that do not require prior authorization (PCP & SCP) – Appointment within 48 hours of request	80%	Overall= 82.8% Fresno= 82.9% Kings= 81.4% Madera= 84.6%	Q2 2019	CVH Performance RY2018	Overall= 82.8% Fresno= 82.9% Kings= 81.4% Madera= 84.6%
Access to Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	80%	Overall= 64.0^% Fresno= 68.3^% Kings=52.3^% Madera= 50.8^%	Q2 2019	CVH Performance RY2018	Overall= 64.0^% Fresno= 68.3^% Kings=52.3^% Madera= 50.8^%
Access to First Prenatal Visit (PCP & SCP) – Within 10 business days of request	80%	Overall= 100% Fresno= 100% Kings= 100*% Madera= 33.3*%	Q2 2019	CVH Performance RY2018	Overall= 100% Fresno= 100% Kings= 100*% Madera= 33.3*%
Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall= 84.0% Fresno= 86.9% Kings= 60.0*% Madera= 66.7*%	Q2 2019	CVH Performance Ry2018	Overall= 84.0% Fresno= 86.9% Kings= 60.0*% Madera= 66.7*%
Access to Physician Exams and Wellness Checks – within 30 calendar days of request	80%	Overall= 91.3 % Fresno=93.4% Kings= 60.0*% Madera= 100*%	Q2 2019	CVH Performance RY2018	Overall= 91.3 % Fresno=93.4% Kings= 60.0*% Madera= 100*%
Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	80%	Overall= 88.8*% Fresno= 83.3*% Kings= 100*% Madera=N/A	Q2 2019	CVH Performance RY2018	Overall= 88.8*% Fresno= 83.3*% Kings= 100*% Madera=N/A
Appropriate After-Hours (AH) emergency instructions	90%	Overall= 94.3% Fresno= 93.6% Kings= 95.7% Madera= 98.2%	Q2 2019	CVH Performance RY2018	Overall= 94.3% Fresno= 93.6% Kings= 95.7% Madera= 98.2%
AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes (Per P&P)	90%	Overall= 78.7% Fresno= 76.7% Kings= 87.0% Madera= 82.1 %	Q2 2019	CVH Performance RY2018	Overall= 78.7% Fresno= 76.7% Kings= 87.0% Madera= 82.1 %
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 Satisfaction by DHCS was last evaluated in the 2016 DHCS CAHPS Survey, and results were aligned close to the Medicaid State Average. Member perception of quality of care and care coordination is multifaceted and affected by the provider, the plan, member demographics and individual health status and experience so evaluation and intervention are directed towards touchpoints by the member.

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

The following CAHPS Metrics will be used to evaluate the effectiveness of the interventions:

1. Getting Needed Care (Ease to get appointment with specialist, and ease to get care, tests, and treatment);
2. Getting Care Quickly (Getting care right away (urgent), getting appointment as soon as needed (routine) and see doctor within 30 minutes of apt. time
3. Rating of all health care
4. Rating of personal doctor
5. How well do doctors communicate (did your doctor explain things in a way that was easy to understand and did the doctor listen to the patient)

The goal for member satisfaction is to reach the Quality Compass 50th percentile. This survey is a 3-year data cycle. A CAHPS scaled-back survey is conducted annually and survey results will be reflected on the table in Section C below in off-cycle years.

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 2018	RY Rate 2019	Baseline Source	Baseline Value
Got urgent care as soon as needed	CAHPS Scaled-back member survey	79%	Q2 2019	RY 2018 CVH results	79%
Got routine care as soon as needed	CAHPS Scaled-back member survey	66%	Q2 2019	RY 2018 CVH results	66%
Easy to see specialist	CAHPS Scaled-back member survey	59%	Q2 2019	RY 2018 CVH results	59%

Ancillary services	CAHPS Scaled-back member survey	75%	Q2 2019	RY 2018 CVH results	75%
CAHPS metric: Getting Needed Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.35%	78%	Q2 2019	RY 2018 CVH results	78%
CAHPS metric: Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.55%	74%	Q2 2019	RY 2018 CVH results	74%
CAHPS metric: Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 72.82%	69%	Q2 2019	RY 2018 CVH results	69%
CAHPS metric: Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 80.00%	77%	Q2 2019	RY 2018 CVH results	77%
CAHPS metric: How well doctors communicate	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 90.70%	90%	Q2 2019	RY 2018 CVH results	90%
				RY 2018 CVH results	***3 yr data cycle; DHCS survey data available in 2019**
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: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)				
☐ 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 reduce the number of prescriptions for antibiotics inappropriately prescribed to CalViva Health adult members diagnosed with acute bronchitis.

Rationale: Antibiotic resistance is both costly and a major public health issue, totaling up to $20 billion in direct healthcare costs.[1] Every year, at least 2 million people become infected with bacteria that are resistant to antibiotics, and at least 23,000 people die as a result.[2] In general, antibiotic-resistant infections result in longer and/or more expensive treatments, longer hospital stays, additional doctor visits, and increased disability and mortality risk.[1] According to the CDC, the use of antibiotics is "the single most important factor leading to antibiotic resistance around the world."[3] Moreover, the CDC estimates 30 percent of unnecessary antibiotics are prescribed in outpatient clinics.[2]

Barriers to appropriate antibiotic prescribing include providers not ordering the appropriate laboratory tests to confirm if an antibiotic is needed, and patients demanding an antibiotic. [1] To help address these barriers, CalViva helps promote the Choosing Wisely® patient education materials and is also involved with the California Medical Foundation's Alliance Working for Antibiotic Resistance Education (AWARE) annual campaign to promote appropriate antibiotic use among providers and patients. According to a meta-analysis published in the British Medical Journal patients prescribed an antibiotic for a respiratory infection consistently developed bacterial resistance to that antibiotic; this effect was greatest in the first two months immediately after treatment [pooled odds ratio 2.37 (CI 1.42-3.95)] but could persist for up to 12 months. This contributes to an increased number of organisms resistant to first line antibiotics, which may lead to increased use of second line antibiotics.[4] Therefore, it is crucial that providers have updated tools and information to ensure that antibiotics are not prescribed inappropriately or overprescribed.

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[1]Centers for Disease Control and Prevention (CDC). Antibiotic Resistance Threats in the United States, 2013. April 2013. Available at http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats- 2013-508.pdf. Downloaded January 17, 2014.
[2]Centers for Disease Control and Prevention. (2017). Antibiotic use in the United States, 2017: Progress and Opportunities. Atlanta, GA: US Department of Human Services. Retrieved from https://www.cdc.gov/antibiotic-use/stewardship-report/index.html.
[3]Centers for Disease Control and Prevention (CDC), Antibiotic/Antimicrobial Resistance. Accessed January 12, 2017 at /www.cdc.gov/drugresistance.
[4]Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD. (2010). Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. BMJ. 2010 May 18; 340:c2096.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
The HEDIS measure, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (a higher rate indicates appropriate treatment of adults with acute bronchitis). Madera county baseline HEDIS result for RY 2017 was 18.26% and RY2018 was 24.58% which was 0.33% below the MPL (181 numerator events out of the 240 in the denominator).

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance clinic in Madera County to initiate targeted interventions to improve AAB rate. (Submit PDSAs)	P	Q1, Q2	CVH/HN
Conduct regular meetings with the Madera County clinic to share results and receive updates on improvement activities. (Submit PDSAs)	P	Q1, Q2	CVH/HN
Mail 2019 AWARE toolkit containing provider and member educational resources on appropriate antibiotic use. Mailed by AWARE offices (Physicians For A Healthy California) to top 20% of antibiotic prescribers (MDs) identified in Fresno, Kings, and Madera Counties.	P	Q2, Q3	CVH/HN
Provider Relations to distribute AWARE Toolkit to targeted providers and mid-level clinicians identified as high prescribing for two or more consecutive years.	P	Q2, Q3	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 RY2018	Rate RY2019	Baseline Source	Baseline Value

HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB)	Directional improvement to meet or exceed the MPL 27.63% (RY 2019)	Madera: 24.58%	TBD	RY 2017 CVH results	Madera: 18.26%
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: Annual Monitoring for Patients on Persistent Medications (MPM)

☐ **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: Reduce the occurrence of preventable adverse drug events for CalViva Health members on Persistent Medications (MPM).

Rationale: High blood pressure is asymptomatic and is often dubbed as the "silent killer" (Association, 2018). The American Heart Association defines normal blood pressure as less than 120/80 mm Hg (Association, 2018)**.** In managing blood pressure, members are advised to adopt positive life style modifications which include making dietary changes and increasing physical activity for maintaining a healthy weight, limiting alcohol intake, and engaging in smoking cessation programs (Center for Disease Control and Prevention, 2018). However, for patients managing chronic diseases such as hypertension medication adherence is paramount in improving overall health benefits. Some of those medications include angiotensin converting enzyme inhibitors (ACE inhibitors or ACE-I) and angiotensin receptor blockers (ARBs) and diuretics. There is still not enough information on how to improve adherence in a cost-effective manner (Seabury, 2014). The CDC estimates that approximately over one million individuals are seen in emergency departments for adverse drug events in which case many are preventable (Centers for Disease Control and Prevention, 2017). As our members advance in age, there is a likelihood that they will take more medications to care for their chronic diseases. Therefore, it is imperative that this population not only adhere to their medication but seek regular care with their provider to make sure that their current medication is correct for them or adjust as needed by conducting routine laboratory tests.

Association, A. H. (2018,). *American Heart Association - Monitor Your Blood Pressure*. Retrieved December 29, 2018, from American Heart Association: https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure

Control, C. f. (2018). *Effective Diagnosis, Treatment, and Monitoring of Hypertension in Primary Care - Participant Guide Treatment of Hypertension.*

Centers for Disease Control and Prevention. (2017, June 19). Medication Safety Program. Retrieved January 23, 2018, from Adverse Drug Event Monitoring: https://www.cdc.gov/medicationsafety/program_focus_activities.html

Seabury, S. G. (2014). Understanding and Overcoming Barriers to Medication Adherence: A Review of Research Priorities. Journal of Managed Care and Specialty Pharmacy, 775-783.

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

The HEDIS Measure, Annual Monitoring for Patients on Persistent Medications (MPM) will be used to evaluate the effectiveness of the interventions implemented for this measure. The measure evaluates the percentage of adults 18 years and older who have received at least 180 treatment days of ambulatory medication therapy of either ACE/ARBs or diuretics. Madera County's baseline HEDIS result for ACE/ARBs in RY 2017 was 82.64% and in RY 2018 was 84.74%. The baseline HEDIS results for diuretics in RY 2017 was 82.20% in RY 2018 was 84.88%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with high volume, low compliance clinic in Madera County to improve MPM rates (submit PDSA).	P	Q1-Q2	CVH/HN
Conduct regular meetings with the clinic in Madera County to receive updates on improvement rates for MPM.	P	Q1, Q2	CVH/HN
Continue with in-home screening program MedXM to complete required MPM laboratory testing.	M	Q1-Q2	CVH/HN
Continue with member incentive to improve MPM laboratory rates county wide.	M	Q1-Q2	CVH/HN
MPM Provider Tip Sheets available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended treatment guidelines.	P	Q1	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 RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL update 85.97% (RY 2018)	Madera: 84.74%	TBD	RY 2017 CVH results	Madera: 82.64%
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL update 86.06% (RY 2018)	Madera: 84.88%	TBD	RY 2017 CVH results	Madera: 82.20%
Analysis: Intervention Effectiveness w Barrier Analysis					
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**				

Section A: Description of Intervention (due Q1)

2-3: 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 help members with diabetes maintain control over their blood sugar and minimize the risk of complications associated with this highly prevalent chronic disease through 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. For people with diabetes, it is crucial to not only manage one's blood sugar but to manage their blood pressure in effort to prevent the onset of kidney disease known as diabetic nephropathy (Mayo Clinic A1c Test). 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

Mayo Clinic A1c Test. (n.d.). Retrieved December 2018, 30, from Mayo Clinic: https://www.mayoclinic.org/tests-procedures/a1c-test/about/pac-20384643

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:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- Eye exam (retinal) performed.
- Medical attention for nephropathy.

- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.
- BP control (<140/90 mm Hg).

Fresno County baseline HEDIS results for HbA1c in RY 2017 were 84.91% and in RY 2018 was 83.21%. The baseline HEDIS results for Medical Attention to Nephropathy in RY 2017 was 90.51% in RY 2018 was 87.10%.

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) and nephropathy testing (submit PDSA).	P	Q1-Q2	CVH/HN
Conduct regular meetings with Fresno County provider to receive updates on improvement rates for CDC HbA1c and nephropathy testing.	P	Q1, Q2	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for CDC sub HbA1c testing, and urine analysis.	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 2018)

Measure(s)	**Specific Goal**	**Rate RY2018**	**Rate RY2019**	**Baseline Source**	**Baseline Value**
HEDIS® Comprehensive Diabetes Care – HbA1c Testing	Meet or Exceed DHCS MPL update 84.93% (RY 2018)	Fresno: 83.21%	TBD	RY 2017 CVH results	Fresno: 84.91%

HEDIS® Comprehensive Diabetes Care – Medical Attention for Nephropathy	Meet or Exceed DHCS MPL update 88.56% (RY 2018)	Fresno: 87.10%	TBD	RY 2017 CVH results	Fresno: 90.51%
Analysis: Intervention Effectiveness w Barrier Analysis					
Initiative Continuation Status	☐ **Closed**	☐ **Continue Initiative Unchanged**	☐ **Continue Initiative with Modification**		

Section A: Description of Intervention (due Q1)				
2-4: Breast Cancer Screening (BCS)				
☒ **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 increase and improve the survival rates of CalViva members in Fresno County who are diagnosed with breast cancer through early detection.

Rationale: Breast Cancer Screening tests are used to find cancer before a person has any symptoms. The American Cancer Society recommends the following cancer screening guidelines for most adults: women age 45 to 54 should get mammograms every year; women 55 and older should switch to mammograms every 2 years, or can continue yearly screening; and screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.1

Multiple barriers limit screening mammography among minority women. Pain and embarrassment associated with screening mammography, low income and lack of health insurance, poor knowledge about breast cancer screening, lack of physician recommendation, lack of trust in hospitals and doctors, language barriers, and lack of transportation were the most frequently identified barriers. Recognizing predictors of screening among minority women and addressing culturally specific barriers may improve utilization of screening mammography among these women.2

1 American Cancer Society. American Cancer Society Guidelines for the Early Detection of Cancer. Breast Cancer. May 2018. Available at: https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

2 Journal of the National Medical Association. (March 2010). Barriers related to mammography use for breast cancer screening among minority women. Accessed January 3, 2019 at: https://www.ncbi.nlm.nih.gov/pubmed/20355350

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 2018 was 52.71%.

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
Organize Mobile Mammography Coach at high volume, low compliance clinic site in Fresno County.	M	Q1, Q2	CVH/HN
Health Education to distribute educational materials on the importance of breast cancer screening	M	Q1, Q2	CVH/HN
Implement Provider Incentives to close the 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 competentclinic site to support members in accessing their breast cancer screening services. Strategies include: geomapping analysis specific regions and zip codes where disparity is occurring, on site interpreters, transportation services, etc.	M	Q1-Q4	CVH/HN
Alternative or create partnership with imaging center.	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 2018)

Measure(s)	Specific Goal	Rate RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Breast Cancer Screening	Meet or Exceed DHCS MPL update 52.71%	51.78%	TBD	RY 2017 CVH results	Fresno: 51.1%

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)				
3-1: Improving Childhood Immunizations (CIS-3)				
☐ 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 immunizations are critical to community health, and favorably impact overall health outcomes. The increase in life expectancy during the 20th century is largely due to improvements in child survival. This increase is associated with reductions in infectious disease mortality due to immunizations. Childhood immunizations are proven to help a child stay healthy, protect them from serious illnesses such as polio, tetanus, and hepatitis, and avoid the potentially harmful effects of diseases like mumps and measles. According to HealthyPeople.gov, each birth cohort vaccinated with the routine immunization schedule saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by 9.9 billion, and saves 33.4 billion dollars in indirect costs.1

Therefore, CalViva Health has selected Childhood Immunizations Status – Combination 3 (CIS-3) in Fresno County for a Performance Improvement Project (PIP) topic. Childhood immunizations is a component of the seven priority focus areas (Foster Healthy Communities) identified by DHCS for the Medi-Cal Quality Strategy.2 The CIS-3 measure in Fresno, Madera, and Kings Counties are at/above the MPL RY 2018 (71.3%).

1 HealthyPeople.gov. (n.d.). Retrieved October 30, 2017, from Immunization and Infectious Diseases : https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases
2 Kent, J. (2017). 2017 DHCS Strategy for Quality Improvement in Health Care (Quality Strategy). California Department of Health Care Services (DHCS).

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 3 (CIS-3), 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 pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR), three Hemophilic influenza type B (HiB); three hepatitis B, one varicella-zoster virus (chicken pox or VZV); and four pneumococcal conjugate vaccinations on or before their second birthday. The baseline rate of 62.5% was determined based on the RY 2017 HEDIS hybrid data for one high volume, low preforming clinics in Fresno County.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Continue interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 4), and monitor intervention effectiveness (Module 5).	P	Q1-Q2	CVH/HN
Member newsletter article: Childhood Immunizations	M	Q3	CVH/HN
Implement direct member incentive for completion of childhood immunizations series to improve rates	M	Q1-Q2	CVH/HN
Elimination of the double bookings option/implementation of walk-in/RN visits	M	Q1-Q2	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for Childhood Immunizations.	P	Q1-Q2	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	Q2	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 RY2018	Rate RY2019	Baseline Source	Baseline Value
Childhood Immunization Combo 3	Meet or Exceed SMART Aim Goal of 71.0%	Fresno: 62.5%	TBD	RY 2017 CVH results	Fresno: 58.9%

Analysis: Intervention Effectiveness w Barrier Analysis	
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

3-2 Addressing Postpartum Visit 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: Improve maternal health in Fresno County.

Rationale: Postpartum care continues to be a priority in the 2019 DHCS Strategy for Quality Improvement in Health Care in the delivery of effective, efficient and affordable care under Medi-Cal Managed Care (Priority 2). DHCS has also adopted the strategy of eliminating health disparities in the Medi-Cal population (Priority 7).[1] The PIP proposed by CalViva Health addresses both priorities by aiming to develop interventions specifically for disparities within a population receiving postpartum care. Closing gaps in care due to disparity is also a priority for CalViva Health, which has developed a strategy to address disparities using the Robert Wood Johnson Foundation's definition of health equity:

Health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.[2]

The postpartum visit is important for support of breastfeeding, screening for postpartum mood and anxiety disorders, follow-up of conditions such as diabetes and hypertension, and family planning. It is also often the only time to incorporate the essentials of care between pregnancies, integrate all relevant clinical information and provide information to the patient. Given the disparate rates between the Kerman and Mendota Clinics in Fresno County, and the opportunities identified through barrier analysis and literature review, postpartum care is a critical PIP disparities topic for CalViva in rural Fresno County.

[1] Kent, J. (2017). *2017 DHCS Strategy for Quality Improvement in Health Care (Quality Strategy)*. California Department of Health Care Services (DHCS).
[2] Braveman, P. E. (2017). What Is Health Equity? And What Difference Does a Definition Make? Princeton: Robert Wood Johnson Foundation.

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

The HEDIS measure, Postpartum Care (PPC), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women who completed a postpartum visit including a pelvic exam or postpartum care on or between 21-56 days after delivery, as documented through either administrative data or medical record review. The HEDIS timeframe for postpartum care is from November 6, 2017 to November 5, 2018. The baseline rate of 50% was determined based on the RY 2017 HEDIS data for the high volume, low preforming clinic.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with a high volume, low compliance Clinic with identified disparity in Fresno County to continue to monitor postpartum care rates and disparity activity (Modules 4 and 5).	P	Q1-Q2	CVH/HN
Implement and monitor EMR OB Alert	M	Q1-Q2	CVH/HN
Monitor the use of the revised ACOG OB History Form to address cultural issues	M	Q1-Q2	CVH/HN
Provider Tip Sheet on Postpartum Care will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended postpartum care guidelines.	P	Q2	CVH/HN
Provider level incentive for PCPs to close Care Gaps and improve HEDIS scores	P	Q1, Q2	CVH/HN
Implement Postpartum Member Incentive by sending a $25 gift card to members for whom we receive a correctly completed and timely Postpartum Care Notification Form from their provider in all CVH Counties	M	Q1, Q2	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 RY2018	Rate RY2019	Baseline Source	Baseline Value
HEDIS® Postpartum Care Visits	Meet or Exceed SMART Aim Goal of 64.0%	Fresno: 60.0%	TBD	RY 2017 CVH results	Fresno: 50.0%

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 and identify high risk members by Case Management	CVH/HN		☐		
4. Promote CA Smokers' Helpline to smokers	CVH/HN		☐		
5. Launch a 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)	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 April 30 filing due date	CVH/HN		☐		
4. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN		☐		
5. Group Needs Assessment Update– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement	CVH/HN		☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
Cultural & Linguistics, Health Education and Quality Improvement (QI) programs.					
6. 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		☐		
7. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN		☐		
QUALITY AND SAFETY OF CARE					
Integrated Case Management • Implement use of ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: o Readmission rates o ED utilization o Overall health care costs Member Satisfaction	CVH/HN		☐		
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN		☐		
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health BH) through delegated reports on BH	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)*
(may include member satisfaction surveys, provider surveys, etc.)					
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 evaluation annually.	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 #5

Attachment 5.A

Utilization Management
2019 Program Description

~~2018~~ 2019

Health Net Community Solutions, Inc. ~~of California~~

CalViva Health

Utilization Management (UM)

Program Description

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

The CalViva Health Utilization ~~and Care~~ Management (UM~~/CM~~) Program Description summarizes the policies, processes and standards that govern ~~Health Net's~~ UM~~/CM~~ programs. Detailed policies and procedures support this document to assist in program implementation and to provide a step-by-step procedural instruction for Utilization ~~/ Care~~ Management staff in the program execution of both delegated and non-delegated models.

The Program is structured to assure that medical decisions are made by qualified health professionals, using written criteria based on sound clinical evidence, without undue influence ~~of Health Net management~~ or concerns for the plan's fiscal performance.

The Utilization~~/Case~~ Management Program Description summarizes the utilization management policies and procedures, the utilization management process, and the use of utilization management standards.

The Utilization Management Program delegates specified aspects of medical management to utilization management committees established by each Participating Provider Group (PPG).

The level of delegation is based on Health Net's pre-contractual and annual evaluation of the PPG's performance of utilization management functions.

Background

~~Health Net of California, Inc., is a wholly owned subsidiary of Health Net, Inc., a managed care organization with health care operations throughout the United States. Health Net, Inc. is a subsidiary of Centene Corporation, a publicly traded company.~~ CalViva Health is contract~~s~~ed with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for ~~network~~ utilization management services. Health Net Community Solutions, Inc. is a subsidiary of Health Net, ~~Inc~~LLC. ~~Health Net, Inc. is a subsidiary of~~ and Centene Corporation, a publicly traded company. Health Net is a registered service mark of Health Net, LLC.

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net or CalViva Health.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, medical records and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the UM~~/CM~~ Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information is regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, are available to all HN ~~associates~~ staff via the corporate intranet website, "~~Learning Management System~~Cornerstone Learning".

The Health Net~~, Inc.~~ Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

Information Systems and Analysis

Health Net's Information Systems consist of various integrated subsystem databases, which support UM~~/CM~~. The major sources of data utilized for UM~~/CM~~ activities are obtained from the following subsystems:

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Medical Management
- Customer Service
- Appeals and Grievance
- Case Management

Analytical resources are directly available from the following Health Net ~~of California~~ departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, National Medical Advisory Council, Customer Services and Claims. Additional sources of information include member and provider feedback.

Section 2

Mission

Centene Corporation

"Transforming the health of the community one person at a time by offering unique, cost-effective coverage solutions for low-income populations through locally based health plans and a wide range of specialty services."

Health Net~~, Inc.~~ Mission

The mission of Health Net~~, Inc.~~ is:

"To help people be healthy, secure and comfortable."

State Health Programs UM~~/CM~~ Vision

The mission of Health Net's State Health Programs Utilization Management ~~and Care Management~~ Program is to design and implement programs that facilitate the highest level of the member's health care outcomes, and to monitor and evaluate the effectiveness of these programs in compliance with the Health Net Medi-Cal Contract, and State and Federal regulations.

The Utilization ~~and Care~~ Management Program identifies and manages members who are currently accessing health care services.

The purpose of the UM~~/CM~~ Program is to:

- Assist in the coordination of medically necessary health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address access and timeliness of care
- Initiate documentation to support investigation of potential quality of care issues
- Identify and resolve problems that result in excessive resource utilization and inefficient delivery of health care services
- Identify and resolve problems that result in under or over utilization
- A~~cc~~ssess the effects of cost containment activities on the quality of care delivered
- Promote the role of the primary care physician in the management of patient care

- Identify opportunities to improve the health of members through ~~disease management activities, focused population interventions, preventive care services and~~ coordination with Case Management and Public Health Programs
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs
-

Goals and Objectives

The Program has the following specific objectives:

- Monitor consistency in application of all UM~~/CM~~ functions for members
- Review and evaluate health care services for quality, medical necessity and appropriate levels of care
- Identify actual and potential quality issues through this review process and refer to the appropriate quality management personnel
- Evaluate the need for case management and discharge planning in coordination with the PCP
- ~~Analyze the effectiveness of outcomes achieved from case management~~
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Case Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Provider Oversight to determine delegation status for UM activities
- Evaluate the UM Program on a regular basis to respond to changes in the health care environment

- Collaborate with county Public Health-Linked Programs

Section 3

Description of Program

Description of Program

Utilization and Care Management

The Health Net Utilization ~~and Care~~ Management Program is designed for all State Health Program members to receive quality, medically necessary health care services, delivered at the appropriate level of care in a timely, effective manner by Health Net's delegated and non-delegated providers. The Utilization~~/Case~~ Management Program is under the clinical supervision of the Health Net Chief Medical ~~and Health Care Services Operations~~ Officer who has substantial involvement in developing and implementing the Program.

Scope of Utilization ~~and Care~~ Management

The scope of Health Net's non-delegated Utilization Management activities includes timely, direct referrals, preauthorization's, concurrent review, discharge planning, care management ~~and/or long term catastrophic case management, disease management, Palliative Care Referrals~~ and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code 1367.01.

Through Health Net's Provider Oversight Process, Participating Provider Groups (PPGs) may be delegated the responsibility for the aforementioned UM activities.

Health Net has developed, implemented, and continuously updates and improves the UM Program to ensure appropriate processes are in place to review and approve the provision of medically necessary covered services. The plan has qualified staff who are responsible for the UM ~~program~~Program. The plan separates its medical decisions f~~o~~rom fiscal and administrative management to assure the medical decisions are not unduly influenced by fiscal and administrative management. The plan ensures covered services are provided as set forth in the California Code of Regulations (CCR), Title 22, Chapter 3, Article 4, beginning with Section 51301 and CCR, Title 17, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, except as excluded under the terms of the Plan's Medi-Cal contract and as referenced in applicable Medi-Cal Managed Care Division (MMCD) Policy Letters. Additionally, Health Net's State Health Programs Utilization Management ~~and Care Management~~ Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and MRMIB for Utilization Management and Care Coordination activities.

The ~~program~~ Program is conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq~~.~~.

Prior authorization is not required for emergency and sensitive services, family planning services, annual preventive care visits to an OB/GYN, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective pregnancy termination, basic obstetrical care, minor consent services, and immunizations at the Local Health Department (LHD). Utilization Management policies and procedures are available to members and providers upon request.

Health Net Utilization ~~and Care~~ Management nurses provide decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources to support the plan of care. ~~Care Managers may include registered nurses, social workers and other health professionals with significant clinical experience. Care managers work collaboratively with members and/or family and the member's care team to manage care and resources across the continuum. The member's care team may include the member's physician(s), care providers, hospital and/or skilled facility utilization management and discharge planning staff, social workers, and members of the hospice or palliative care team.~~

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Health Net and its delegated PPGs do not require prior authorization for emergency and sensitive services as outlined under the Scope of Utilization ~~and Care~~ Management section of the UM~~/CM~~ Program Description. Direct referrals enhance the member's ability to directly access specialists such as dermatologists, podiatrists, ophthalmologists and OB/GYNs.

Preauthorization / Prior Authorization

Health Net requires delegated PPGs to create and maintain programs, policies and procedures, which at a minimum, meet Health Net's established standards. Health Net Utilization Management staff determines pre-service decisions for request types that are not delegated.

Pre-service decisions include both the initial determination of requests for urgent and non-urgent services and requests for continuity of care services. Pre-service decisions are required for elective inpatient admissions, referrals for selected ambulatory surgery, home health care, durable medical equipment, home IV infusion, and selected diagnostic and radiology procedures. The purpose of obtaining a pre-service decision is to prospectively evaluate proposed services to determine if they are medically necessary, covered by the member's benefit plan, the most current and appropriate medical interventions utilizing criteria for determining medical and behavioral health appropriateness that are based on

sound clinical evidence, provided by a contracted practitioner or provider, where appropriate or possible, and provided in the most appropriate setting.

Health Net has established a referral tracking process to track and monitor referrals requiring prior authorization. Health Net's referral tracking system includes authorized, denied, deferred and/ or modified referrals. Finally, the process of referral tracking includes monitoring of timeliness.

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for hospitalized patients. Any review for continued benefit coverage and provision of an approved ongoing course of treatment over a period of time or number of treatments. Concurrent review is a Member member-centric process that includes medical necessity review, discharge and transitional care planning and coordination of care.

A goal of CCR is to support the Member and Member's healthcare team to optimize health outcomes during in the event the Member experiences a health status change. This is done through CCR work and advocacy with the PPG, Member and the Interdisciplinary Care Team to:

- 1) Ensure services are accessed timely,
- 2) Education Educate to the Member's healthcare team on the Member's benefit structure and resources,
- 3) Facilitateion of expeditious authorizations of services when appropriate, and
- 4) Facilitateion of referrals to appropriate Member resources, such as Managed Health Network, Inc. (MHN), case management, and community resources.

The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and Member care management support programs. Health Net nurses and Medical Directors, delegated partners, and MHN conduct onsite or telephonic concurrent review of patients admitted to hospitals, rehabilitation units, or skilled nursing facilities. HN may monitor and provide concurrent review support for selected delegated partners, which retain a UM delegated status. The inpatient review process occurs within 1 business day from the day of hospital admission or within 1 business day of notification of admission and continues throughout the patient's hospital stay. The review process includes application of standardized nationally recognized criteria for medical appropriateness review, levels of care, discharge planning, and transitional care management including assessment of medically appropriate alternatives to inpatient care.

The concurrent review nurses use nationally recognized criteria, which includes InterQual® criteria, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy Policy to assess the appropriateness of the admission, level of care, and length of stay. The determination of medical appropriateness includes consideration of the individual patient's needs, as well as the capacity of the local delivery system such as in remote sections of the state. Board-certified physician specialists are utilized in making medical determinations as needed.

Health Net non-clinical ~~associates~~ staff supports pre-service and concurrent review ~~by~~ with data entry, receipt~~,~~ and documentation of notification, and receipt and attachment of clinical content. Reviews of requests that do not meet guidelines or criteria for certification are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess for member specific case management and disease management needs and refer such cases to case management for evaluation. Concurrent Review Nurses collaborate with Case Managers on all members identified in active case management.

CCR goals include supporting the member and member's healthcare team to optimize health outcomes ~~during~~ in the event the member experiences a health status change. This is done through ~~our~~ work and advocacy with the PPG, member and/or the interdisciplinary care team to 1) ensure services are accessed timely, 2) educat~~eion~~ to the member's healthcare team on the member's benefit structure and resources, 3) facilitat~~eion of~~ expeditious authorization~~s~~ of services when appropriate, and 4) facilitat~~eion of~~ referrals to appropriate member resources, where appropriate, such as MHN, case management, and community resources. The CCRN supports a smooth transition from the acute care setting or SNF to the next level of care/community by bridging the inpatient to outpatient process through facilitation of health care services and member care management support programs.

Discharge Planning

HN, MHN and/ or delegated partners conduct and facilitate discharge planning to promote continuity and coordination of care in conjunction with the practitioner, member, and member's family to ensure a timely and safe discharge. Discharge planning begins pre-service or on the first day of the member's admission, whenever possible. The concurrent review nurse is responsible for facilitating, coordinating and authorizing referrals for discharge needs, including but not limited to, home health care, durable medical equipment and/or transfers to a lower level of care (e.g., skilled nursing facility or acute rehabilitation).

HN Concurrent Review nurses identify potential case management cases and refer such cases to Case Management and other outpatient programs for post discharge evaluation and/or services

The criteria used for evaluating and guiding timely discharge planning is nationally recognized criteria including InterQual®, Hayes, Medicare Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) or Guidelines and Health Net's Medical Hierarchy policy. Discharge planning is part of the Utilization/Care Management Program and includes, but is not limited to:

- Assessment of continuity of care needs.
- Assessment of member's support system to determine necessary services and support needs.
- Development of a ~~plan~~ discharge plan of care based on short-term medical/psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

~~*Transition Care Management Program*~~

~~The purpose of the Transition Care Management Program 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 Transition Care Management Program (TCM) is a care transition model that utilizes the Coleman Care Transition Intervention (CTI) as the underlying foundation. The TCM 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.~~

~~Health Net's TCM conceptualizes the Coleman model within its foundation. 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 role playing and 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 the progress toward established goals
- Discussing encounters with other health care professionals
- Reinforcement of the importance of maintaining and sharing the PHR
- Supporting the patient's self-management role
- Medication reconciliation with access to Health Net pharmacist.
- Educating 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 Integrated 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 located throughout California. They are linked through common management teams and systems. Health Net's Medical Directors participate in all aspects of Care Transition/Transition Care Management operations.~~

Retrospective Review

Delegated PPGs conduct retrospective review activities in compliance with Health Net standards. Conversely, Health Net performs this activity for non-delegated providers.

Health Net and its delegated partners perform post-service review of medical records when services rendered have not been authorized. Any services failing to meet criteria are forwarded to Health Net and delegated partners' medical directors for final determination and payment adjudication recommendations. The purpose of post-service review is to evaluate the request for authorization against documented medical record evidence that the member received the services and that services meet the criteria for medical necessity. Post-service review determinations are processed within the timeframes specific to the product line after obtaining all necessary information required to review the request.

Second Opinion

A member, member's authorized representative or provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned members who request a second opinion to a participating physician within their medical group. If a member requests a second opinion about specialty care from a participating specialist physician who practices outside of the member's PCP's medical group, the request will be forwarded to Health Net medical management for review. Health Net does not routinely require prior authorization for such services given that the second opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the member to

obtain a second opinion outside the network. There is no cost to the member for second opinion either in network, or authorized out of network.

Members may obtain a second opinion from a qualified health care professional. If an appropriate professional is not available in-network, Health Net will arrange for the member to obtain a second opinion out-of-network at no cost to the member.

Management of Information Systems

Health Net utilizes automated documentation systems to enter, view, and audit medical ~~and case~~ management information.

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver quality, cost effective medical services to members and their dependents. Selection of a Primary Care Physician (PCP) and establishment of a relationship with that physician is the foundation for members obtaining appropriate health care services. PCPs include Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access / Availability to Health Care Services

An ongoing review of the Health Plan's network is conducted to ensure the availability and access to all needed levels of care. The review includes an analysis of the scope of the network physicians, including Primary Care Physicians, specialists, facilities and ancillary services in relationship to members' needs. Site and medical record reviews are also conducted to ensure that access to care and services, and the confidentiality of member records are met. Recruitment will take place in areas where unmet needs are identified.

Coordination with Quality Improvement Programs

The Health Net State Health Programs Utilization~~/Care~~ Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the appropriate committees. Corrective actions, as appropriate, are required to continually improve care and service.

Coordination with Internal Programs

For delegated providers, Health Net requires regular, standardized UM reports. For non-delegated providers and with the aforementioned submitted material, Health Net's Utilization Management Department:

- Identifies and refers sentinel events and potential quality of care/service issues to the Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization management and care management activities.
- Identifies and refers appropriate members for Public Health and "Carve Out" services, e.g., CCS, Members with Serious Mental Health, School Based Services (LEA carve out) and Regional Centers
- Identifies and refers appropriate members for Health Education Services, including tobacco cessation and obesity prevention programs.
- Identifies and refers appropriate members for Cultural and Linguistic Services, including members needing translation of documents or interpreter service for office visits
- Offers Disease Management (DM) Programs for all members who meet enrollment criteria for specific gateway conditions regardless of a member's delegated provider group status. DM activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

MHN Services is ~~a~~ the behavioral health ~~TPA contracted with~~subsidiary of HNCS and HNCA ~~to~~ that administers the Medi-Cal mild to moderate mental health services carved in to the Managed Care Plans.

MHN provides early and periodic screening, diagnosis and treatment services for members ages 0 to 21. These services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other ~~evidence~~ evidence-based behavioral intervention services that develop or restore, to the maximum practicable, the functioning of the members diagnosed with Autism Spectrum Disorder (ASD) as well as other disorders that result in behavioral disturbances. ~~Prior to February 1, 2016, members may have received these services either from MHN or the Regional Center. Beginning February 1, 2016, members who were receiving their services at the Regional Center transitioned and received their services from MHN and not the Regional Center.~~

~~These preparations include ensuring continuity of care by initiating single case agreements for non-panel providers, interfacing with Regional Centers to facilitate a seamless handoff,~~

~~streamlining utilization management procedures to accommodate the increase in volume, and adding additional staff as needed.~~

MHN will manage specified mental health benefits to adults and children who are diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Members with moderate to severe distress or impairment~~,~~ as well as members seeking other services not provided by MHN, will be referred to the County Specialty MHP.

~~-~~MHN's utilization management decisions are based on ~~McKesson's~~ Change Healthcare's InterQual Level of Care Criteria; MHN's evidence-based internal criteria; and the Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). MHN's evidence-based internal criteria guidelines are based on a variety of clinical sources such as the evidence-based American Psychiatric Association Practice Guidelines.

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). MHN and Health Net do not impose Quantitative(QTL), or Non-Quantitative Treatment Limitations(NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. CalViva will cover the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered a Non-Quantitative Treatment Limitation (NQTL) under the definitions of the federal rules. MHN may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by MHN and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical~~-~~ and mental health and substance use disorder

benefits. Factors considered in the determination process will be supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

The core objective of utilization management at MHN is to manage ~~the~~ available behavioral health care benefits to achieve the best possible clinical outcomes for members with the most efficient use of resources. The focus of the process is on care, not costs. To that end, MHN has developed a clinical infrastructure to support its system as follows:

- Treatment is in the least restrictive setting at which safe and effective treatment can be rendered; this helps to preserve and foster as much independence, freedom and autonomy for the patient as possible.
- Multidisciplinary cooperation ~~to~~ incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation ~~which~~ views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The MHN utilization management program provides clinical~~encompasses pre-service, concurrent, and post-service~~ review for services requiring authorization. The bulk of the outpatient services provided by MHN do not require authorization. All MHN staff making utilization management decisions are appropriately ~~inpatient, alternative and some outpatient care of CalViva Health members. L~~licensed Care Managers and Medical Directors~~professionals and Customer Service Representatives coordinate these activities~~. MHN staff providing services to CalViva members ~~The Care Managers and other treatment team members~~ are located at MHN ~~Service Centers~~offices in California.

MHN coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, ~~Inc.~~LLC Health Net Pharmaceutical Services, administers and manages the prescription drug benefit including select injectable for Health Net ~~of California~~'s Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Pharmacy Prior Authorization, Recommended Drug List/formulary management, Education programs for physicians, pharmacies and members, and Pharmaceutical Safety.

The basic Medi-Cal "formulary" is prescribed by the state; however managed care organizations have latitude within each drug class for equivalent substitution. A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications for placement on the formulary, as well as approve all criteria guiding prior authorization decisions.

~~Care Management~~

~~Delegated PPGs conduct basic care management activities in compliance with Health Net's standards.~~

~~In both delegated and non-delegated situations, the Care Management Program provides individualized assistance to members experiencing complex, acute, or catastrophic illnesses and members who are out-of-area. The focus is on early identification of high-risk members, applying a systematic approach to coordinating care and developing treatment plans that will increase satisfaction, and improve health and functional status. In addition, certain Care Management responsibilities are an integral part of Carve-Out and Public Health Programs, for example, CCS or Regional Center Programs.~~

~~The Care Management Program of Health Net's State Health Programs uses actively licensed nurses, social workers, and Medical Directors to provide an integrated network of programs and services for the management of high-risk, chronic, and catastrophically ill or injured individuals.~~

~~Health Net makes available a comprehensive, high-risk perinatal Case Management Program to State Health Program members regardless of delegation status. Care Managers work with Primary Care Physicians and other providers to develop individualized plans for appropriate members.~~

~~Integrated Case Management (ICM) Program~~

~~The Plan makes case management services available to all members.~~

~~The goals of the ICM 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 self-management and 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 tools to empower the 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:

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

Members are initially identified for participation in the program using data stratification that includes:

- Claims and encounter data
- Hospital discharge data
- Pharmacy data
- Information gathered as part of the Health Information Form and concurrent review process, as applicable.

Members may also be identified for case management programs by direct referral from sources, which may include:

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

- A practitioner request for case management

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.

MemberConnections

MemberConnections is a special educational and outreach 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

Continuity and Coordination of Care

Several mechanisms are implemented to monitor, evaluate and facilitate continuity and coordination of care among its members served by delegated and non-delegated providers. These activities include:

- The administration of care management for complex cases requires the use of multiple health services. Care Managers act as facilitators, resource finders and coordinators who are responsible for bridging communication and problem solving with practitioners. In addition, they assist in facilitating members and their families to implement a smooth and coordinated plan of care.

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers. Care Managers are patient advocates who ensure that these members receive timely and uninterrupted medical care during the transition process.

- Implementation of specific population-based, disease management or disease-focused interventions such as interventions for frequent emergency room utilization, high risk perinatal case management, asthma or diabetes.

Primary Care Physician responsibility:

The Primary Care Physician is responsible for the management and coordination of a member's complete medical care including initial and primary care, initiating specialty referral, and maintaining continuity of care to include coordination of specialty care, emergency services, and inpatient services.

Health Net supports the medical home model of primary care, and provides significant support to the primary care provider practices. This support ensures the primary care doctor has all care plans, and health risk assessments created by Health Net's programs or by one of the County or carve out programs such as CCS on file. Health Net requires that primary care providers provide in-office access to patients at a minimum of 20 hours per week and have availability for urgent and emergent member needs 24 hours a day, 7 days a week.

As an additional aid to the primary care provider, Health Net provides Nurse Advice and Triage line 24 x 7. Health Net strives continually to meet the access and availability standards through our network relationships, member and provider education and Triage services.

Population Based Programs/Be In Charge!℠ Programs

In 2016 Health Net began transitioning the *Be In Charge!℠* Programs. Complex Case Management transitioned in-house in September 2016 and was titled Integrated Case Management. The other programs are expected to be transitioned to Envolve PeopleCare in 2018.

Be In Charge!℠ Programs

CalViva Health provides the *Be In Charge!℠* Programs for Medi-Cal members to help manage their health. These programs provide specific interventions to facilitate the member's individual 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 goal of the *Be In Charge!℠* Programs is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to have member engagement and to have preventative wellness, and chronic care disease management in accordance with national peer-reviewed published guidelines. Preventative medicine services, achieved through proactive education and active engagement of the members, promotes optimal health.

The *Be In Charge!℠* Programs include:

- Disease Management
- Nurse Advice Line
- Adult Weight Management
- Raising Well Pediatric Weight Management
- Audio Library
- Health education classes and programs are offered in specific counties to target issues identified for the Medi-Cal population, such as asthma, diabetes, nutrition, heart health, hypertension and healthy pregnancy.

Disease Management

The Disease Management – *Be In Charge!℠* Program provides disease specific management for members with asthma, diabetes, and heart failure (HF. 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, better functional status. 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 Integrated 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. The NAL is URAC accredited.

Adult Weight Management

Members age 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 85th percentile are eligible for the program. Participants, including their parents or guardians, are given personalized, telephonic support from health coaches who specialize in weight management. Coaches include registered dietitians, 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.

Health Education

Health Net State Health Programs provides health education programs, materials, and services to Medi-Cal members. These services are based on community health, cultural, and linguistic needs to encourage members to practice positive health and lifestyle behaviors, to use appropriate preventive care and primary health care services, and to follow self-care regimens and treatment therapies. Health education services may include individual, group and community-level education, and are supported by trained health educators to encourage positive health and lifestyle behaviors. Health Education programs, services and materials vary by membership type but generally include:

- Weight Management Programs – In addition to the adult and pediatric weight management programs, members also have access to Fit Families for Life community classes and print educational resources to help members achieve healthy eating and active living.
- Pregnancy Matters – Pregnancy members receive educational resources including text messaging to help them achieve a successful pregnancy and healthy baby.

- ~~California Smokers' Helpline - The service provides personalized telephonic counseling and educational resources.~~
- ~~Healthy Hearts Healthy Lives Program - Members can access preventive and disease management resources to maintain a healthy heart.~~
- ~~myStrength™, an online wellness program that addresses depression, anxiety, and substance abuse. This program is available at www.mystrength.com or through the myStrength mobile app.~~
- ~~Community Health Education Classes - Members can participate in health promotion classes covering topics such as diabetes, nutrition, exercise, asthma, hypertension, dental, pregnancy, parenting and more.~~
- ~~T2X – Members can participate in electronic health education campaigns and programs through the web, mobile applications, and text messaging. Current campaigns and programs include asthma, immunizations, nutrition, smoking cessation, anti-bullying, sexually transmitted diseases (STDs), adolescent well care visits, talking to their doctor, teen pregnancy, and depression. More topics will be added in the future.~~
- ~~Health Education incentive programs- Members may participate in various incentive programs to encourage them to receive postpartum visit, get certain preventive health screenings, and attend community health education classes.~~
- ~~Health Promotion Text Messaging Programs-Medi-Cal members may participate in various text messaging programs to get educational messages and health reminders to stay healthy.~~
- ~~Health Education Materials - Members have access to culturally appropriate health education brochures, flyers, newsletter, and screening guidelines on 25 health topics and up to 3 threshold languages.~~

Over and Under Utilization

All providers are required to submit to Health Net claim/encounter data for all services. Multiple methodologies are utilized to monitor under and over utilization, referral timeliness, provider appeals, denials and member appeals and grievances. The types of methods include:

- Annual on-site evaluation of network-wide PPGs Medi-Cal utilization management programs
- Over/Under utilization identified through member complaints tracking
- Focused audits
- Analysis of medical group-specific inpatient utilization, ER usage, and pharmacology data
- Evaluation of individual direct contract physician practice patterns

Also through these monitoring efforts, Health Net's Utilization Management Department regularly tracks its performance.

Through these comprehensive monitors, Health Net's Utilization Management Department:

- Measures compliance to guidelines
- Tracks performance against established goals
- Educates and addresses variances from agreed upon clinical criteria
- Conducts provider outreach programs to modify performance

Finally, Health Net completes the Quality Management education process with its contracted providers through local interaction with the regional Medical Directors at the Joint Operations Meetings, the Delegation Oversight team, the Provider Manual and Provider Updates, corrective action plans, the peer review and credentialing process.

Utilization Decision Criteria

~~Health Net's State Health Programs Utilization Management Program utilizes recognized guideline and criteria sets for utilization decision making, such as Title 22, DHCS Manual of Criteria for Medi-Cal Authorization (MOC) and Medi-Cal Provider Manuals.~~

Health Net's State Health Programs Utilization Management Program ~~will~~ use the following guidelines to make medical necessity decisions (numbered in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

~~Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for programs under Federal oversight such as Medicare). Federal definition of medical necessity: 42 CFR 438.210(a)(5) and expanded for those under the age of 21 in 42 USC Section 1396d(r)~~

A. State law/guidelines ~~(e.g., when State requirements trump or exceed federal requirements):~~ (Title 22 CCR, Title 17 CCR, Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters, and California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v))
B. Plan-specific clinical policy

~~Centene clinical policy~~

C. If no Plan- ~~or Centene-~~specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;
D. In the case of no guidance from A-E, additional information that the applicable Health Plan Medical Director will consider, when available, includes:
   1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
   2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
   3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
   4. Medical association publications;
   5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
   6. Published expert opinions;
   7. Opinion of health professionals in the area of specialty involved;
   8. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:
A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
D. Preferred Drug List (PDL)

~~Note for Medicaid members: w~~When state Medicaid coverage provisions conflict with the coverage provisions in Plan- or Centene-specific clinical policy, state Medicaid coverage provisions take precedence. ~~Please r~~Refer to the state Medicaid manual for any coverage provisions.
~~Health Net also follows the National Policy - Hierarchy Medical Resources for Utilization Management criteria which includes the use of InterQual® Clinical Decision Support Criteria along with other company- based medical policies and technical assessment tools which are approved by the Health Net Inc. Medical Advisory Council (MAC).~~

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's ~~of California's Medi-Cal~~ UM~~/CM~~ Program, medical decisions made by Plan or PPG medical directors will not be unduly influenced by fiscal or administrative management. In order to accomplish this, Health Net affirms that:

- Utilization management decisions are based on medical necessity and medical appropriateness

- Health Net does not compensate physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and attention is paid to the risk of under-utilization
- Health Net and its delegates distribute to all practitioners, providers, ~~members~~ , and employees a statement describing Health Net's policies and restrictions on financial incentives
- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service
- Health Net Regional Medi-Cal Medical Directors and the Chief Medical Director for State Health Programs do not report to Health Net's Chief Financial Officer or its Marketing Director.

Consistency of Application of Utilization Decision Criteria

Health Net's Regional Medical Director, Care Managers and CalViva Health Chief Medical Officer participate in biweekly regional Utilization Management rounds. At these meetings, a selection of appropriate inpatient admissions and outpatient services are reviewed and summarized. Problematic cases are discussed in detail to promote staff education and appropriate utilization. Potential PPG management issues are identified and referred to the Provider Oversight Department.

Inter-rater Reliability Review Process:

Health Net's Medical Directors and Registered Nurses who perform UM and CM activities all participate annually in the InterQual® Products Group Interrater Reliability (IRR) Program. The Acute, Home Care, Imaging, and Procedures modules may all be required, in adult and pediatric versions, depending upon the reviewer's job description. A passing score must be achieved, or corrective action plans are developed. IRR results are reported annually at the Health Net State Health Programs UMQI Committee Meeting.

Health Net evaluates delegated PPGs' consistency of application of decision criteria through:

- Annual PPG oversight audit, which requires a file audit of denial files using Health Net Provider Delegation Audit Tool with Medi-Cal Addendum
- Annual PPG oversight audit with specific inter-rater reliability verification
- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed.

Standards of Timeliness of UM Decision Making

Health Net follows established time frames for internal and delegated PPG decision making to minimize any disruption in the provision of health care. The established time frames regarding medical necessity and authorization depend on the urgency of the clinical situation. Turnaround Time (TAT) Standards for requests are based on current DHCS, DMHC, and/or State regulatory guidelines, whichever guideline maintains the most stringent standard, is applied.

Health Net's delegated providers are informed of the decision timeliness standards in the Provider Operations Manual. A Health Net Medical Programs Manager, assessing the compliance of each medical group, performs an annual evaluation including review of timeliness. All requests for determination are communicated back to the member and the provider within the timeframes and methods dictated by the DHCS, DMHC, and/or State regulatory guidelines, whichever is the most stringent requirement.

Denials

A member case is referred to the appropriate clinical practitioner, i.e., a Medical Director or a Pharmacist when UM medical necessity criteria are not met. He/she may request additional pertinent clinical information, may contact the requesting practitioner by telephone to discuss the case, or may consult with a board-certified medical specialist before making the determination of medical necessity.

The appropriate clinical practitioner makes UM medical necessity denial decisions, clearly stating the reason for the denial. Members, practitioners and providers receive written notification of all denials in accordance with all regulatory guidelines

Denial notification letters include the reason for the denial, criteria utilized in the decision, benefit coverage when appropriate, the appeal mechanism, the right to a Fair Hearing, DHCS and DMHC required specific language, and alternative treatment recommendations when applicable. Health Net has implemented translation of denial letters into "threshold languages" in collaboration with Industry Collaboration Effort (ICE).

Rationale contained in denial letters includes a *summary denial reason/rationale* that is easily understandable for the member. In addition, a *detailed denial reason/rationale* is included which outlines benefit provisions, guidelines, protocols or similar criteria on which the denial is based.

Appeals

A licensed physician reviews all member medical necessity appeals.

CalViva Health does not delegate the appeals process. CalViva Health has established procedures and turnaround times for standard and expedited appeals including the right to an external review.

Under the Administrative Service Agreement with CalViva Health, CalViva Health is responsible for appeals for their members. However, Health Net receives the appeal, collects the clinical information, prepares the case and initial review and determinations are made by a Health Net State Health Programs Medical Director. The case is forwarded to the CalViva Health CMO for review and final determination.

CalViva Health maintains well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials issued by CalViva Health, MHN or its delegates.

Each denial letter that is sent to the member includes the member's right to appeal and/or fair hearing, independent medical review, and instructions on how to initiate a routine or expedited appeal.

The member's right of appeal is communicated to the practitioners in the Provider Operations Manual and to the members in the copies of denial notifications sent. The Member Handbook also delineates the appeals process describing how to initiate an appeal verbally by contacting the Member Services Department by phone. The Member Services representative then forwards requests for member appeals to the Appeals and Grievances Department.

Practitioner appeals are forwarded to the Provider Services Department. Appeals initiated by practitioners on behalf of a member for medical services that have not yet been provided are considered to be member appeals.

Health Net Medical Directors will utilize board certified physician consultants from appropriate specialty areas, including behavioral health, to determine medical necessity when specialty specific input is deemed necessary.

Evaluation of Medical Technology and Procedures

Health Net performs technology assessment through formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages. Health Net's Medical Policy Department provides support in the development of technology statements in response to specific requests and for proactively assessing current medical literature for new technology that may be sought by members.

Health Net utilizes nationally recognized primary sources for evidence based information including the Hayes Medical Technology Directory, ~~McKesson's~~ Change Healthcare's InterQual criteria and information from nationally recognized evidence-based medical journals, colleges and academies. Health Net may also perform a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness, as reported in peer–reviewed journals, seek opinions and assessments by relevant specialists, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations and use reports and publications of government agencies (for example, the Food and Drug Administration [FDA], Centers for Disease Control [CDC], National Institutes of Health [NIH]).

Health Net Medical Policies are developed to guide utilization management decision making when there is no InterQual criterion or the InterQual criteria need to be revised to meet the needs of the population. These policies are developed through the review of the peer reviewed evidence based medical literature.
Once approved, it becomes established Health Net medical management policy, and providers and members have access to the information on Health Net's website. The clinical criteria are reviewed at least annually by the policy committees or more frequently as dictated by current medical literature. Satisfaction with the Utilization Management Process

At least annually, Health Net surveys members and practitioners regarding their satisfaction with utilization management procedures and addresses identified areas and sources of dissatisfaction with interventions implemented by Health Net or delegated PPGs. Reports are presented at the ~~Health Net Community Solutions~~Health Net UMQI Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the ~~Health Net Community Solutions~~Health Net UMQI Committee.

Communication Services

The Plan, MHN and the delegated partners provide access to Utilization Management staff for members and practitioners seeking information about the utilization management process and the authorization of care. Staff within Health Net, MHN and delegated partners are available at least eight hours a day during normal business days to receive and respond to inbound inquiries. In addition, Medi-Cal members have 24/7 access to the Nurse Advice and Triage Line. Inbound and outbound communication regarding utilization management issues are accomplished through the following:

- Toll-free member/provider services telephone number/fax or email.
- Voicemail message capability during and after business hours; message retrieval for messages left after hours performed the next business day.
- Free translation and interpreter services for CalViva Health members upon request.

The Plan will notify contracting health care providers, as well as, members and potential enrollees upon request of all services that require prior authorization, concurrent authorization or post-service authorization and ensure that all contracting health care providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

Emergency Services

Health Net and its delegated PPGs provide geographically accessible coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider and needed to stabilize an emergency medical condition. Emergency services are covered both inside and outside the plan or network and do not require pre-authorization.

Evaluation of the Health Net State Health Programs UM~~/CM~~ Program Description and the UM~~/CM~~ Policies and Procedures

After Health Net completes its internal review and approval process, the CalViva Health UM~~/CM~~ Program Description is forwarded to CalViva Health for review and approval.

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Health Net's Chief Medical ~~and Health Care Services Operations~~ Officer has direct responsibility for the Utilization~~/Care~~ Management Program.

Health Net Organizational Structure and Resources

MHN Medical Management Resources

The MHN Medical Director is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. They participate in UM activities such as the MHN UM/QI Committee and the HN CA Utilization Management Committee (UMC), as well as quality improvement committee activities.

MHN Medical Staff have duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery and ensuring that adequate and timely BH services are available to all HN members. The MHN Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the MHN UM/QI Committee, and to the Health Net Quality Improvement Committee (HNQIC). MHN Medical Staff sits on the following committees: HN Quality Improvement Committee, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, the MHN Quality Improvement Committee, the MHN Utilization Management Committee and the MHN Clinical Leadership Committee (CLC). Additionally, Health Net Medical Directors and UM/QI staff sits on MHN's QI and UM Committees.

Medical Management Resources

Health Net Chief Medical Officer

The 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 Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

The Chief Medical Officer has decision-making responsibilities for Health Net medical matters. The Chief Medical Officer oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other medical management leadership team members. Medical Management departments for

which he/she has clinical oversight responsibility to include: Quality Improvement, ~~Healthcare Services (UM/CM)~~Utilization Management, Case Management, Appeals and Grievances, Compliance, Program Accreditation and Disease Management.

The Chief Medical Officer's responsibilities include, but are not limited to: leading the health plan in national medical management initiatives and corporate strategic directives; overseeing medical activities, programs and initiatives to monitor quality of care, delivery and access; directing the implementation of the Utilization~~/Case~~ Management Program; working collaboratively with other Health Net departments (e.g., Sales, Marketing, Contracting, Network Management and Pharmacy Management); leading analysis of management, financial and utilization reports to target areas for improvement; and overseeing compliance with accreditation standards and regulatory requirements.

Chief Medical Director, State Health Programs

The Chief Medical Director, State Health Programs (SHP), is responsible for Utilization Management and Case Management activities for Medi-Cal. In addition, the Chief Medical Director is responsible for QI activities for these programs. The Chief Medical Director is the chair of the Health Net Community Solutions Committee and is actively involved in implementing the SHP UM Program. The State Health Programs Chief Medical Director reports to HN's Chief Medical Officer.

Medical Directors

The Medical Directors administer and coordinate the overall development of medical policies, utilization and ~~/~~case management programs and integrating physician services with the organization's medical service and delivery systems to ensure the best possible quality care for the Health Net members in all product lines. The Medical Directors provide input and recommendations to the various departments within the organization as to policies and procedures that impact the delivery of medical care. The Senior Medical Directors participate actively in quality improvement committees and programs to obtain and ensure continued accreditation with regulatory bodies.

Health Net Medical Directors ~~–~~are physicians with current, unrestricted licenses responsible and accountable for ensuring appropriate clinical relevance and focus of the Utilization~~/Case~~ Management Program for all product lines.

The Medical Directors interface with Participating Provider Groups (PPG), individual practitioners and facilities on a day-to-day basis to ensure the performance of the provider community meets established Health Net standards. They facilitate utilization review and quality improvement initiatives to ensure quality and cost effective delivery of health services. The Medical Directors maintain effective, constructive and innovative relationships with the physician groups statewide. They provide expert clinical support and assistance to the Health Net's Utilization~~/Case~~ Management staff and other Health Net ~~associates~~staff.

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as consultants and clinical resources to the Quality Improvement and Utilization Management staff. Committee involvement comprises of Health Net Quality Improvement Committee, Credentialing Committee, Peer Review Committee, Delegation Oversight Committee and Medical Advisory Council.

Healthcare Services (UM/CM) Resources

Vice President, Medical Management ~~and Case Management~~

The Vice Presidents are responsible for executing the Utilization Management Program, which includes but is not limited to, pre-service, inpatient concurrent review, retrospective review and case/disease management. This individual is responsible for the organization-wide implementation, assessment and measurement of utilization management activities in order to improve the quality of care and services provided to the membership.

Director, Medical Management

The Directors are responsible for statewide oversight of the UM~~/CM~~ Program and:

- Oversee~~s~~ the daily operational processes to assure continuum of care.
- Participates in planning and development of processes and procedures to assure organizational and regulatory requirements are met.
- Ensures a patient advocacy approach with a seamless integration of services and balance within the member's benefit structure.
- Emphasizes continuity of transition of care, assisting members in obtaining access to care, and member education.
- Ensures the appropriate coordination and timely CCS referrals.

Health Net UM~~/CM~~ Clinical Staff

HN UM~~/CM~~ clinical nursing staff (i.e. Review Nurses~~Care Managers and Case Managers~~) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Case/Disease Management when appropriate,
- Management of out-of-area cases, and
- Monitoring effectiveness of delegated entities and contracted providers.

Additionally for State Health Plan Members in California

- Referral of members to County CCS offices when eligible
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance~~.~~
- Coordination with County programs, such as County social services for in home support services and County mental health~~.~~

All UM~~/CM~~ LVN, LCSW and RN staff is under the direct supervision of a Manager, HCS or UM~~/CM~~, who is an RN.

Additional licensed and clerical staff supports UM~~/CM~~ activities for all product lines.

MHN Medical Director and MHN Medical Staff

The MHN Medical Director, Western Region, is a board-certified psychiatrist responsible for providing clinical and administrative leadership in the area of behavioral health. In addition to overseeing the implementation of MHN behavioral health program and clinical policies, the MHN Medical Director advises the quality improvement committee/sub-committees on behavioral health issues and provides specialty consultation for UM activities as well as Appeals and Grievances.

The MHN Medical Staff has duties which encompass two areas: overseeing the comprehensive quality improvement program for all aspects of BH care delivery, and ensuring that adequate and timely BH services are available to all HN members. The MHN Medical Staff works with the HN Quality Improvement/Program Accreditation Department staff to collect and analyze data on availability, access, member satisfaction, and continuity and coordination of behavioral health care. Data are analyzed and reported to the MHN QI Committee and to the Health Net Quality Improvement Committees. The MHN Medical Staff sits on the following committees: HN Quality Improvement Committee, HN Credentialing Committee, the HN Pharmacy and Therapeutics Committee, the HN Medical Advisory Council, the MHN Quality Improvement Committee, and the MHN Utilization Management Committee. Additionally, Health Net's Medical Directors and UM/QI staff sits on MHN's QI and UM Committees.

Only physicians, doctoral-level clinical psychologists (as appropriate for behavioral health reviews), and pharmacists may issue medical necessity denial determinations. All licensed staff has education, training and professional experience in clinical practice.

Health Net Community Solutions Committee

The Health Net Community Solutions Committee reports directly to the Health Net Board of Directors. The committee is charged with the monitoring of the medical management and quality of care and services rendered to members within State Health Programs including identification and selection of opportunities for improvements, monitoring interventions and addressing UM and QI activities which effect implementation and effectiveness. In order to integrate UM activities into the QI system, the Health Net Community Solutions Committee biannually reviews reports of the number and types of appeals, denials, deferrals and modifications. The Committee membership includes a designated behavioral health care practitioner for any discussion of behavioral health aspects of UM/QI for this program. The Committee membership also includes practicing network physician representatives. The Health Net Community Solutions Committee is chaired by the Senior Medical Director for SHP and meets quarterly. The SHP Dental UM/QI Committee reports to the Health Net Community Solutions Committee.

Section 5

Delegation

Delegation

Health Net delegates utilization management to eligible contracted Participating Provider Groups (PPGs) and strategic partners (delegated partners).

Health Net has a thorough process in place to assess a potential delegate's readiness for delegation and to systematically monitor the performance. Health Net has designated Clinical Care Administrators (CCA) ~~Medical Program Managers (MPMs)~~ who are registered nurses specially trained to perform this evaluation. ~~MPMs~~ CCAs evaluate and monitor delegated partners annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities. Additionally, ~~MPMs~~ CCAs are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, ~~MPMs~~CCAs, in conjunction with the Regional Medical Directors, focus efforts on delegated partners with areas of noncompliance that~~whose metrics~~ indicate potential problems in the UM process to implement improvement strategies. ~~MPMs~~ CCAs evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC).

Delegated partners are required to submit ~~semi-annual reports (for Commercial HMO and Medicare) or~~ quarterly reports (for Medi-Cal) to Health Net. Reports are reviewed and assessed for content and feedback is given for reports submitted.

Responsibility of Delegation Oversight includes, but is not limited to:

A. ~~Assesses~~ Assessing and ~~determines~~ determining the appropriateness of delegation for each component of the delegated responsibilities: utilization management, ~~integrated case management (for select number of delegated partners), Special Needs Population Model of Care (for select number of delegated partners) administrative services,~~ credentialing and recredentialing, claims processing and payment ~~and disease management~~. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

B. Perform~~ings~~ ongoing monitoring of any open CAP items as requested by the Delegation Oversight Workgroup (DOW)/Delegation Oversight Committee (DOC). This may include additional file reviews, policy and procedure reviews, and educational sessions, on site meetings to ensure the delegated partner is meeting compliance.
C. Performing any additional delegation oversight activities as requested by the DOC.

Delegation Oversight Committee

A. Reviews Delegation Oversight~~the previous~~ activities and recommendations of the DOW~~/DOC~~ and, as needed identifies corrective actions specific to delegated partner(s) that are not meeting compliance. The DOC will review the results of annual or focused audits,

the corrective actions recommended and already undertaken by the delegate, minutes from the follow-up meetings or correspondence with the delegate, and results of follow-up audits, as appropriate.

B. As needed, i~~I~~nitiates remedial actions specific to delegated partner(s) in order to maintain Health Net's compliance with regulatory and accreditation requirements. Remedial actions may include but are not limited to:

- Increasing monitoring/oversight
- Freezing membership
- Revoking delegation
- Terminating the organization's contract with Health Net.
- Imposing financial penalties as allowed per contract.
- Removes sanctions, if appropriate.

Sub-delegation

Delegated partners are obligated to provide oversight and documented evidence of monitoring the utilization review process whenever a sub-delegated provider and/or review organization perform this process. The delegate is required to document evaluation of the following oversight of the sub-delegate activities:

- Written agreement to participate in the delegate evaluation process by the sub-delegate.
- Approval of the sub-delegated contractor's utilization management program.
- A signed sub-delegation agreement.
- Mechanisms for evaluating the sub-delegate's program reports.
- Concise documentation of all utilization management activities that are delegated to a sub-delegate.
- Adherence to reporting requirements by oversight of the sub-delegate.
- At least annual review of the sub-delegate's program.

Onsite review of the contracted delegates shall be performed annually. More frequent assessments shall be performed, as needed. Documentation of these oversight activities shall be maintained by the delegate but must be available for Health Net's review upon request.

Section 6

Utilization and Case Management (UM/CM) Program Evaluation

UM/CM Program Evaluation/Work Plan

UM/CM Program Evaluation

Health Net's Vice President of Medical Management annually prepares the CalViva Health Utilization/Care Management Program Evaluation and presents the evaluation to CalViva Health for review.

The annual evaluation of the CalViva Health Utilization/Care Management Program provides structure for the determination of program effectiveness and the impact of the program on members and providers. The process identifies program strengths and barriers, improvement opportunities and activities not completed, in addition to assessing demographics and effectiveness of the UM/CM Program initiatives.

The process of evaluation includes a comparison of the results of utilization/care management improvement activities against past year's performance. The evaluation documents evidence of resolution of identified problems or areas needing improvement.

Additional sources of data utilized to obtain feedback from providers and members on CalViva Health Utilization/Care Management Program and to identify opportunities for improvement include:

- Member grievances
- Member appeals
- Results of member satisfaction surveys
- Provider appeals
- Provider grievances
- Provider satisfaction surveys
- UM decision making timeliness
- Identification and referral of members eligible for carve-out programs
- HEDIS results
- Information from QI studies
- Joint Operation Meeting information
- PPG Report Cards
- Data and other feedback from Public Health-Linked Programs
- Over and under utilization
- Community Advisory Councils

UM/CM Program Work Plan

Health Net's SHP Senior Medical Director and Vice President Medical Management annually develop the CalViva Health UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan

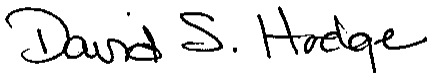
process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Fresno-Kings-Madera Regional Health Authority Approval

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



~~December 19th, 2017~~

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

~~December 19th, 2017~~

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

Health Net Community Solutions UM/QI Committee
Medi-Cal Utilization Management ~~/ Care Management~~ Program Approval

The Health Net Chief Medical Director and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
~~Farid Hassanpour~~Alex Chen, ~~DO~~MD
Chief Medical ~~Director~~Officer

_____ Date _____
Jennifer Lloyd
Vice President of Medical Management

Committee Approval

The Health Net Community Solutions UM/QI Committee has reviewed and approved this Utilization~~/Case~~ Management Program Description.

_____ Date _____
~~Farid Hassanpour, DO~~Alex Chen, MD
Chief Medical ~~Director~~Officer

Item #5

Attachment 5.B

Utilization Management
2019 Work Plan

CalViva Health
2019
Utilization Management (UM)/ Case Management (CM)
Annual Work Plan

Created: January 25, 2019
Last updated: March 13, 2019 2:45 PM PT

Attachment O

TABLE OF CONTENTS

Created: January 25, 2019
Last updated: March 13, 2019 2:45 PM PT

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

Created: January 25, 2019
Last updated: March 13, 2019 2:45 PM PT

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide continuing education opportunities to staff. Conduct Medical Management Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of Continuing Medical Education (CME) standing, verification of certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Monthly As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire and annually thereafter through Cornerstone (online learning platform). Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing April 2019, July 2019, October 2019, January 2020

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup ▪ Health Education Taskforce There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, task forces and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2019. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 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 2019 UMCM Program Description. Write and receive CalViva approval of 2018 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2019 UMCM Work Plan. Write and receive CalViva approval of 2019 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2019 Q 1 2019 Q 1 2019 Q 3 2019 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology 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. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Turnaround times (TAT) • Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	Health Net administers McKesson InterQual® IRR Tool to physician and non-physician UM reviewers annually Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool	<u>Physician IRR</u> Administer Physician IRR test using case review method and McKesson InterQual® IRR tool in Q3-4 2019. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2019.	Q3-4 2019 Q3-4 2019

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.4 UM Process Improvement Initiative	☒ Medi-Cal	Increase Medical Director collaboration with the UM teams to ensure members are receiving appropriate services timely	5% Increase in number of inpatient and preservice referrals for Medical Director review	Managers will huddle with clinical staff daily to review cases. Medical Directors will be attending daily huddles/rounds to identify cases for further consultation and direction. Institute nurse cross training and training regarding appropriate use of policies related to MD referrals, Monitoring productivity report and quality audits by volume and by staff member to ensure referrals are appropriate. MD referral rates will be incorporated into existing reports.	Ongoing Ongoing Jan 2019 and Ongoing Ongoing Q1 2019 and Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
2.5 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals reported to HNCS UM/QI Committee bimonthly Collaborate with QI Department for review of Appeals at least annually, including an analysis of trends. Identify opportunities for removing or adjusting prior authorization requirements or criteria based on appeals that are regularly overturned Bring this analysis to UM/QI committee for discussion and input from community practitioner committee members. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 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. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2019 Goals: • 10% reduction in admissions over prior year • 5% increase in discharge to recuperative and alternative care	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. Focus on the top 10 admitting diagnosis, and long length of stay admissions will also continue in 2019; adding a focus on 0-2 day stay admissions for appropriateness of admission. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. % 0-2 day admits In addition PPG metrics will include: 7. Specialty referrals for target specialties 8. C-section rates. PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis.	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers on a biannual basis and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 2019 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Specialties and PPG's identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional team meetings lead by the Medical Directors.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Claims timeliness 2. Provider dispute volume & timeliness 3. Prior authorization volume & timeliness 4. Specialty referral volume for in network/out of network 5. Specialty referral access timeliness 6. Credentialing volume The DO Dashboard also includes additional data provided on the dashboard where the RMD and the Finance department track and report on i.e. Utilization rate, Financial, HEDIS score etc.	CalViva PPG profile dashboard includes metrics for claims, utilization management processing and timeliness and credentialing for delegated providers CalViva delegated PPGs reports are evaluated on a quarterly basis for variance and compliance rates Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Claims timeliness • Provider dispute timeliness • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. CAPs identified during an annual audit by the HN delegation Oversight is monitored and followed-up by HN Delegation Oversight.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

4. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 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. 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. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, LCSWs, Program Specialists, Program and Care Coordinators to perform physical health and integrated CM activities. Continue use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program. Measure program effectiveness based on the following measures: o Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 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. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Implement use of Pregnancy Program materials to increase outreach to moderate and high risk member through education packets, text reminders, etc. Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Q1 Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFT, and Care Coordinators to perform BH CM activities. Use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 Planned Interventions	Target Completion Date
4.4 Disease Management (DM)	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a 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. Evaluation of outcome data from HEDIS®-like measures. Review/analyze DM partner annual report	Continue transition to insourced disease management programs for: asthma, diabetes, and heart failure. Transition process began Q4 2018. Ongoing program monitoring to assure that reporting needs are met including enrollment statistics.	April 2019 Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2019 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. 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. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data. 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 check write review. Monthly report of PA requests.	Continued active engagement with pharmacy. Continue narcotic prior authorization requirements. Consider implementation of opioid edits based on updated CDC guidelines for prescribing opioids.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.5 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. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2019 Planned Interventions	Target Completion Date
4.6 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2019 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. Based on the standardized formula, monthly report indicates CCS %. Goal: Health Net identifies 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus for SHP. Work in CY 2018 to further develop internal systems and handoffs are expected to yield improvements in 2019. Continue current CCS policies and procedures. 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). 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2019 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Case Management, the Pharmacy Program, the Pregnancy Program, or a Disease Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Disease Management and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2019**				

Item #6

Attachment 6.A

Case Management
2019 Program Description

Health Net

CalViva HEALTH

2019

Health Net Community Solutions, Inc. CalViva Health

Case Management Program Description

Table of Contents

PURPOSE

The purpose of the Case Management (CM) Program Description is to define case management, identify case management functions, determine methods and processes for member identification and assessment, manage member care and measure outcomes.

Delegated Participating Provider Groups (PPGs) conduct basic case management activities in compliance with the Plan's standards.

In both delegated and non-delegated situations, the Case Management Program provides individualized assistance to members experiencing complex, acute, or catastrophic illnesses and members who are out-of-area. The focus is on early identification of high-risk members, applying a systematic approach to coordinating care and developing treatment plans that will increase satisfaction, and improve health and functional status. In addition, certain Case Management responsibilities are an integral part of Carve-Out and Public Health Programs, for example, CCS or Regional Center Programs.

The Plan makes available a comprehensive, high-risk perinatal Case Management Program to members regardless of delegation status. Care Managers work with Primary Care Physicians and other providers to develop individualized plans for appropriate members.

Background

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

Provider Network

Health Net operates largely as a delegated group network model for the delivery of health care. Services are provided under the following types of contractual arrangements:

- Practitioners and providers contracted with Health Net's network of Participating Provider Groups (PPGs)
- Practitioners and providers contracted directly with Health Net or CalViva Health.

Health Net contracts with many multi-specialty Participating Provider Groups (PPGs) throughout California who, in turn, contract with or employ primary care and specialty care practitioners. Health Net maintains contracts with a full range of providers including acute care hospitals, home health care, infusion therapy, dialysis, durable medical equipment, outpatient surgery, radiology/imaging, skilled nursing, rehabilitation, laboratory services and hospices.

Health Net delegates to its PPGs and selected providers specific credentialing, utilization management, medical records and claims functions, where appropriate.

Confidentiality

Health Net has policies and procedures for the collection, handling, storage and release of confidential information to protect the privacy and confidentiality rights of members, employees, providers and the Company, and to ensure the appropriate and legitimate use of information. Health Net contracts require that practitioners and providers maintain the confidentiality of member information and records. Information or copies of records may be released only to authorized individuals as permitted by state and federal law.

Prior to participation in the CM Program, participants are educated regarding confidentiality requirements. All protected member information is maintained in a secure fashion in accordance with federal and state law. All staff charged with handling any confidential member information is regularly updated in privacy and confidentiality policies and procedures. Full access to HIPAA (Health Insurance Portability and Accountability Act) policies and procedures as well as self-paced, online resources, are available to all HN staff via the corporate intranet website, "Cornerstone Learning".

The Health Net Privacy Office is responsible to review, approve and disseminate confidentiality policies and practices regarding the collection, use and disclosure of medical information.

SCOPE

Definition of Case Management

Case Management is a key vehicle for managing the health of the population. The Plan adheres to the Case Management Society of America's (CMSA) definition of case management which was updated in 2016: "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and quality cost effective outcomes".
The Plan also abides by the principles of case management practice, as described in CMSA's most recent version of the Standards of Practice for Case Management, revised in 2016.

The Case Management Program and the tools utilized to manage care were developed based on evidence based clinical practice guidelines and preventive health guidelines adopted by the Plan. The assessments utilize the CMSA Standards of Practice for Case Management and other evidence based tools including the PHQ2/9. Disease specific assessments include research of latest scientific sources, articles and publications from national organizations, such as the American Diabetes Association. The program also includes adherence to HEDIS® effectiveness of care measures and the associated technical specifications to ensure member compliance.

The Plan trains and utilizes motivational interviewing techniques to guide member goal identification and actions.

Levels of case management include:

- **Care Coordination** – appropriate for members with primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of case management is used for continuity of care transitions and supplemental support for members managed by the county.
- **Case Management** – appropriate for members needing a higher level of service, with clinical needs. Members in case management may have a complex condition or multiple co-morbidities that are generally well managed. Members in case management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services included at this level of case management include the level of care coordination along with identification of member agreed upon goals and progress towards meeting those goals.
- **Complex Case Management** – a high level of case management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex case management is performed by CalViva for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of complex case management include all coordination and case management services from above, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence.

Goals and Objectives

The Mission of Plan's Case Management Program is to:

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

The Goals of the Case Management Program are:

Measure	Goal	Frequency
Member experience survey – each question and overall	> 90%	Annual
Member complaints/grievances	< 1/10,000 members	Annual
Reduce Non-Emergent ER Visits from 90 days pre CM	> 3%	Annual
Reduce Readmissions from 90 days pre CM	> 3%	Annual
Members managed in high risk OB program have greater % of members completing the 1st pre-natal visit with in the 1st trimester or 42 days of enrollment than pregnant members not managed.	> 5% of non- managed members	Pregnancy
Members managed in high risk OB program have greater % of members completing the post-natal visit between 21-56 days post-delivery than pregnant members not managed.	> 5% of non- managed members	Pregnancy

Case Management Functions:

Case Management functions include:

- Early identification of members who have special needs.
- Assessment of member's risk factors.
- Development of an individualized plan of care in concert with the member and/or member's family, primary care provider (PCP), and managing providers.
- Identification of barriers to meeting goals included in the plan of care.
- Application of appropriate interventions to remove barriers to meeting goals included in the plan of care.
- Referrals and assistance to ensure timely access to providers.
- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed.
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition.
- Continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/case management activities.
- Addressing the member's right to decline participation in the case management program or disenroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all case management procedures in compliance with HIPAA and state law.

Program Segments

The Plan has defined a set of case management population criteria for use with all CalViva members (children, adults and seniors, children with special needs (CSHCN), developmentally disabled (DD), seniors and persons with disabilities (SPD) etc.). This creates efficiencies and a consistent measurement process of case management program effectiveness across the CalViva membership. The criteria below is not all inclusive; clinical judgment should be used to

determine a member's appropriateness for each level of case management, considering such factors as stability of the condition(s), available support system, current place of residence, etc.

The Plan also offers a case management program specific to our pregnant moms and new babies, called CalViva Pregnancy Program. The program is focused on helping prospective moms to have a healthy happy pregnancy and wellness of the fetus and newborn. The program goals are quality of care in prenatal visits acknowledgement of and American College of Obstetricians and Gynecologists (ACOG) standards. The quality measures include HEDIS® rates for timelines of prenatal care and timeliness of postpartum care.

Complex Case Management Criteria
The Plan uses Impact Pro a predictive modeling and care management analytic tool with a built in proprietary risk stratification algorithm to differentiate members who are impactable and have higher risk and more complex health needs from those at lower risk. The risk stratification algorithm utilizes member specific data identified through claims, TARs, pharmacy and data provided by the State. Members are stratified into one of ten Population Health Categories: Level 01: Healthy, 02: Acute Episodic, 03: Healthy, At Risk Level and 04A: Chronic Big 5 Stable, 04B: Chronic Other Condition Stable, 04C: BH Primary Stable, Level 05A: Health Coaching, Level 05B: Physical Health CM, Level 05C Behavioral Health CM, Level 06: Rare High Cost Condition, Level 07A: Catastrophic: Dialysis, Level 07B: Catastrophic: Active Cancer, Level 07C: Catastrophic: Transplant Level 08A: Dementia, Level 08B: Institutional (custodial care)_ Level 09A: LTSS and MMP - Service Coordination, Level 09B: LTSS and MMP - High Needs Care Management or Level 10: End of Life. Members stratified into levels 05B and 5C are identified as high risk and impactable and are referred to case management as described below. Members stratified in Impact Pro into Level 5B: Physical Health CM and Level 05C Behavioral Health CM AND have other designated parameters such as: • CM engagement score ≥ 80 • ORCA (opioid risk classification) score of medium or high • Priority Flag = Yes • Annual ER designated cost shall be referred to the case management program. Additionally, any member, regardless of the risk stratification, who reach a designated score based on responses to the Screening HRA shall be referred to Case Management.
Case Management Criteria
Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to: • HIV/AIDS • Cancer • Sickle cell • Asthma/COPD • Diabetes

• Congestive Heart Failure • Children with special health care needs • Other State-mandated criteria
Care Coordination Criteria
• Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing health care services related to continuity of care • Participation in county program requiring supplemental Plan support

INFRASTRUCTURE AND TOOLS

Organizational Structure

Chief Medical Director

The Chief Medical Director has operational responsibility for and provides support to the Plan's Case Management Program. The Plan Chief Medical Director (CMD), Vice President of Medical Management (VPMM), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the Case Management Program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to case management. A behavioral health practitioner is involved in the implementation, monitoring, and directing of behavioral health aspects of the Case Management Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the CMD, the Plan may have one or more Medical Director and/or Associate Medical Directors.

The CMD's responsibilities include, but are not limited to, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations.
- Monitors compliance with the Case Management Program.
- Provides clinical support to the case management staff in the performance of their case management responsibilities.
- Provides a point of contact for practitioners with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.
- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed.
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees.

Behavioral Health Practitioner

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of the Plan's Case Management Program. A behavioral health

practitioner may participate in case management rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. The behavioral health practitioner may be a clinical director, a Plan network practitioner, or behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e. doctoral-level clinical psychologist or certified addiction medicine specialist) or pharmacist, as appropriate, may be consulted on cases involving behavioral health issues.

Vice President of Case Management (VPCM)

The VPCM is a registered nurse with experience in utilization management and case management activities. The VPCM is responsible for overseeing the day-to-day operational activities of the Plan's Case Management Program. The VPCM reports to the Plan Senior Vice President of Medical Management. The VPCM, in collaboration with the CMD, assists with the development of the Case Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Case Management Director/ Manager

The Director/Manager of Case Management is a registered nurse or other appropriately licensed healthcare professional with case management experience. The Case Management Director/Manager directs and coordinates the activities of the department including supervision of Care Managers, Program Specialists and Program Coordinators. The Case Management Director reports to the Vice President of Case Management. The Case Management Manager reports to the Director of Case Management. The Case Management Director/Manager work in conjunction with the Utilization Management Director to execute the strategic vision of Health Plan objectives and attendant policies and procedures and state contractual responsibilities.

Supervisor, Program Coordinator (PC)

The Supervisor PC is highly skilled high school graduates or equivalent with 5 or more years of prior authorization, physician's office, customer service, claims processing or provider relations experience preferably in a managed care setting. The Supervisor PC oversees day to day operations and supervision of the Program Coordinators in CM and performs collaborative duties related to coordinated care programs. The Supervisor PC provides support to the Program Coordinators to promote quality and continuity of services delivered to members and providers. The Supervisor PC reports to the Director of CM.

Care Team (CT) Staffing Model

Care Coordination/Case Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers work closely with the Concurrent Review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Care Manager's average case load would be 40 – 50 cases. ICT roles and responsibilities include: care managers, social workers, other licensed

clinical staff, program specialists, program coordinators, care coordinators, and Member Connection Representatives.

Medical Director

- Physician who holds an unrestricted license to practice medicine in the Plan's state and is board-certified with experience in direct patient care if required.
- Serves as a clinical resource for care managers and members' treating providers.
- Participates in multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases.
- Provides a point of contact for providers with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.

Care Manager

- Licensed RN, Licensed Clinical Social Worker, or Licensed Marriage and Family Therapist.
- CM certification preferred.
- Responsible for oversight of non-clinical members of the CC/CM team.
- Responsible for working with the member and their physician to identify needs and create a care plan to help the members achieve their goals.
- Participates in inpatient rounds with concurrent review nurses to assist with discharge planning and coordination with the member's treating providers.
- Communicates and coordinates with the member and their caregivers, physicians, behavioral health providers, Disease Management staff, and other members of the CT to ensure that member's needs are addressed.

Social Workers/Program Specialists (SW/PS)

- Non-licensed Social Worker or licensed vocational nurse.
- Considered a care manager with an assigned caseload and responsible for following all standards of case management practice.

Program Coordinator (PC) II /Service Coordinator (SC)

- Can be either an LPN or a highly trained non-clinical staff person working under the direction and oversight of a CM.
- Provides support for moderate or low risk members.
- Collects data for Health Risk Screening.
- Provides information to CM/PS for care plan.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager/Program Specialist.

Program Coordinator (PC) I

- Non-clinical staff person working under the direction and oversight of a PC II or CM.
- Provides administrative support to CC/CM team.
- Collects data for Health Risk Screening.

- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager.

Member Connections Representative (MCR)

- Health outreach workers typically hired from within the communities served to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.
- Works both in the office and in the community, sometimes with face to face member interaction.
- Performs member outreach, education, and home safety assessments.
- May assist with community outreach events such as: Health Check days, Healthy Lifestyle events, Baby Showers, Diaper Days, Reading Events, etc.
- Member Connections Representatives report to the Manager of Member Connections.

Integrated Care Team meetings are held at least bi-weekly. The participants are comprised of plan behavioral health and physical health care managers, social workers, non-clinical associates, medical directors, and a pharmacy coordinator. Other participants may include: PCPs or specialists, behavioral health providers and/or County Mental Health Plan staff and/or MCR depending on the case.

Information System

Assessments, care plans, and all case management activities are documented in a clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the care team to generate reminder/task prompts for follow-up according to the timelines established in the care plan. Reminders/tasks can be sent to any team member, e.g. allowing Care Managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g. inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's case to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of case management interventions.

MEMBER IDENTIFICATION AND ACCESS TO CASE MANAGEMENT

A key objective of Plan's Case Management Program is early identification of members who have the greatest need for care coordination and case management services. This includes, but is

not limited to, those classified as children or adults with special health care needs; with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are frail, elderly, disabled, or at the end of life.

Data Sources

Members are identified as potential candidates for case management through several data sources as available to the Plan, including, but not limited to:

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data
- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency department utilization reports
- Laboratory data
- Readmission reports
- State/CMS enrollment process and other State/CMS supplied data
- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD/SSI)
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments, Member Evaluation Tool (MET)
- Information provided by practitioners, such as Notification of Pregnancy

Reports identifying members for case management are run on at least a monthly basis and forwarded to the care team for outreach and further appraisal for case management.

Referral Sources

Additionally, direct referrals for case management may come from resources such as:

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Case Management Program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.
- Envolve PeopleCare Nurse Advice Line staff –has policies and procedures in place for referring members to the Health Plan for case management screening. This may be accomplished via a "triage summary report" that is sent to the Plan electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at the Plan.
- Envolve PeopleCare Disease Management (DM) Program staff –work closely with the case management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as case management rounds, are held between the care team and DM staff.
- Hospital staff, e.g. hospital discharge planning and emergency department staff - facility staff is notified of the Plan's Case Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital

staff is encouraged to inform Plan UM staff if they feel a member may benefit from case management services; UM staff then facilitate the referral.

- Health Plan Staff - UM staff work closely with case management staff on a daily basis and can initiate a referral for case management verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.
    - Health Plan MemberConnections® Program – Member Connections Representatives (MCRs) are trained in all departments within the Health Plan and have a full understanding of all staff functions. MCRs work closely with the care team, referring members who may benefit from case management services.
    - Health Plan Member Services - Member Services staff is also trained in all departments within the Plan and have a full understanding of all staff functions, including the role and function of the care team.
    - Other intradepartmental referrals e.g., Provider Specialists, Plan Advocates, and QI Department.
- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - members are educated about case management services in the Member Handbook, received upon enrollment and available on the Plan website, member newsletters, and through contact with Member Services and/or other Plan staff.
- Community/social service agencies – community agency staff are informed of the Case Management Program during interactions with the Plan care team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential case management needs to Plan staff (California Childrens Services (CCS), Local Health Department (LHD), Local Mental Health Plan (MHP) etc.)
- Delegated entity staff (e.g. vision, dental, DME/home health, etc, as applicable) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for case management. The Plan also regularly communicates with delegates through oversight meetings, case management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.
- State agency/state enrollment center.

The specific means which a member was identified as a potential candidate for case management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to case management. Multiple referral avenues help to minimize the time between need for and initiation of case management services. Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

SCREENING AND ASSESSMENT

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification as potential candidates for case management. Care team staff obtain consent to complete the case management screening and/or initial assessment once member contact is made. Case Management staff also explains the care manager role and

function and benefits of the Case Management Program to the member and/or their authorized representative or guardian.

General standardized assessments have been developed internally to address the specific issues of the Plan's unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for case management. All assessments are documented in the clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity.

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Case Management Program, and are informed they are entitled to decline participation in, or disenroll from case management at any time, if allowed per state regulations. The member/guardian is notified of the potential need for the care team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always obtained prior to any contact. Documentation of verbal member consent to participate in the Case Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented.

Members unable to be contacted via telephone are mailed a letter requesting that the member call the care team. Member Connection Representatives may also be utilized when necessary, to assist in outreach for members who are difficult to contact. Member Connection Representatives go the member's physical address and attempt to initiate contact. They may also outreach to local community agencies and provider offices in an effort to locate a member. If a MCR is successful in locating the member, they may perform a general screening in person, including observation of the member in their home surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc.

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly stable and the member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are assigned to a care team who confirms the findings of the screening assessment and may complete a more thorough assessment with the member. Outreach to members stratified as high is made within 7 calendar days, moderate priority within 14 calendar days and for those at low priority, within 30 calendar days of screening completion and identification.

A Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history.

Stratification as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management may be revised at this time, or following further assessment.

The Care Manager then attempts outreach to the member and/or authorized representative or guardian telephonically within one week for members identified as high priority and thus appropriate for Complex Case Management, to perform an in-depth assessment to more closely identify and prioritize the member's individual needs. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about a member's condition(s). These condition-specific assessments, such as the Diabetes and Asthma assessment, are derived from evidence-based clinical guidelines. During the in-depth case management assessment, the Care Manager evaluates the full scope of the member's situation, including:

- Evaluation of communication barriers; cultural, linguistic, hearing, and visual, preferences or limitations.
- The member's health status, including condition–specific issues and likely co-morbidities.
- Assessment of behavioral health status (e.g. presence of depression and/or anxiety) and cognitive functioning.
- Assessment of social determinants of health issues such as alcohol or drug dependency, smoking, significant life stressors, etc.
- Documentation of the member's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring.
- Assessment of activities and instrumental activities of daily living.
- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.
- Assessment of life planning activities such as living wills, advance directives, etc.
- Evaluation of caregiver resources and potential involvement in care plan implementation.
- Assessment of personal resources, limitations, and presence of social determinants
- Evaluation of available benefits and other financial resources.
- Evaluation of need for, and availability of, community resources.
- Assessment of educational and vocational factors.

Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital case managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. The role and function of the Care Manager is also explained to the member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system.

The care team reviews the gathered information and begins to build a plan of care. The initial assessment and plan of care are completed no later than 60 days after a member or caregiver acting on member's behalf, agrees to participate in Complex Case Management, but in most cases is completed earlier. A member is considered eligible for case management services upon their consent to participate unless otherwise defined by individual state laws. Care teams may

include Nurse Care Managers, Program Coordinators, Social Workers, Behavioral Health Specialists, and Member Connection Representatives. Each contributes different skills and functions to the management of the member's case. Other key participants in the development of the care plan may include:

- Member
- Member authorized representative or guardian
- PCP and specialty providers
- Plan Medical Directors
- Hospital discharge planners
- Ancillary providers (e.g.. home health, physical therapy, occupational therapy)
- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g. United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation; companionship, etc.)
- Other non-health care entities (e.g. Meals on Wheels, home construction companies, etc.)

Behavioral Health Services

The Plan is responsible to provide mild to moderate mental health services to all members, including Applied Behavioral Analysis (ABA) when medically necessary. The Plan strongly supports the integration of both physical and behavioral health services through screening and strengthening prevention and early intervention, Specialty mental health services are not covered under the Plan and are paid under Medi-Cal FFS. The Plan will ensure that Members who need Specialty Mental Health Services are referred to and are provided these services by an appropriate Medi-Cal FFS mental health provider or the local mental health plan in accordance with contract requirements. The Plan will assist members with scheduling referred services with appropriate urgency to the applicable care setting and exchange appropriate information with those providers to ensure coordination and continuity of care. The Plan shall also assist individuals requesting Voluntary Inpatient Detoxification (VID) services and provide care coordination to assist the member in locating a general acute care hospital (may not be a chemical dependency treatment facility or Institution for mental disease).

Continuity and Coordination of Care between Medical and Behavioral Health Care

When staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify the Plan Care Manager of the member. If the member's primary diagnosis is a behavioral health condition, the case is referred to a Behavioral Health Care manager, who serves as the lead Case Manager, working in tandem with the medical care team. Whether the member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health Case Manager will serve as the lead Case Manager. The medical and behavioral health Case/Care Managers confer with each other to confirm which Case/Care Manager will serve as the lead or secondary Case/Care Manager. If the Case/Care Managers cannot agree, a supervisor is consulted for a decision.

When assigned to a physical health Care Manager, he/she reviews the member's clinical information to assure the patient is receiving appropriate behavioral health care. If the patient does not appear to be receiving this care, the Care Manager:

- Contacts the medical provider to ask about a behavioral health consult.
- Assists the member, or coordinates with the behavioral health Case Manager, to make arrangements for the behavioral health consult.
- Follows up to make sure a behavioral health consult was conducted.

When appropriate (including but not limited to when the primary Care Manager is revising the plan of care or evaluating a member for discharge from case management), the medical and behavioral Case/Care Managers confer with each other to ensure that the necessary expertise is available to monitor and guide members' care. The primary Care Manager, is responsible for assuring appropriate physical and behavioral health follow-up in case management discharge planning.

Coordination with External Programs

The Plan will refer identified members to external agencies offering appropriate services and programs to complement those provided by the Plan. Programs and services may include, but are not limited to: Public Health Departments, Severe Mental Health Services, California Children's Services (CCS), Transplant services with the exception of kidney, Regional Center for the developmentally disabled, Home and Community-Based Services (HCBS) Waiver program administered by the State Department of Developmental Services (DDS), Regional Center or local governmental health program as appropriate for the provision of Targeted Case Management services. The Plan shall continue to provide all Medically Necessary Covered Services per the Memorandum of Understanding for all eligible members that are not authorized or covered by external agencies. The Plan shall ensure the coordination of services and joint case management between its Primary Care Providers, specialty providers, and the local programs or agencies.

ONGOING MANAGEMENT

Plan of Care Development

The initial assessment serves as the foundation for the member's care plan. The care team identifies issues and needs, and utilizing input from team participants, develops a proposed care plan. The care plan is developed in conjunction with the member; the member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care plan as needed. Prioritized goals are established and barriers to meeting goals or complying with the plan of care are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of the discharge plan as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care plan.

The proposed plan of care is discussed with the member and/or member authorized representative or guardian, the PCP, and the health care team. The member's role is discussed and member/caretaker and provider input is obtained and used to modify the goals according to member's ability and willingness to participate. The Care Manager assures all parties are in agreement with the care plan to ensure successful implementation.

Members assigned to Care Coordination, or members identified as moderate/medium priority assigned to Case Management have an abbreviated care plan. The care plan for members in Complex Case Management includes, at a minimum:

- Prioritized goals – goals are specific, realistic, and measurable and are associated with a timeframe for completion. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible.
- Identification of barriers to meeting the goals and recommended solutions for each barrier.
- Resources to be utilized, including the appropriate level of care.
- Interventions to reach those goals, including development of member self-management plans. The care manager assures the member has a full understanding of their responsibilities per the self-management plan.
- Planning for continuity of care.
- Collaboration with and involvement of family and significant others, health care providers, etc.(as applicable).
- The schedule for on-going communication with the member and other involved parties, based on individual needs and member preference.
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated.

The care plan is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines such as for diabetes and asthma management, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Monitoring and Evaluation

Once the plan of care is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Revisions to the care plan are made when necessary, e.g. when the member's condition progresses or regresses, when goals are reached, etc. Significant revisions to the plan of care are also shared with the PCP. A schedule for follow up and monitoring of the member's progress is developed, using as a minimum the intervals defined according to priority level and current needs. The Care Manager may assign tasks to other members of the care team, such as a Program Specialist to manage or assist with social determinants of health issues or a Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/tasks to be created for each case, alerting the care team when follow-up contacts are needed. Follow-up reminders can be set for daily, weekly, monthly, etc. contacts. Intervals for follow-up are based on the goals and time lines in the care plan.

The Care Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers' or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Member or caretaker agreement to participate in the Case Management Program (agreement may be oral or written; if oral, the Care Manager documents the discussion with the member/caretaker).
- Notes, including a summary of team conferences and all communications with the member/family, health care providers and any other parties pertaining to the member's case.
- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available.
- The case management care plan, including:
    - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers.
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - The member's self-management plan.
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below.

The Care Manager regularly evaluates the member's progress considering the following factors:

- Change in the member's medical status.
- Change in the member's social stability.
- Change in the member's functional capability and mobility.
- Progress made in reaching the defined goals.
- The member's adherence to the established care plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels, etc.
- Changes in the member or family's satisfaction with the Case Management Program and other services addressed in the care plan.
- The member's quality of life.
- Benefit limits and financial liability.

The Care Manager completes a re-assessment at any time the member has a significant change of condition or, at a minimum, once per year if the member remains active in case management. If the member loses eligibility for more than 30 days then a new assessment is performed upon enrollment back into the complex case management program to ensure the member is being assessed for current case management needs. The plan of care is also updated at these times and shared with the PCP, as applicable.

The Care Manager implements necessary changes to the care team care plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, or other members of the health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The care team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care plan, the Care Manager assures all involved are in agreement with changes to the care plan to ensure ongoing success.

The care team also monitors the case on an ongoing basis for sentinel events and quality indicators and, if present, makes the appropriate referral to the Quality Improvement Department.

Discharge from Case Management

The Care Manager may receive input from the PCP, member/family/guardian/caretaker, and other health care providers involved in the member's plan of care to determine the appropriateness for closing the case. The following criteria are used on an ongoing basis to determine when discharge from case management should occur:

- Member terminates with the Health Plan.
- Member/family requests to disenroll from the Case Management Program.
- The member/family refuses to participate in case management despite efforts to explain how it can benefit the member.
- Plan is unable to reach member despite at least three (3) different types of attempts (phone attempts at different times during day, visit to home, letter submission with address correction request, and/or contacting PCP/WIC/Specialists/Programs) to locate and engage the member.
- The member reaches maximum medical improvement or reaches established goals regarding improvement or medical stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources.
- Insurance benefits are exhausted and community resources are in place.
- Member expires.

If the above criteria indicate a case should be closed, the Care Manager, as appropriate:

- Coordinates care with the new medical entity and community resources as required, allowing for a smooth transition for the member.
- If Complex Case Management has been refused by the member/family, the Care Manager provides the member with contact information for future reference and documents the refusal in the clinical documentation system.
- Contacts the PCP and other providers, when appropriate, regarding impending discharge from case management.
- Discusses the impending discharge from case management with the member/family.
- Presents community resources and assists in making arrangements with those relevant at the time of discharge.

A letter noting the member is discharged from case management is generated and sent to the PCP and the member. The letter documents the reason for discharge and includes, if the member has not terminated with the Plan, a reminder to contact the care team in the future should medical concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented. A member satisfaction survey may be included with the discharge letter, as described below.

PROGRAM ASSESSMENT AND IMPACT MEASUREMENT

Population Health Assessment

At least annually, the Plan assesses the entire member population and any relevant subpopulations (e.g. Children with Special Needs, Seniors and Persons with Disabilities Foster Care) to determine if the Plan's programs meet the needs of members. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age (especially children/adolescents and elderly), gender, ethnicity, race, and/or primary language, and benefit category. Other data used includes diagnostic and utilization data (e.g. overall claims received, inpatient admissions and ED visits, and pharmacy data). The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and members with mild to moderate mental illness.

Results of the population assessment are analyzed and subsequent enhancements made to the Case Management Program if opportunities for improvement or gaps in case management services are identified. Potential revisions to the Case Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.
- Revisions to types of case management activities assigned to specific members of the care team (e.g., clinical versus non-clinical staff responsibilities).
- Implementation of targeted training, e.g. related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff.
- Improvement in identification of appropriate community or other resources provided to members and the resources available to staff and the process for assisting members in accessing resources.

The annual population assessment may be a separate document or included as part of the Utilization Management/Case Management program evaluation and will be presented to appropriate committees, such as the Quality Improvement Committee, for review and feedback.

Member Experience with Case Management

Member experience with the Case Management Program is assessed no less than annually. Member experience surveys, specific to case management services, are completed at least annually for members enrolled in case management. Surveys are completed via mail or telephonically for members who have been enrolled in case management for ≥ 45 days. The results of the surveys are aggregated and evaluated annually and are included in the overall evaluation of the Case Management Program, which may be part of the annual Quality Improvement and/or Utilization Management program evaluation as described below.

Member complaints and grievances regarding the Case Management Program are monitored no less than quarterly. Results of the analysis of member experience surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and determine which opportunities to pursue regarding changes to the Case Management Program, as needed.

Outcomes

Case Management Program outcomes are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.
- Improved clinical outcomes.
- Member/provider satisfaction.
- Health Plan specific state requirements/expectations.

The Plan measures effectiveness of Complex Case Management no less than annually using at least three (3) measures that assess the process or outcomes of care for members in Complex Case Management. Additional details regarding these measures are identified in the Utilization Management/Quality Improvement (UM/QI) work plan. Measures of effectiveness may include indicators such as:

- Readmission rates.
- ED utilization.
- Rate of pregnant with an appropriate prenatal visit.
- Rate of pregnant with an appropriate post-partum discharge visit.

Measurement and analysis of the Case Management Program is documented as part of the annual Quality Improvement and/or Utilization Management program evaluation. The Case Management Program is evaluated at least annually and modifications to the program are made as necessary. The Plan evaluates the impact of the Case Management Program by using:

- Results of the population assessment.
- The results of member experience surveys (i.e. members in case management).
- Member complaint and grievance data regarding the Case Management Program.
- Practitioner complaints and practitioner satisfaction surveys regarding the Case Management Program.
- Other relevant data as described above.

The evaluation covers all aspects of the Case Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Quality Improvement/Utilization Management Committee for review, action and follow-up. The final document is then submitted to the RHA Commission through the Quality Improvement/Utilization Management Committee for approval.

Condition Specific CM and DM Programs

Members in condition specific Case/Disease Management Programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The case management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from case management when not specifically addressed in the program. Disease Management is managed within the Plan and the Plan Care Managers coordinate care and member interactions to prevent duplication of contacts and services.

Plan Case Management Programs may include, but are not limited to:

- Children and Adults with Special Health Care Needs
- Sickle Cell
- Post Hospitalization Follow-up
- High Risk Pregnancy

Plan Disease Management Programs may include, but are not limited to:

- Asthma
- Diabetes
- Heart Failure

Transitional 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.

Health Net's TCM conceptualizes the Coleman model within its foundation. 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 role playing and 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 the progress toward established goals
- Discussing encounters with other health care professionals
- Reinforcement of the importance of maintaining and sharing the PHR
- Supporting the patient's self-management role
- Medication reconciliation with access to Health Net pharmacist.
- Educating 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 located throughout California. They are linked through common management teams and systems. Health Net's Medical Directors participate in all aspects of Care Transition/Transition Care Management operations.

Palliative Care Program

The Palliative Care Program is a no-cost service that CalViva offers to its members. Palliative Care is a free program that CalViva offers to members with the goal of providing an extra layer of support by providing disease education, pain management, symptom control, and additional resources and guidance to enhance the member's quality of life. Through a partnership of vendors throughout California, Palliative Care is able to provide nurses, medical directors, and social workers in a home setting to members at no additional cost. Palliative Care empowers the member and family through a collaborative effort of communications, coordination of care, and advance planning, while allowing the goals of both the member and family to be the guiding principle

The Palliative Care Program may be appropriate if there is a chronic or serious illness that is significantly impacting the quality of life or daily activities of the member. The Palliative Care team works in accordance with the member's current primary physician and specialists to provide pain management, symptom management and disease management to enhance the member's quality of life. Palliative Care services are in addition to other current benefits, and existing curative medical treatment and social services may continue as before.

Diagnoses that may qualify a member for Palliative Care include but are not limited to:

- Advanced Cancer
- COPD
- CAD/CHF
- Liver Disease
- AIDS

Other indicators that may qualify the member for Palliative Care include but are not limited to:

- Multiple Hospitalizations or ER Visits
- Limited Social Support and a Serious Illness
- Declining ability to complete activities of daily living
- Member previously enrolled in hospice program that may have revoked due to wanting to seek curative treatment
- Long term planning needs

Palliative care services

- Advance Care Planning- Discussions and counseling of Advance Directives, Physician Orders for Life-Sustaining Treatment (POLST) forms and alike between qualified healthcare professional and the member, family member, or legally-recognized decision-maker.

- Palliative Care Assessment and Consultation- This service aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care

consultation or assessment, topics may include, but are not limited to: treatment plans, including palliative care and curative care, pain and medicine side effects, emotional side effects, spiritual concerns, member goals, advance directives, including POLST forms, legally recognized decision maker.

- Individualized Plan of Care- The plan of care may include, but not limited to pain and symptom and curative care, and all other palliative care services. This is developed with the member, decision-maker, and the Palliative Care team. This will reflect any changes from any ongoing care and discussion. The plan of care does not include services already received through another Medi-Cal funded benefit program.

- Palliative Care Team- This team consists of Palliative Care Vendors that employ qualified health care professionals such as Primary Care Providers (MD or DO), Registered Nurse, Licensed Vocational Nurse, Nurse Practitioners, Social Workers, Chaplain, and Coordinators. The team also includes Health Plan Palliative Care Coordinators/Liaisons and Medical Directors who works together with the Palliative Care Vendors to provide the Palliative Care Services.

- Care Coordination- Palliative Care Team provides care coordination continuously that reflects the member's needs and plans of care.

- Pain and Symptom Management- Pain and symptom management is part of the member's plan of care. Prescription drugs, physical therapy and other medically necessary services may be coordinated as authorized.

- Mental Health and Medical Social Services- Psychotherapy, bereavement counseling, medical social services, and discharge planning are some of the ways Mental and Social Services are provided by the Palliative Care Team.

- Chaplain Services- Chaplain Services are provided to members if the need is indicated in the care plan and/or requested by member.

- 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)

Palliative Care Services may be provided in inpatient, outpatient, home-based, community-based and other variety of settings. The setting may be based on what is medically necessary for the member's needs.

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

Health Net Community Solutions UM/QI Committee
Medi-Cal Utilization Management Program Approval

The Health Net Chief Medical Director and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Barbara Swartos
Vice President of Medical Management

Committee Approval
The Health Net Community Solutions UM/QI Committee has reviewed and approved this Case Management Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

Item #7

Attachment 7.A

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	**YES**	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, concerns, and/or items of significance to report as it relates to the Plan's IT Communications and Systems other than what has been previously reported in prior meetings.		

Privacy and Security	**Risk Analysis (Last Completed mm/yy: 5/14)**	**Risk Rating: Low**	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 & 7/18**	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	**7**	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	2018	2018	2018	2018	2019	2019	2019
Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No/Low Risk	8	0	4	4	1	3	1
High Risk	0	0	0	0	0	0	0
Total Cases By Month	**8**	**0**	**4**	**4**	**1**	**3**	**1**
Year	2013	2014	2015	2016	2017	2018	2019
No/Low Risk	91	48	54	36	28	38	5
High Risk	3	6	3	5	1	1	0
Total Cases By Year	**94**	**54**	**57**	**41**	**29**	**39**	**5**

Message from the COO	At present time, there are no issues, concerns, and/or items of significance to report as it relates to the Plan's Privacy and Security activities.

Member Call Center CalViva Health Website	**Year**		**2018**	**2018**	**2018**	**2018**	**2019**	**2019**
	Quarter		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	(Main) Member Call Center	**# of Calls Received**	**42, 624**	**33, 657**	**31,095**	**28,135**		
		# of Calls Answered	**41, 872**	**33, 162**	**30,937**	**27,948**		
		Abandonment Level (Goal < 5%)	**1.80%**	**1.50%**	**0.50%**	**0.70%**		
		Service Level (Goal 80%)	**85%**	**91%**	**93%**	**91%**		
	Behavioral Health Member Call Center	**# of Calls Received**	**1,417**	**1,058**	**1,121**	**1,034**		
		# of Calls Answered	**1,389**	**1,031**	**1,101**	**1,011**		
		Abandonment Level (Goal < 5%)	**2.00%**	**2.60%**	**1.80%**	**2.20%**		
		Service Level (Goal 80%)	**83%**	**87%**	**88%**	**83%**		
	Transportation Call Center	**# of Calls Received**	**9,777**	**10,910**	**13,854**	**13,776**		
		# of Calls Answered	**9,669**	**10,888**	**13,770**	**13,583**		
		Abandonment Level (Goal < 5%)	**1.10%**	**0.20%**	**0.60%**	**1.40%**		
		Service Level (Goal 80%)	**84%**	**86%**	**86%**	**84%**		
	CalViva Health Website	**# of Users**	**22,000**	**17,000**	**18,000**	**17,000**		
		Top Page	**Find a Provider**	**Find a Provider**	**Main Page**	**Main Page**		
		Top Device	**Mobile (59%)**	**Mobile (58%)**	**Mobile (57%)**	**Mobile (58%)**		
		Session Duration	**~ 3 minutes**	**~ 3 minutes**	**~ 3 minutes**	**~ 3 minutes**		
Message from the COO	At present time, there are no issues, concerns, and/or items of significance to report as it relates to the Plan's Call Center activities. Quarter 1 2019 numbers are not yet available for the Call Center or the Website. CalViva Health has discussed enhancements to the website (i.e. a Member Portal, Do You Qualify Page, etc.) at the Plan's March 6, 2019 Public Policy Committee Meeting.							

Provider Network Activities & Provider Relations	**Year**	**2018**	**2018**	**2018**	**2018**	**2018**	**2018**	**2019**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**109**	**112**	**112**	**111**	**112**	**112**	**111**
	PCP	**329**	**342**	**342**	**339**	**345**	**348**	**346**
	Specialist	**1143**	**1167**	**1162**	**1170**	**1181**	**1185**	**1272**
	Ancillary	**181**	**182**	**182**	**187**	**191**	**190**	**194**
	Year	**2017**	**2017**	**2018**	**2018**	**2018**	**2018**	**2019**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Pharmacy	**165**	**163**	**164**	**165**	**167**	**164**	
	Behavioral Health	**182**	**181**	**206**	**261**	**226**	**336**	
	Vision	**86**	**83**	**79**	**77**	**71**	**77**	
	Urgent Care	**5**	**5**	**7**	**10**	**10**	**11**	
	Acupuncture	**5**	**8**	**6**	**6**	**11**	**5**	
	Year	**2017**	**2017**	**2017**	**2018**	**2018**	**2018**	**2018**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	% of PCPs Accepting New Patients - Goal (85%)	**85%**	**88%**	**77%**	**88%**	**89%**	**91%**	
	% Of Specialists Accepting New Patients - Goal (85%)	**96%**	**96%**	**95%**	**97%**	**97%**	**98%**	
	Year	**2018**	**2018**	**2018**	**2018**	**2018**	**2018**	**2019**
	Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
	In-Person Visits by Provider Relations	**137**	**210**	**261**	**336**	**201**	**247**	**161**
	Provider Trainings by Provider Relations	**47**	**76**	**78**	**110**	**82**	**47**	**24**
	Year	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
	Total In Person Visits	**1,377**	**1,790**	**2,003**	**2,604**	**2,786**	**3,316**	**161**
	Total Trainings Conducted	**30**	**148**	**550**	**530**	**762**	**808**	**24**
Message From the COO	The Plan is continuing to monitor the impacts of state and federal requirements to ensure providers have been screened and enrolled in order to deliver care to Medi-Cal beneficiaries. A process / criteria has been discussed as it pertains to New Providers and Existing Providers. March of 2019 has been identified as a date of importance pertaining to these activities.							

	Year	2017	2017	2017	2018	2018	2018	2018
	Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Claims Processing	Medical Claims Timeliness (30 days / 45 days) - Goal (90% / 95%) - Deficiency Disclosure	93.57% / 99.79% YES	94% / 99% YES	95% / 99% NO	97% / 99% NO	98% / 99% YES	97%/99% NO	90% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) - Goal (90% / 95%) - Deficiency Disclosure	95.66% / 98.54% NO	93% / 97% YES	92% / 96% YES	90% / 99% YES	96% / 99% YES	97%/99% YES	98% / 99% N/A
	Pharmacy Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% /100% NO	100% / 100% NO	100% / 100% NO
	Acupuncture Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	94% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	100% /100% NO	100% /100% NO
	Vision Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100 % / 100% NO	100% / 100% NO	100 % / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure						99% / 99% NO	98% / 99% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	97% / 100% NO	82%/ 100% NO	96% / 100% NO	91% / 100% NO	84% / 100% NO	99% / 100 % NO	100% /100% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	97% / 100% NO	95% / 100% NO	94% / 98% NO	90% / 100% YES	83% / 97% YES	78% / 88% YES	98% / 99% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	96% / 100% NO	94% / 99% NO	91% / 100% NO	98 / 100% NO	94% / 98% NO	95% / 100% NO	99% / 100 % NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	86 % / 100% NO	100% / 100% NO	99% / 100% NO	89% / 100% NO	98% / 100% NO	93% / 98% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure	97 % / 100 % NO	97% / 100% NO	99% / 100% NO	90% / 100% NO	86% / 100% NO	95% / 100% NO	95% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure						95% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) - Goal (90% / 95%) - Deficiency Disclosure							100% / 100% NO
Message from the COO	Quarter 4 2018 data is now available for Acupuncture, Vision, Transportation and the PPG(s). The discussions around the Behavioral Health Claim's timeliness issues are now complete. The corrective action plan has been closed and the error in reporting has been corrected. PPG 2's Claims timeliness issues were resolved in Q4 2018. Corrective Action Plans are in effect with PPG 2 to perform. PPG 1 is currently in "run-out" activity as a relationship is no longer in place.							

Provider Disputes	**Year**	**2017**	**2017**	**2017**	**2018**	**2018**	**2018**	**2018**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Medical Provider Disputes Timeliness Quarterly Results (45 days) - Goal (95%)	95%	93%	95%	90%	88%	97%	98%
	Behavioral Health Provider Disputes Timeliness (45 days) - Goal (95%)	100%	N/A	100%	100%	100%	99%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) - Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) - Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Transportation Provider Dispute Timeliness (45 Days) - Goal (95%)						N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) - Goal (95%)	99%	96%	94%	96%	100%	100%	100%
	PPG 2 Provider Dispute Timeliness (45 Days) - Goal (95%)	N/A	100%	99%	66%	54%	17%	67%
	PPG 3 Provider Dispute Timeliness (45 Days) - Goal (95%)	100%	100%	100%	95%	94%	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%)	97%	68%	100%	100%	100%	N/A	95%
	PPG 6 Provider Dispute Timeliness (45 Days) - Goal (95%)	100%	88%	99%	N/A	100%	N/A	N/A
	PPG 7 Provider Dispute Timeliness (45 Days) - Goal (95%)						N/A	N/A
	PPG 8 Provider Dispute Timeliness (45 Days) - Goal (95%)							N/A
Message from the COO	Quarter 4 2018 data is now available for Acupuncture, Vision, Transportation and the PPG(s). Corrective Action Plans are in effect with PPG 2 to perform. PPG 1 is currently in "run-out" activity as a relationship is no longer in place.							

Item #7

Attachment 7.B

Financials as of January 31, 2019

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Balance Sheet
As of January 31, 2019

	Total
ASSETS	
Current Assets	
Bank Accounts	
Cash	52,012,132.72
Savings CD	0.00
ST Investments	0.00
Wells Fargo Money Market Mutual Funds	5,149,618.18
Total Bank Accounts	**$ 57,161,750.90**
Accounts Receivable	
Accounts Receivable	108,120,420.76
Total Accounts Receivable	**$ 108,120,420.76**
Other Current Assets	
Interest Receivable	10,055.68
Investments - CDs	0.00
Prepaid Expenses	535,393.26
Security Deposit	0.00
Total Other Current Assets	**$ 545,448.94**
Total Current Assets	**$ 165,827,620.60**
Fixed Assets	
Buildings	7,076,972.34
Computers & Software	4,258.19
Land	3,161,419.10
Office Furniture & Equipment	152,928.11
Total Fixed Assets	**$ 10,395,577.74**
Other Assets	
Investment -Restricted	312,775.59
Total Other Assets	**$ 312,775.59**
TOTAL ASSETS	**$ 176,535,973.93**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
Accounts Payable	98,713.51
Accrued Admin Service Fee	3,949,726.00
Capitation Payable	89,766,688.64
Claims Payable	75,686.85
Total Accounts Payable	**$ 93,890,815.00**
Other Current Liabilities	
Accrued Expenses	625,479.97
Accrued Payroll	51,495.96
Accrued Vacation Pay	258,568.26
Amt Due to DHCS	0.00
IBNR	141,150.17
Loan Payable-Current	0.00
Premium Tax Payable	0.00
Premium Tax Payable to BOE	5,961,058.18
Premium Tax Payable to DHCS	10,489,337.75
Total Other Current Liabilities	**$ 17,527,090.29**
Total Current Liabilities	**$ 111,417,905.29**
Long-Term Liabilities	
Renters' Security Deposit	0.00
Subordinated Loan Payable	0.00
Total Long-Term Liabilities	**$ 0.00**
Total Liabilities	**$ 111,417,905.29**
Equity	
Retained Earnings	59,820,200.78
Net Income	5,297,867.86
Total Equity	**$ 65,118,068.64**
TOTAL LIABILITIES AND EQUITY	**$ 176,535,973.93**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Budget vs. Actuals: Income Statement
July 2018 - January 2019 (FY 2019)

	Total		
	Actual	Budget	Over/(Under) Budget
Income			
Interest Earned	557,040.94	70,000.00	487,040.94
Premium/Capitation Income	687,313,467.34	666,023,726.00	21,289,741.34
Total Income	**687,870,508.28**	**666,093,726.00**	**21,776,782.28**
Cost of Medical Care			
Capitation - Medical Costs	575,751,122.97	555,365,502.00	20,385,620.97
Medical Claim Costs	1,494,666.07	1,411,662.00	83,004.07
Total Cost of Medical Care	**577,245,789.04**	**556,777,164.00**	**20,468,625.04**
Gross Profit	**110,624,719.24**	**109,316,562.00**	**1,308,157.24**
Expenses			
Admin Service Agreement Fees	27,801,169.00	27,527,500.00	273,669.00
Bank Charges	660.08	9,800.00	(9,139.92)
Computer/IT Services	74,509.33	91,000.00	(16,490.67)
Consulting Fees	4,200.00	61,250.00	(57,050.00)
Depreciation Expense	169,334.41	175,000.00	(5,665.59)
Dues & Subscriptions	100,951.48	104,300.00	(3,348.52)
Grants	1,175,741.42	1,225,000.00	(49,258.58)
Insurance	116,529.96	123,041.00	(6,511.04)
Labor	1,812,134.60	1,850,286.00	(38,151.40)
Legal & Professional Fees	72,855.97	111,300.00	(38,444.03)
License Expense	393,586.08	364,000.00	29,586.08
Marketing	532,572.10	500,000.00	32,572.10
Meals and Entertainment	11,710.24	12,700.00	(989.76)
Office Expenses	32,440.99	45,500.00	(13,059.01)
Parking	877.11	700.00	177.11
Postage & Delivery	1,881.08	1,400.00	481.08
Printing & Reproduction	1,543.98	2,800.00	(1,256.02)
Recruitment Expense	1,081.19	21,000.00	(19,918.81)
Rent	1,200.00	7,000.00	(5,800.00)
Seminars and Training	4,729.85	14,000.00	(9,270.15)
Supplies	5,125.26	5,600.00	(474.74)
Taxes	73,425,382.94	73,425,359.00	23.94
Telephone	19,443.49	18,200.00	1,243.49
Travel	13,065.82	16,400.00	(3,334.18)
Total Expenses	**105,772,726.38**	**105,713,136.00**	**59,590.38**
Net Operating Income	**4,851,992.86**	**3,603,426.00**	**1,248,566.86**
Other Income			
Other Income	445,875.00	350,000.00	95,875.00
Total Other Income	**445,875.00**	**350,000.00**	**95,875.00**
Net Other Income	**445,875.00**	**350,000.00**	**95,875.00**
Net Income	**5,297,867.86**	**3,953,426.00**	**1,344,441.86**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health
Income Statement
FY 2019 vs FY 2018

	Total	
	Jul 2018 - Jan 2019	Jul 2017 - Jan 2018 (PY)
Income		
Interest Earned	557,040.94	119,547.01
Premium/Capitation Income	687,313,467.34	694,615,737.68
Total Income	**$ 687,870,508.28**	**$ 694,735,284.69**
Cost of Medical Care		
Capitation - Medical Costs	575,751,122.97	584,089,860.29
Medical Claim Costs	1,494,666.07	1,368,941.02
Total Cost of Medical Care	**$ 577,245,789.04**	**$ 585,458,801.31**
Gross Profit	**$ 110,624,719.24**	**$ 109,276,483.38**
Expenses		
Admin Service Agreement Fees	27,801,169.00	28,094,044.00
Bank Charges	660.08	4,467.55
Computer/IT Services	74,509.33	74,338.01
Consulting Fees	4,200.00	0.00
Depreciation Expense	169,334.41	168,078.98
Dues & Subscriptions	100,951.48	93,444.43
Grants	1,175,741.42	1,063,373.97
Insurance	116,529.96	114,293.74
Labor	1,812,134.60	1,665,155.00
Legal & Professional Fees	72,855.97	40,954.43
License Expense	393,586.08	363,191.22
Marketing	532,572.10	394,886.59
Meals and Entertainment	11,710.24	9,861.38
Office Expenses	32,440.99	30,797.76
Parking	877.11	809.50
Postage & Delivery	1,881.08	919.93
Printing & Reproduction	1,543.98	1,917.06
Recruitment Expense	1,081.19	384.66
Rent	1,200.00	2,100.00
Seminars and Training	4,729.85	5,276.00
Supplies	5,125.26	5,560.10
Taxes	73,425,382.94	71,015,817.26
Telephone	19,443.49	17,653.32
Travel	13,065.82	10,977.15
Total Expenses	**$ 105,772,726.38**	**$ 103,178,302.04**
Net Operating Income	**$ 4,851,992.86**	**$ 6,098,181.34**
Other Income		
Other Income	445,875.00	387,067.64
Total Other Income	**$ 445,875.00**	**$ 387,067.64**
Net Other Income	**$ 445,875.00**	**$ 387,067.64**
Net Income	**$ 5,297,867.86**	**$ 6,485,248.98**

Item #7

Attachment 7.C

Compliance Report

RHA Commission Compliance – Regulatory Report

Show tools

Regulatory Filings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2018 YTD Total
# of DHCS Filings													
Administrative/ Operational	10	6	10										26
Member & Provider Materials	1	3	0										4
# of DMHC Filings	7	6	3										16

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	2018 YTD Total
# of MC609 FWA Submissions to DHCS	2	0											
# of Cases Open for Investigation (Active Number)	16	16											

Summary of Potential Fraud, Waste & Abuse cases

In 2019, the Plan identified and investigated two cases which were determined to reflect a suspected fraud and/or abuse case. Accordingly, two MC609 reports were filed with the DHCS. In one case, CalViva was informed that the Department of Justice (DOJ) was conducting a criminal investigation of this provider for allegedly misusing or overbilling procedure codes. The second case was referred to DHCS for a possible violation of the Stark Law. There were no cases that needed to be referred to other law enforcement agencies by the Plan.

Compliance Oversight & Monitoring Activities	Description
CalViva Health Oversight Activities	**Health Net** CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related other to critical projects or transitions that may affect CalViva Health. CalViva Health continues to review ongoing updates on Health Net's efforts to improve specialty provider access for CalViva Health members. **Kaiser** Post-Contract termination, encounter data submissions and other financial reporting will continue into 2019 and possibly 2020.
Oversight Audits	The following audits are in-progress: Access & Availability, Quality Management, Pharmacy Services and Q3 2018 Provider Disputes.
Regulatory Reviews/Audits	**Status**
Department of Managed Health Care ("DMHC") Undertaking Reports – Termination of contract with Kaiser	On December 7, 2018, the DMHC closed the Undertaking requirement pending the submission of a Material Modification for Alternative Access Standards, and a Significant Network Change Amendment. These filings were submitted by January 31, 2019. In response to the Plan's filings, the DMHC has sent two Comment Letters for which CalViva must respond by 3/29/19 and 4/4/19, respectively.
Department of Health Care Services ("DHCS") 2018 Medical Audit	The DHCS Final Report was issued on December 17, 2018 and requested a CAP for a finding related to lack of documentation showing that new providers received the training package within 10-working days. The Plan filed the response to the CAP on January 18, 2019. The DHCS has requested periodic updates that the CAP is being fully implemented. Consequently, final DHCS approval is still pending.
Department of Health Care Services ("DHCS") Encounter Data Corrective Action Plan	On March 13, 2019, DHCS e-mailed CalViva stating that it is closing the encounter data Corrective Action Plan (CAP). An official DHCS signed notice will follow.
Department of Health Care Services ("DHCS") Quality Corrective Action Plan	The Plan met with DHCS on February 11, 2019 to review the CAP progress. Preliminary results showed goals were achieved for specific measures in Madera County. Awaiting DHCS Final approval of the CAP.
Department of Health Care Services ("DHCS") 2019 Medical Audit and Department of Managed Health Care 2019 Medical Survey	DHCS and DMHC conducted their respective audit during the week of February 25, 2019. Since then, the Plan continues to provide responses to the various agencies' audit document requests.

New Regulation / Contractual Requirements	
Health Homes Program (HHP)	The HHP is an integrated service delivery system for populations with complex, chronic conditions intended to improve outcomes by reducing fragmented care and promoting patient-centered care. This program will be implemented only in Fresno County initially. All required DHCS "deliverable" filings (e.g. Plan readiness status, policies and procedures, provider network information, etc.) were submitted on 3/1/19, several of which have been approved so far. Additional DMHC and DHCS filings are due throughout 2019 as the HHP is being implemented in phases.
Diabetes Prevention Program (DPP)	With the assistance of the Plan's administrator, Health Net, we are working to ensure the DPP providers and vendors meet all the DHCS requirements.
Committee Report	
Public Policy Committee	The Public Policy Committee meeting was held on March 6, 2019, 11:30 a.m. in Fresno County, at 7625 N. Palm Ave. Suite 109. Fresno, CA 93711. The Q4, 2018 Grievance & Appeal report, Health Education Incentive program report and annual compliance report were presented to the Committee. CalViva Health's COO, Jeff Nkansah, solicited Committee input on how to improve the Plan's website to better meet the needs of it members. Several suggestions were made and documented. The next meeting will be held on June 12, 2019, 11:30 a.m. in Kings County, at 1400 Lacey Blvd., Hanford, CA

2019 New California Health Care Laws

Bill	Name	Description	Applies to CalViva	Effective Date	Plan Action/Notes
Assembly Bills					
AB 375 & SB 1121	Chau & Dodd	AB 375 - This bill enacts the California Consumer Privacy Act (CCPA) of 2018 intended to further the privacy rights of Californians by providing consumers an effective way to control the collection and sale of their personal information (PI) by businesses, service providers, and third parties. It also allows consumers to delete some PI. SB 1121 (Dodd) was thus introduced as a clean-up measure to, among other things, make crucial clarifications to the CCPA's HIPAA language.	Probably not	1/1/2020	Probably not but CVH will work with HN to assess the specific requirements of the bill before determining its impact on our current privacy and security policies/practices. Note, CVH does not collect and sell members' personal information.
AB 595	Wood	AB 595 requires prior approval by the Department of Managed Health Care (DMHC) Director for a health plan that intends to merge or consolidate with, or enters into an agreement resulting in its purchase, acquisition or control by, any entity. It also allows the DMHC director to disapprove a transaction if the transaction would substantially lessen competition.	Yes	1/1/2019	NA at this time as CalViva does not intend to merge/consolidate or enter into an agreement resulting in its purchase, acquisition or control by, any entity.

2019 New California Health Care Laws

Bill	Name	Description	Applies to CalViva	Effective Date	Plan Action/Notes
Assembly Bills					
AB 2193	Maienschein	This bill mandates that a health plan develop a maternal mental health (MMH) program to address mental and behavioral issues by July 1, 2019. This bill also requires health plans to make available guidelines and criteria regarding MMH upon request to medical providers, including a contracting obstetric provider. Defines "MMH" as a mental health condition that occurs during pregnancy or during the postpartum period that includes, but is not limited to, postpartum depression.	Yes	7/1/2019	CVH to work with HN (MHN) to implement program. Update EOC and policies to include new guidelines by July 1, 2019.
AB 2941	Berman	This bill requires, within 48 hours of a state of emergency that a health plan file a plan of action to ensure enrollees maintain access to medically necessary services in the limited circumstance of a declared state of emergency.	Yes	1/1/2019	CVH to work with HN to implement standard. Update EOC and policies to include new guidelines.
AB 2674	Aguiar-Curry	This bill would require the DMHC review provider complaints of unfair payment patterns from health plans on or before July 1, 2019, and at least annually thereafter. The bill would authorize the DMHC to conduct an audit or an enforcement action, as specified, if the department determines the complaint review indicates a possible unfair payment pattern.	Yes	7/1/2019	This bill requires the DMHC to conduct an audit for unfair payment practices by plans. All health plans including CVH will be subject to these audits and enforcement actions if DMHC finds unfair payment patterns exist.
AB 2760		This bill would require a prescriber to offer a prescription for naloxone hydrochloride or another drug when certain conditions are present and to provide education on overdose prevention to the patient and specified others.	No	7/1/2019	NA

2019 New California Health Care Laws

Bill	Name	Description	Applies to CalViva	Effective Date	Plan Action/Notes
Senate Bills					
SB 1287		This bill would revise the Medi-Cal definition of "medically necessary" for purposes of an individual under 21 years of age to incorporate the existing federal standards related to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. **Must be accurately reflected in all materials by July 1, 2022.**	Yes	7/1/2022	CVH had previously updated its EOC and EPSDT policy to conform to this regulation.
SB 1423		This bill would modify the minimum qualifications that an interpreter is required to possess in order to provide oral interpretation services to an LEP beneficiary enrolled in either a managed care plan or a mental health plan.	Yes	1/1/2019	CVH to work with HN to implement law and amend policy where needed.

Item #7

Attachment 7.D

Appeals & Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2019

Current as of End of the Month: January

Revised Date: 2/20/2019

Attachment E

CalViva - 2019

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2019 YTD	2018
Expedited Grievances Received	20	0	0	20	0	0	0	0	0	0	0	0	0	0	0	0	20	170
Standard Grievances Received	87	0	0	87	0	0	0	0	0	0	0	0	0	0	0	0	87	859
Total Grievances Received	**107**	**0**	**0**	**107**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**107**	**1029**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16
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%**	**98.1%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Expedited Grievances Resolved Compliant	17	0	0	17	0	0	0	0	0	0	0	0	0	0	0	0	17	160
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%**	**98.8%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	99	0	0	99	0	0	0	0	0	0	0	0	0	0	0	0	99	807
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%**	**100.0%**
Total Grievances Resolved	**116**	**0**	**0**	**116**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**116**	**969**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**97**	**0**	**0**	**97**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**97**	**740**
Access - Other - DMHC	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	30
Access - PCP - DHCS	16	0	0	16	0	0	0	0	0	14	0	14	0	0	0	0	30	124
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	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	37
Administrative	30	0	0	30	0	0	0	0	0	0	0	0	0	0	0	0	30	196
Continuity of Care - Acute	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Continuity of Care - Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Newborn	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Continuity of Care - PCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Continuity of Care - Pregnancy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Continuity of Care - Specialist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Continuity of Care - Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Continuity of Care - Terminal Illness	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	11	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11	167
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	32
Pharmacy	6	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	51
Transportation	16	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	16	84
Quality Of Care Grievances	**19**	**0**	**0**	**19**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**229**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20
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	4	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4	26
PCP Care	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	88
PCP Delay	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3	54
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	33
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Exempt Grievances Received - Classifications	312	0	0	**312**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**312**	5286
Authorization	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	73
Avail of Appt w/ Other Providers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Avail of Appt w/ PCP	16	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	16	214
Avail of Appt w/ Specialist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Claims Complaint	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Acute	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Newborn	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - PCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Continuity of Care - Pregnancy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Specialist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Terminal Illness	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Eligibility Issue	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	52
Health Care Benefits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
ID Card - Not Received	15	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	15	725
Information Discrepancy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	42
Interpersonal - Behavior of Clinic/Staff - Provider	35	0	0	35	0	0	0	0	0	0	0	0	0	0	0	0	35	775
Interpersonal - Behavior of Clinic/Staff - Vendor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other	8	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	8	116
PCP Assignment	126	0	0	126	0	0	0	0	0	0	0	0	0	0	0	0	126	2037
Pharmacy	9	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9	165
Transportation	77	0	0	77	0	0	0	0	0	0	0	0	0	0	0	0	77	1010
Wait Time - In Office for Scheduled Appt	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	35
Wait Time - Too Long on Telephone	5	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	31

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	10	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	10	124
Standard Appeals Received	31	0	0	31	0	0	0	0	0	0	0	0	0	0	0	0	31	420
Total Appeals Received	**41**	**0**	**0**	**41**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	41	**544**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	5
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%**	**98.8%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Expedited Appeals Resolved Compliant	9	0	0	**9**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	9	114
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%**	**92.7%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	43	0	0	43	0	0	0	0	0	0	0	0	0	0	0	0	43	387
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%**	**100.0%**
Total Appeals Resolved	**52**	**0**	**0**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	**510**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**52**	**0**	**0**	**52**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**52**	506
Continuity of Care - Acute	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Newborn	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - PCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Pregnancy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Specialist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuity of Care - Terminal Illness	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	48
DME	7	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	7	59
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	3
Advanced Imaging	23	0	0	23	0	0	0	0	0	10	0	10	0	0	6	6	39	143
Other	6	0	0	6	0	0	0	0	0	3	0	3	0	0	5	5	14	96
Pharmacy	13	0	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13	138
Surgery	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	19
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	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pharmacy	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	32	0	0	**32**	0	0	0	0	0	0	0	0	0	0	0	0	32	319
Uphold Rate	**61.5%**	**0.0%**	**0.0%**	**61.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**61.5%**	**62.5%**
Overturns - Full	17	0	0	**17**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	17	173
Overturn Rate - Full	**32.7%**	**0.0%**	**0.0%**	**32.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**32.7%**	**33.9%**
Overturns - Partials	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	15
Overturn Rate - Partial	**3.8%**	**0.0%**	**0.0%**	**3.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**3.8%**	**2.9%**
Withdrawal	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**1**	3
Withdrawal Rate	**1.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**1.9%**	**0.6%**
Membership	353,445	-	-		-	-	-		-	-	-		-	-	-			
Appeals - PTMPM	0.15	-	-	0.15	-	-	-	-	-	-	-	-	-	-	-	-	0.15	0.12
Grievances - PTMPM	0.33	-	-	0.33	-	-	-	-	-	-	-	-	-	-	-	-	0.33	0.23

Item #7

Attachment 7.E

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 1/01/2018 to 1/31/2019

Report created 1/31/2019

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	Patricia F. Frederickson <PATRICIA.F.FREDERICKSON@HEALTHNET.COM>
TAT Metric	Katherine Marie F. Coy <KATHERINE.F.COY@HEALTHNET.COM>
CCS Metric	carol.x.hartoonians@healthnet.com
Case Management Metrics	Kenneth Hartley <KHARTLEY@cahealthwellness.con
Authorization Metrics	John Gonzalez

Attachment

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2018 to 1/31/2019
Report created 1/31/2019

ER utilization based on Claims data	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2018-Trend	2019-01	2019-Trend	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Qtr Trend	CY- 2018	YTD-2019	YTD-Trend
																Quarterly Averages					Annual Averages		
Expansion Mbr Months	85,795	85,741	85,458	85,482	85,408	85,369	85,486	85,694	86,230	86,399	86,411	86,654		86,035		85,665	85,420	85,803	86,488		85,844	86,035	
Family/Adult/Other Mbr Mos	246,397	246,541	246,534	246,466	246,615	246,810	246,223	245,368	244,688	243,661	243,678	244,502		246,491		246,491	246,630	245,426	243,947		245,624	246,491	
SPD Mbr Months	31,695	31,784	31,841	31,886	31,910	32,030	32,127	32,225	32,233	32,286	32,288	32,268		32,238		31,773	31,942	32,195	32,281		32,048	32,238	
Admits - Count	2,356	2,206	2,352	2,165	2,215	2,191	2,331	2,283	2,219	2,257	2,133	2,190		2,239		2,305	2,190	2,278	2,193		2,242	2,239	
Expansion	672	585	643	625	654	660	691	674	698	638	622	636		615		633	646	688	632		650	615	
Family/Adult/Other	1,162	1,129	1,170	1,053	1,082	1,043	1,127	1,156	1,065	1,148	1,032	1,088		1,127		1,154	1,059	1,116	1,089		1,105	1,127	
SPD	521	491	538	485	478	485	511	453	455	469	478	465		496		517	483	473	471		486	496	
Admits Acute - Count	1,617	1,530	1,648	1,518	1,523	1,460	1,513	1,481	1,462	1,443	1,396	1,433		1,535		1,598	1,500	1,485	1,424		1,502	1,535	
Expansion	510	435	497	484	508	476	507	504	537	447	466	471		468		481	489	516	461		487	468	
Family/Adult/Other	625	641	661	581	573	541	531	572	502	575	505	550		604		642	565	535	543		571	604	
SPD	481	453	489	451	441	440	473	405	422	419	424	412		462		474	444	433	418		443	462	
Readmit 30 Day - Count	314	237	313	262	285	284	287	275	293	296	274	299		313		288	277	285	290		285	313	
Expansion	92	69	104	73	94	94	102	103	95	104	78	94		94		88	87	100	92		92	94	
Family/Adult/Other	101	78	96	96	83	92	77	88	85	93	71	101		93		92	90	83	88		88	93	
SPD	120	90	113	93	108	96	107	84	113	99	125	104		126		108	99	101	109		104	126	
Readmit 14 Day - Count	31	21	19	25	25	23	24	22	24	21	27	20		37		24	24	23	23		24	37	
Expansion	12	7	4	8	9	3	3	7	8	8	5	6		14		8	7	6	6		7	14	
Family/Adult/Other	8	6	5	7	11	7	11	5	8	3	10	11		11		6	8	8	8		8	11	
SPD	11	8	10	10	5	13	10	10	8	10	12	3		12		10	9	9	8		9	12	
**ER Visits - Count	21,432	18,562	18,886	17,003	17,475	16,222	16,262	15,973	16,069	15,640	14,854	15,839		5,816		19,627	16,900	16,101	15,444		17,018	5,816	
Expansion	4,691	3,947	4,276	3,927	4,296	4,108	4,167	4,072	4,069	3,676	3,419	3,581		1,061		4,305	4,110	4,103	3,559		4,019	1,061	
Family/Adult/Other	14,514	12,761	12,537	10,759	11,207	10,309	10,172	10,075	10,143	10,178	9,980	10,755		4,286		13,271	10,758	10,130	10,304		11,116	4,286	
SPD	2,192	1,821	2,050	1,855	1,946	1,781	1,899	1,817	1,837	1,778	1,443	1,495		461		2,021	1,861	1,851	1,572		1,826	461	
Admits Acute - PTMPY	53.3	50.4	54.4	50.1	50.2	48.1	49.9	48.9	48.3	47.8	46.2	47.3		50.5		52.7	49.5	49.0	47.1		49.6	50.5	
Expansion	71.3	60.9	69.8	67.9	71.4	66.9	71.2	70.6	74.7	62.1	64.7	65.2		65.3		67.3	68.7	72.2	64.0		68.1	65.3	
Family/Adult/Other	30.4	31.2	32.2	28.3	27.9	26.3	25.9	28.0	24.6	28.3	24.9	27.0		29.4		31.3	27.5	26.2	26.7		27.9	29.4	
SPD	182.1	171.0	184.3	169.7	165.8	164.8	176.7	150.8	157.1	155.7	157.6	153.2		172.0		179.1	166.8	161.5	155.5		165.7	172.0	
Bed Days Acute - PTMPY	274.4	235.6	268.3	229.1	249.8	216.8	215.2	234.8	225.3	242.1	221.0	241.3		232.2		259.4	231.9	225.1	234.8		237.8	232.2	
Expansion	361.1	314.9	358.9	318.8	370.2	304.5	323.0	373.6	362.8	348.6	342.2	340.7		300.4		345.0	331.2	353.2	343.8		343.3	300.4	
Family/Adult/Other	147.9	116.3	114.5	108.2	109.7	98.7	87.9	98.4	78.9	99.8	85.9	106.5		108.6		126.2	105.6	88.4	97.4		104.4	108.6	
SPD	1,023.4	946.5	1,213.9	917.9	1,009.3	886.4	900.9	904.5	967.6	1,007.2	899.8	996.3		987.2		1,061.4	937.8	924.4	967.8		972.6	987.2	
ALOS Acute	5.1	4.7	4.9	4.6	5.0	4.5	4.3	4.8	4.7	5.1	4.8	5.1		4.6		4.9	4.7	4.6	5.0		4.8	4.6	
Expansion	5.1	5.2	5.1	4.7	5.2	4.6	4.5	5.3	4.9	5.6	5.3	5.2		4.6		5.1	4.8	4.9	5.4		5.0	4.6	
Family/Adult/Other	4.9	3.7	3.6	3.8	3.9	3.8	3.4	3.5	3.2	3.5	3.5	3.9		3.7		4.0	3.8	3.4	3.6		3.7	3.7	
SPD	5.6	5.5	6.6	5.4	6.1	5.4	5.1	6.0	6.2	6.5	5.7	6.5		5.7		5.9	5.6	5.7	6.2		5.9	5.7	
Readmit % 30 Day	13.3%	10.7%	13.3%	12.1%	12.9%	13.0%	12.3%	12.0%	13.2%	13.1%	12.8%	13.7%		14.0%		12.5%	12.6%	12.5%	13.2%		12.7%	14.0%	
Expansion	13.7%	11.8%	16.2%	11.7%	14.4%	14.2%	14.8%	15.3%	13.6%	16.3%	12.5%	14.8%		15.3%		13.9%	13.5%	14.5%	14.6%		14.1%	15.3%	
Family/Adult/Other	8.7%	6.9%	8.2%	9.1%	7.7%	8.8%	6.8%	7.6%	8.0%	8.1%	6.9%	9.3%		8.3%		7.9%	8.5%	7.5%	8.1%		8.0%	8.3%	
SPD	23.0%	18.3%	21.0%	19.2%	22.6%	19.8%	20.9%	18.5%	24.8%	21.1%	26.2%	22.4%		25.4%		20.8%	20.5%	21.4%	23.2%		21.5%	25.4%	
Readmit % 14 Day	1.9%	1.4%	1.2%	1.6%	1.6%	1.6%	1.6%	1.5%	1.6%	1.5%	1.9%	1.4%		2.4%		1.5%	1.6%	1.6%	1.6%		1.6%	2.4%	
Expansion	2.4%	1.6%	0.8%	1.7%	1.8%	0.6%	0.6%	1.4%	1.5%	1.8%	1.1%	1.3%		3.0%		1.6%	1.4%	1.2%	1.4%		1.4%	3.0%	
Family/Adult/Other	1.3%	0.9%	0.8%	1.2%	1.9%	1.3%	2.1%	0.9%	1.6%	0.5%	2.0%	2.0%		1.8%		1.0%	1.5%	1.5%	1.5%		1.3%	1.8%	
SPD	2.3%	1.8%	2.0%	2.2%	1.1%	3.0%	2.1%	2.5%	1.9%	2.4%	2.8%	0.7%		2.6%		2.0%	2.1%	2.2%	2.0%		2.1%	2.6%	
**ER Visits - PTMPY	598.8	638.7	663.0	569.0	662.3	582.2	536.4	527.6	531.0	518.0	491.9	523.0		191.3		647.2	557.2	531.7	511.0		561.8	191.3	
Expansion	656.1	552.4	600.4	551.3	603.6	577.4	584.9	570.2	566.3	510.6	474.8	495.9		148.0		603.0	577.4	573.8	493.8		561.8	148.0	
Family/Adult/Other	706.9	621.1	610.2	523.8	545.3	501.2	495.7	492.7	497.4	501.3	491.5	527.8		208.7		646.1	523.5	495.3	506.9		543.1	208.7	
SPD	829.9	687.5	772.6	698.1	731.8	667.2	709.3	676.6	683.9	660.8	536.3	556.0		171.6		763.3	699.0	689.9	584.4		683.8	171.6	
Services	TAT Compliance Goal: 100%													T Compliance Goal: 10		TAT Compliance Goal: 100%					TAT Compliance Goal: 100%		
Preservice Routine	96.7%	83.3%	70.0%	100.0%	100.0%	93.3%	100.0%	100.0%	96.7%	100.0%	100.0%	96.7%		100.0%		83.3%	97.8%	98.9%	98.9%				
Preservice Urgent	100.0%	100.0%	96.7%	96.7%	100.0%	100.0%	96.7%	96.7%	100.0%	100.0%	100.0%	96.7%		100.0%		98.9%	98.9%	97.8%	98.9%				
Postservice	100.0%	100.0%	100.0%	96.7%	96.7%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	97.8%	98.9%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	93.3%	93.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		96.7%		100.0%	94.1%	100.0%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100.0%	96.7%	100.0%	100.0%				

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2018 to 1/31/2019
Report created 1/31/2019

ER utilization based on Claims data	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2018-Trend	2019-01	2019-Trend	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Qtr Trend	CY- 2018	YTD-2019	YTD-Trend
Deferrals - Urgent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%		100.0%		100.0%	100.0%	100.0%	93.8%				
Deferrals - Post Service	null	null	null	NA	NA	NA	NA	NA	NA	NA	NA	NA		null		null	null	null	null				
	CCS ID RATE													CCS ID RATE		CCS ID RATE					CCS ID RATE		
CCS %	7.82%	7.71%	7.80%	7.78%	7.84%	7.82%	7.97%	7.95%	8.00%	7.94%	7.97%	7.97%		8.07%		7.77%	7.81%	7.97%	7.96%		7.88%	8.07%	
	Perinatal Case Management													rinatal Case Managem		Perinatal Case Management					Perinatal Case Management		
Total Number Of Referrals	55	53	61	64	73	80	127	247	98	72	61	36		45		169	217	472	169		1,027	45	
Pending	0	0	0	0	0	0	0	0	0	0	2	3		1		0	0	0	5		5	1	
Ineligible	13	12	16	4	9	2	10	16	12	10	9	2		5		41	15	38	21		115	5	
Total Outreached	42	41	45	60	64	78	117	231	86	62	50	31		39		128	202	434	143		907	39	
Engaged	17	11	10	25	15	7	10	19	14	19	22	3		10		38	47	43	44		172	10	
Engagement Rate	40%	27%	22%	42%	23%	9%	9%	8%	16%	31%	44%	10%		26%		30%	23%	10%	31%		19%	26%	
New Cases Opened	17	11	10	25	15	7	10	19	14	19	22	3		10		38	47	43	44		172	10	
Total Cases Managed	52	54	55	66	71	68	70	79	78	77	86	80		79		75	75	88	103		206	79	
Total Cases Closed	9	9	14	10	10	8	10	15	20	14	9	10		21		32	28	45	33		137	21	
Cases Remained Open	36	38	41	48	56	59	56	48	48	61	69	65		56		41	59	48	65		65	56	
	Integrated Case Management													egrated Case Managem		Integrated Case Management					Integrated Case Management		
Total Number Of Referrals	55	44	43	38	60	61	73	69	146	67	113	45		42		142	159	288	225		814	42	
Pending	0	0	0	0	0	0	1	2	3	4	15	5		7		0	0	6	24		30	7	
Ineligible	6	13	7	6	13	8	3	7	13	9	11	1		1		26	27	23	21		97	1	
Total Outreached	49	31	36	32	47	53	69	60	130	54	87	39		34		116	132	259	180		687	34	
Engaged	22	12	11	10	11	12	29	24	42	20	31	18		12		45	33	95	69		242	12	
Engagement Rate	45%	39%	31%	31%	23%	23%	42%	40%	32%	37%	36%	46%		35%		39%	25%	37%	38%		35%	35%	
Total Screened and Refused/Decline	13	8	13	8	9	19	14	14	29	8	21	9		9		34	36	57	38		165	9	
Unable to Reach	20	15	23	18	28	31	25	35	71	34	51	13		15		58	77	131	98		364	15	
New Cases Opened	22	12	11	10	11	12	29	24	42	20	21	18		12		45	33	95	59		242	12	
Total Cases Closed	23	20	15	16	18	13	7	20	3	26	22	19		16		58	47	30	67		202	16	
Cases Remained Open	48	42	32	31	30	33	41	47	87	102	105	105		109		32	33	87	105		105	109	
Total Cases Managed	86	76	66	62	54	44	62	91	116	133	136	129		125		116	81	129	181		302	125	
Critical-Complex Acuity	56	48	41	45	40	33	45	62	67	38	27	27		25		77	63	77	42		116	25	
High/Moderate/Low Acuity	30	28	25	17	14	11	17	29	19	95	106	102		100		39	18	52	139		186	100	
	Transitional Case Management													sitional Case Manager		Transitional Case Management					Transitional Case Management		
Total Number Of Referrals	30	23	43	42	41	39	68	78	48	62	32	29		42		96	122	191	123		532	42	
Pending	0	0	1	0	0	0	1	2	0	1	0	0		0		1	0	0	1		2	0	
Ineligible	5	5	7	7	6	5	2	13	12	10	8	4		12		17	18	27	22		84	12	
Total Outreached	25	18	35	35	35	34	65	63	36	51	24	25		30		78	104	164	100		446	30	
Engaged	21	15	26	24	15	13	26	20	16	21	9	6		8		62	52	62	36		212	8	
Engagement Rate	84%	83%	74%	69%	43%	38%	40%	32%	44%	41%	38%	24%		27%		79%	50%	38%	36%		48%	27%	
Total Screened and Refused/Decline	1	0	3	2	9	14	21	27	17	16	8	11		13		4	25	65	35		129	13	
Unable to Reach	3	3	7	9	11	9	18	20	6	15	8	8		9		13	29	44	31		117	9	
New Cases Opened	21	15	26	24	15	13	26	20	16	21	9	6		8		62	52	62	36		212	8	
Total Cases Closed	18	14	20	24	17	13	13	28	20	22	20	13		7		52	54	61	55		222	7	
Cases Remained Open	22	20	22	20	18	14	29	21	25	27	14	9		15		22	14	25	9		9	15	
Total Cases Managed	28	28	41	47	39	36	48	54	55	57	41	26		20		63	79	96	71		228	20	
Critical-Complex Acuity	0	0	0	0	0	0	5	2	6	7	4	2		1		0	0	8	7		13	1	
High/Moderate/Low Acuity	28	28	41	47	39	36	43	52	49	50	37	24		19		63	79	88	64		215	19	
	Behavioral Health Case Management													oral Health Case Mana		Behavioral Health Case Management					Behavioral Health Case Managemen		
Total Number Of Referrals	0	0	0	3	6	33	20	19	29	9	56	15		12		0	42	68	80		190	12	
Pending	0	0	0	0	0	0	0	0	0	0	0	1		0		0	0	0	1		1	0	
Ineligible	0	0	0	0	0	0	1	2	6	1	2	2		2		0	0	9	5		14	2	
Total Outreached	0	0	0	3	6	33	19	17	23	8	54	12		10		0	42	59	74		175	10	
Engaged	0	0	0	2	3	1	4	4	4	4	16	4		5		0	6	12	24		42	5	
Engagement Rate	0%	0%	0%	67%	50%	3%	21%	24%	17%	50%	30%	33%		50.0%		0%	14%	20%	32%		24%	50%	
Total Screened and Refused/Decline	0	0	0	0	0	1	0	1	4	0	0	0		0		0	1	5	0		6	0	
Unable to Reach	0	0	0	1	3	32	16	13	18	6	40	8		5		0	36	47	54		137	5	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 1/01/2018 to 1/31/2019
Report created 1/31/2019

ER utilization based on Claims data	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2018-Trend	2019-01	2019-Trend	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Qtr Trend	CY- 2018	YTD-2019	YTD-Trend
New Cases Opened	0	0	0	2	3	1	4	4	4	4	16	4		5		0	6	12	24		42	5	
Total Cases Closed	0	0	0	0	1	2	2	3	4	3	3	6		6		0	3	9	12		24	6	
Cases Remained Open	0	0	0	2	2	2	4	6	5	4	10	15		13		0	2	5	15		15	13	
Total Cases Managed	0	0	0	2	5	5	7	10	10	10	23	24		23		0	6	12	30		42	23	
Critical-Complex Acuity	0	0	0	1	2	2	2	2	3	3	3	2		3		0	3	3	4		7	3	
High/Moderate/Low Acuity	0	0	0	1	3	3	5	8	7	7	20	22		20		0	3	9	26		35	20	
	Record Processing													Record Processing		Record Processing					Record Processing		
Total Records	5,013	6,894	9,166	8,512	9,094	8,968	8,261	7,664	6,808	7,838	5,881	7,124		7,479		22,344	26,574	22,733	20,843		92,494	7,479	
Total Admissions	2,230	2,160	2,300	2,121	2,162	2,153	2,292	2,247	2,198	2,194	1,619	2,178		2,249		6,757	6,436	6,737	5,991		25,921	2,249	

Item #7

Attachment 7.F

QIUM Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: March 21st, 2019

SUBJECT: CalViva Health QI & UM Update of Activities Quarter 4 2018 & February 2019 (March 2019)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health QI & UM performance, program and regulatory activities in Quarter 4 of 2018 through February 2019.

I. Meetings

Two meetings were held in Quarter 4, in October and November and one in February of 2019. The following guiding documents were approved at these meetings:

1. Preventive Screening Guidelines
2. C & L Language Assistance Program Mid-Year Report
3. C & L Work Plan Mid-Year Evaluation
4. Health Education Mid-Year Evaluation
5. 2018 QI Work Plan End of Year Evaluation
6. 2018 UMCM Work Plan End of Year Evaluation
7. Clinical Practice & Preventive Screening Guidelines

In addition, the following general documents were approved at the meetings:

1. QI Annual Policy Review
2. Medical Policies
3. Pharmacy Formulary & Provider Updates
4. Public Health Annual Policy Review

The following is a summary of some, but not all, of the reports and topics reviewed:

- **Quality Improvement Reports -** The quality and safety of many of the health plan functions are assessed and monitored through quality improvement reports. These reports cover health plan performance, programmatic documents and regulatory reports. During this reporting period the QI/UM Committee's review included, but was not limited to:
  1. The **Appeal and Grievance Dashboard through December 2018** tracks volumes, turn-around times, and case classifications. **All Quarter 4 A & G Reports** were presented and reviewed in order to evaluate compliance with standards and regulations. Results demonstrate good compliance with opportunity for continued improvement in some areas. A year-end summary was presented to the committee comparing 2018 totals to 2017 with over results indicating that the total number of grievances received in 2-18 was consistent with 2017. An increase in the number of appeals was noted in 2018 compared to 2017. This increase is attributable primarily to advanced imaging, allergy shots and pharmacy denials. Practitioner education regarding prior authorization criteria has been ongoing and these numbers are expected to decline. A significant increase in Exempt grievances was also noted. This increase was related to the EHS transition and addition of transportation related grievances to our monitoring process.

2. The **Initial Health Assessment Report (Q1 & Q2)** is required to be completed within 120 days of enrollment for all new CalViva members. A multi-pronged approach to monitoring this activity is performed and includes the following:
    a. Medical Record Review (MRR) via onsite provider audits (Small sample but good compliance)
    b. Monitoring of claims and encounters (compliance rate is lower than record review however, coding enhancements are implemented when identified).
    c. Member outreach (Good compliance).

    Data tables were updated to include FSR/MRR IHA and IHEBA data to demonstrate a complete IHA occurrence. Combined IHA/IHEBA completion rates were noted to be higher for pediatric patients compared to adults.
    a. The 3-Step Member Outreach process averaged above 95% for Q3 2018.
    b. Claims and encounters data for 2018 reflected increased compliance for both adult and pediatric members in the first half of 2018 compared to the first half of 2017.

3. **The Potential Quality Issues Report** 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 through peer review activities. In Q4 2018, it was noted that several non-member PQI's in 2018n were not adjudicated in a timely manner. Cases were reconciled and the Q4 report reflected accurate data. Q1-Q3 2018 reports were reconciled and updated as well. A CAP is in development with HN.
4. **Facility Site (FSR) & Medical Record (MRR) & PARS Review** results were reported to the Committee. The FSR/MRR/PARS process is required by DHCS in order to evaluate practitioner office site compliance with medical record documentation, physical environment and access standards required by DHCS and CalViva. In the first 6 months of 2018, the following were completed: 25 FSRs, 21 MRRs and 25 PARS. All Corrective Action standards during this same time period met the compliance standards 100% of the time.
5. **MHN Performance Indicator Report** provides a summary of mental health services provided to CVH members (Mild to Moderate). In Q3, 17 of 18 metrics met or exceeded their targets. Performance was below target for Network Adequacy for BCBA/paraprofessionals providing autism services. Some providers did not have all newly required documentation in their files. MHN Provider Relations staff is working with these providers to address this issue.
6. **Other Reports** reviewed and approved include: Provider Preventable Conditions reports, Provider Office Wait Time report, Public Programs report, and PM 160 Reports.

- **UMCM Reports -** Utilization and Case Management activities are monitored in an ongoing manner through a variety of performance, programmatic and regulatory reports. During this reporting period the UMCM related reports included but were not limited to the following:

1. **The Key Indicator Report (KIR)** provided data as of December 2018. This report includes key metrics for tracking utilization and case management activities. A year-end comparison was reviewed with the following results:
    a. Membership TANF rates for Q4 2018 were at or below goals in all categories (lower number is better).
    b. SPD rates for Q4 2018 were challenging with Acute Average Length of Stay and Readmission rates above goals.
    c. Medi-Cal Expansion rates were at or slightly above goal in all categories.
    d. Early in 2018 (Q1 & Q2) some measures were well above goal for particular measures in the MCE and TANF populations due to a particularly virulent influenza strain, however these rates came down in the second half of the year.

2. **Utilization Management Concurrent Review Report**. The 2018 Utilization Management/Medical Management Concurrent Review Report presents inpatient utilization data and clinical concurrent review activities for Q3 2018. The focus is on improving member healthcare outcomes, minimizing readmission risk, and reducing post-acute gaps in care delivery via proactive discharge planning and expeditious linkages to medically necessary health and support services.
    a. An increase in utilization across all populations (TANF, Expansion, and SPD) for admissions and Emergency visits noted in Q1 and Q2 but has moved towards normalization in Q3.
    b. An analysis of admission types and emergency room visits for Q3 reveal Sepsis and Pneumonia to be the most common diagnoses with Diabetes the most common co-morbidity.

c. Homelessness continues to be a major barrier to safe, appropriate discharge for CalViva members in all populations as the homeless rate continues to rise for the tri-county area.

3. **Case Management, Transitional Case Management (TCM), Palliative Care (PC) & Behavioral Health Case Management (BHCM) Report** This report summarizes the integrated case management, perinatal case management, transition care management and palliative care activities. This report continues to evolve and expand and now includes reporting on behavioral health case management as well. The goal of these programs is to identify members who would benefit from the services offered and to engage them in the appropriate program. The effectiveness of the case management program is based upon:
    - Readmission rates
    - ED utilization
    - Overall health care costs
    - Member Satisfaction

    Positive results are noted for these measures in Quarter 4. Effectiveness of the other program types are established and evaluated and included in the quarterly report.
4. **Other Reports** reviewed and approved include:

- **Pharmacy Reports –** Pharmacy quarterly reports include Operation Metrics, Top Medication Prior Authorization (PA) Requests, and quarterly Formulary changes to assess for emerging patterns in authorization requests and compliance around prior authorization turn-around time metrics.
    - All third quarter 2018 pharmacy prior authorization metrics were within 5% of standard.

II. HEDIS® Activity

1. HEDIS® performance measures are used to assess the quality of care provided to health plan members. Managed Care Plans are required by contract to annually report performance measurement results to DHCS/HSAG. In Q4, HEDIS related activities focused on improving targeted measures above the Minimum Performance Level (MPL) as the calendar year came to an end. Rapid cycle improvement (PDSA) Projects were well underway with new interventions initiated.
    - At the end of September, the Plan received notification from DHCS of a Corrective Action Plan (CAP) related to three measures below the MPL for three years in Madera County. A CAP was submitted on October 10th and was accepted. In February 2019, CVH leadership met with DHCS to provide a progress report on the CAP. Preliminary results indicate we are above the MPL for all three measures for RY19.
    - The 2019 HEDIS Roadmap was completed and submitted to HSAG in January 2019. Data collection for RY19 measures also began in January and continues until May when the final data submission is due.

    <u>Projects for RY2019 include:</u>
    1. Monitoring Patients on Persistent Medications (MPM) Madera County
    2. Avoid Antibiotics in Adults with Bronchitis (AAB) Madera County
    3. Breast Cancer Screening (BCS) Fresno County
    4. Comprehensive Diabetes Care (CDC) -HbA1c & Nephropathy -Fresno County

    Medical Management also continues to move forward with the two Performance Improvement Projects (PIPs) selected, Childhood Immunizations and Postpartum Visits. Two interventions have been initiated for each project. Initial results are positive. These projects will close on June 30th, 2019

III. Findings/Outcomes

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

Item #7

Attachment 7.G

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 21st, 2019

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2019

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2019 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 21st, 2019. At the February meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services. Reports covering the third quarter for 2018 were reviewed for delegated entities and the fourth quarter 2018 report was reviewed for Health Net. A summary of the third quarter data is included in the table below.

II. Table 1. Third Quarter 2018 Credentialing/Recredentialing

	Sante	ChildNet	MHN	Health Net	La Salle	ASH	VSP	Envolve Vision	IMG	CVMP	Adventist	**Totals**
Initial credentialing	55	38	4	1	26	1	16	8	9	1	106	**265**
Recredentialing	108	51	8	1	23	0	47	0	6	0	0	**244**
Suspensions	0	0	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	0	**0**
Totals	**163**	**89**	**12**	**2**	**49**	**1**	**63**	**8**	**15**	**1**	**106**	**509**

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III. The Credentialing Sub-Committee reviewed and approved the Credentialing policies and procedures that were updated for 2019. Two policies had significant changes, one policy was retired and the remaining policies had no changes or minor edits.

IV. The Quarter 4 2018 Credentialing report was reviewed with one case that resulted in an uphold of denial for re-entry with subsequent request for Fair Hearing. Other County-specific Credentialing Sub-Committee reports were reviewed and approved. No other significant cases were identified on these reports.

Item #7

Attachment 7.H

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	March 21st, 2019
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2019

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 21st, 2019. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2018 were reviewed for approval. There were no significant cases to report.

II. The Peer Review policies and procedures were reviewed with the 2019 updates. One policy was accepted with minor edits and one policy with more significant edits was reviewed and also accepted.

III. The Quarter 4, 2018 Peer Count Report was presented at the meeting with the following outcomes:
   - There were three cases closed and cleared. There were no cases pending closure for Corrective Action Plan compliance. There was one case pended for further information.

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

Item #7

Attachment 7.I

Executive Dashboard

	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2018	2019	2019
Month	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**
CVH Members													
Fresno	293,142	292,528	293,074	293,288	293,831	293,382	292,471	292,548	291,230	290,419	288,236	291,690	291,607
Kings	27,780	27,854	27,940	28,046	28,047	28,143	28,233	28,255	28,368	28,723	28,753	28,970	29,201
Madera	36,383	36,221	36,383	36,656	36,775	36,709	36,635	36,730	36,762	36,586	36,553	36,749	36,749
Total	357,305	356,603	357,397	357,990	358,653	358,234	357,339	357,534	356,360	355,728	353,542	357,409	357,557
SPD	30,829	30,884	30,828	30,877	31,082	31,222	31,371	31,514	31,573	31,618	31,714	31,689	31,665
CVH Mrkt Share	70.78%	70.95%	71.00%	71.00%	71.03%	70.99%	70.99%	70.96%	70.92%	70.79%	70.74%	71.02%	71.04%
ABC Members													
Fresno	108,601	107,485	107,400	107,456	107,469	107,531	107,141	107,320	107,028	107,687	107,203	106,822	106,674
Kings	19,690	19,457	19,465	19,593	19,631	19,631	19,686	19,686	19,660	19,603	19,453	19,543	19,567
Madera	19,227	19,096	19,120	19,174	19,172	19,218	19,215	19,339	19,426	19,516	19,547	19,471	19,525
Total	147,518	146,038	145,985	146,223	146,272	146,380	146,042	146,345	146,114	146,806	146,203	145,836	145,766
Default													
Fresno	1,353	822	1,042	899	909	1,080	1,022	979	841	1,055	1,330	682	1,142
Kings	259	137	204	178	168	188	195	152	141	166	212	127	174
Madera	188	117	92	124	122	130	121	132	111	124	130	138	138
County Share of Choice as %													
Fresno	62.30%	70.91%	67.70%	67.50%	65.70%	65.50%	65.10%	65.90%	63.70%	66.0.%	61.90%	64.30%	62.60%
Kings	61.70%	59.76%	52.10%	49.90%	54.60%	58.80%	59.10%	56.60%	61.50%	67.30%	69.80%	66.70%	69.00%
Madera	56.00%	66.39%	67.80%	63.20%	60.90%	63.50%	63.90%	55.40%	57.80%	56.80%	60.00%	53.40%	61.20%
Voluntary Disenrollment's													
Fresno	671	504	497	433	437	435	452	585	481	540	442	401	422
Kings	51	60	73	50	108	57	68	68	41	40	41	50	36
Madera	144	71	63	63	57	56	67	75	57	79	77	66	64