FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Pomaville, Director
Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Ed Hill, Director
Public Health Department

Harold Nikoghosian
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Brian Smullin
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: February 12, 2021

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

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

Thursday, February 18, 2021
1:30 pm to 3:30 pm

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

Teleconference: 605-313-4819
Participant Code: 270393

Meeting materials have been emailed to you.

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

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority

Commission Meeting

February 18, 2021
1:30pm - 3:30pm

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

Teleconference: 605-313-4819
Participant Code: 270393

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B	**Reappointed Board of Supervisors Commissioners** • BL 21-001 2021 Reappointed BOS Commissioners • Appointment confirmations *Action: Ratify reappointment County Board of Supervisors Commissioners*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C Attachment 4.D Attachment 4.E	**Consent Agenda:** • Commission Minutes dated 11/19/2020 • Finance Committee Minutes dated 10/15/2020 • QI/UM Committee Minutes dated 10/15/2020 • Public Policy Committee Minutes dated 9/2/2020 • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5 Information	Attachment 5.A Attachment 5.B *No attachment*	**Annual Administration** • BL 21-002 Annual Administration • Form 700 • Ethics Training	D. Hodge, MD, Chair
6 Action	*No attachment* *No attachment*	**Funding Request** • eConsult • COVID-19 Vaccinations *Recommended Action: Approve Funding Requests*	G. Hund, CEO
7 Action	*No attachment*	**Community Support Program Ad-Hoc Committee Selection** • Select ad-hoc Committee *Action: Selection of Ad-Hoc Committee*	D. Hodge, MD; Chair

	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 8 & 9* ***One vote will be taken for combined items 8 & 9***	
8 Action	Attachment 8.A Attachment 8.B	**2020 Annual Quality Improvement Work Plan Evaluation** • Executive Summary • Year End Evaluation	P. Marabella, MD, CMO
9 Action	Attachment 9.A Attachment 9.B Attachment 9.C	**2020 Annual Utilization Management Case Management Workplan Evaluation** • Executive Summary • Year End Evaluation **2021 Utilization Management Program Description** *Action: Approve 2020 Quality Improvement Year End Evaluation, and the 2020 Utilization Management Case Management Year End Evaluation, and 2021 Utilization Management Program Description.*	P. Marabella, MD, CMO
		PowerPoint Presentations will be used for item 10 - 14 ***One vote will be taken for combined items 10 – 14***	
10 Action	Attachment 10.A	**2020 Annual Compliance Evaluation**	M.B. Corrado, CCO
11 Action	Attachment 11.A	**2021 Compliance Program Description**	M.B. Corrado, CCO
12 Action	Attachment 12.A	**2021 Code of Conduct**	M.B. Corrado, CCO
13 Action	Attachment 13.A	**2021 Anti-Fraud Plan**	M.B. Corrado, CCO
14 Action	Attachment 14.A	**2021 Privacy and Security Plan** *Action: Approve 2020 Compliance Evaluation, 2021 Compliance Program Description, Code of Conduct, Anti-Fraud Plan, and Privacy and Security Plan.*	J. Nkansah, COO
15. Action		**Standing Reports**	
	Attachment 15.A	**Finance Report** • Financials as of December 31, 2020	D. Maychen, CFO
	Attachment 15.B Attachment 15.C Attachment 15.D	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • QIUM Quarterly Report	P. Marabella, MD, CMO
	Attachment 15.E	**Operations** • Operations Report	J. Nkansah, COO
		Executive Report	

	Attachment 15.F *No attachment*	• Executive Dashboard • Annual Report (*mailed to Commissioners in January*) *Action: Accept Standing Reports*	G. Hund, CEO
16.		**Closed Session:** *(a separate confidential call-in number will be provided to Commissioners the morning of the meeting)* **The Board of Directors will go into closed session to discuss the following item(s)** **1. Public Employee Appointment, Employment, Evaluation, or Discipline** A. Staffing – Information B. Staffing – Action Per Government Code Section 54957(b)(1)	
Information ***Action***	*No attachment* *No attachment*		
17		**Final Comments from Commission Members and Staff**	
18		**Announcements**	
19		**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.*	
20		**Adjourn**	D. Hodge, MD, Chair

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

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

Next Meeting scheduled for March 18, 2021 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

Attachments 3.A – 3B

- BL 21-001 Reappointed BOS Commissioners
- BOS Appointment Confirmations

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Pomaville, Director
Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Ed Hill, Director
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Harold Nikoghosian- At-large

Madera County

David Rogers
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www.calvivahealth.org

DATE: February 18, 2021

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Appointed / Re-Appointed County BOS Commissioners

BL #: 21-001
Agenda Item 3
Attachment 3.A

Discussion Points:

Fresno County has re-appointed Supervisor Sal Quintero
Fresno County Alternate is Supervisor Pacheco
Kings County has re-appointed Supervisor Joe Neves
Kings County Alternate is Supervisor Doug VerBoon
Madera County has re-appointed Supervisor David Rogers
Madera County Alternate is Brett Frazier

Term thru:	**Commission Seat**	**Currently Occupied By:**
January 2022 January 2022 January 2022 January 2022 January 2023 January 2023	Board of Supervisors—Fresno County Board of Supervisors—Fresno County Alt Board of Supervisors—Kings County Board of Supervisors—Kings County Alt Board of Supervisors—Madera County Board of Supervisors—Madera County Alt	Sal Quintero Brian Pacheco Joe Neves Doug VerBoon David Rogers Brett Frazier
March 2021	Madera At-Large Commission Appointed	Paulo Soares
May 2021	Fresno At-Large County Appointed Community Medical Center	Soyla Griffin Aldo De La Torre
January 2022	Fresno At-Large Commission Appointed	John Frye Jr.
January 2022	Valley Children's Hospital	Brian Smullin
May 2022	Fresno At-Large County Appointed Fresno At-Large County Appointed	David Cardona, MD David S. Hodge, MD
March 2023	Kings At-Large County Appointed	Harold Nikoghosian
April 2023	Kings At-Large Commission Appointed	Kerry Hydash
May 2023	Fresno At-Large County Appointed	Joyce Fields-Keene
September 2023	Madera At-Large	Aftab Naz, MD
	Indefinite terms:	
	David Pomaville, Fresno County Health Dept	
	Ed Hill, Kings County Health Dept	
	Sara Bosse, Madera County Health Dept	

BOARDS, COMMISSIONS OR COMMITTEES ON WHICH THE BOARD OF SUPERVISORS SERVE 2021		
	COMMITTEE	**2021**
19	**Fresno-Kings-Madera Regional Health Authority** *Alternate	Quintero *Pacheco
20	**Fresno/Clovis Convention & Visitors Bureau** (Chairman or designees)	Magsig PW&P Designee
21	**Fresno-Madera Area Agency on Aging - Governing Board** *Alternate	Brandau *Remaining 4 Board Members
22	**Fresno Regional Workforce Development Board**	Quintero
23	**Indian Gaming Local Benefit Committee**	Magsig Brandau
24	**Kings River East Groundwater Sustainability Agency** ***Alternate**	Mendes *PW&P Designee
25	**Law Library Board of Trustees** (Chairman, another Board Member or a member of the Bar Association)	Brandau
26	**Local Agency Formation Commission** *Alternate	Brandau Magsig *Quintero
27	**McMullin Area of Kings Groundwater Subbasin** ***Alternate**	Pacheco *Mendes
28	**North Fork Kings Groundwater Sustainability Agency**	Mendes
29	**North Kings Groundwater Sustainability Agency** *Alternate	Pacheco *Mendes
30	**Pleasant Valley State Prison Citizens Advisory Committee**	Pacheco Mendes
31	**Retirement Board**	Magsig
32	**San Joaquin River Conservancy** *Alternates	Brandau *Pacheco *Magsig
33	**San Joaquin Valley Insurance Authority (SJVIA)** 4 members *Alternate	Mendes, Brandau, Magsig, Pacheco *Quintero
34	**San Joaquin Valley Supervisors Association**	All Board Members
35	**San Joaquin Valley Unified Air Pollution Control District**	Mendes
36	**San Joaquin Valley Water Infrastructure Authority** *Alternate	Mendes *Pacheco

COUNTY OF KINGS
BOARD OF SUPERVISORS

KINGS COUNTY GOVERNMENT CENTER
1400 W. LACEY BOULEVARD.HANFORD, CA 93230
(559) 582-3211, EXT. 2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

JOE NEVES – DISTRICT 1
LEMOORE & STRATFORD

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

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

CRAIG PEDERSEN – DISTRICT 4
ARMONA & HANFORD

RICHARD FAGUNDES – DISTRICT 5
HANFORD & BURRIS PARK

January 12, 2021

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

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

Dear Cheryl;

At a regular meeting of Kings County Board of Supervisors on January 12, 2021, the following members were appointed to the CalViva - Fresno/Kings/Madera Regional Health Authority:

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

Alternate Appointments
Doug Verboon, Supervisor Dist. 4
1400 W. Lacey Blvd
Hanford, CA 93230
(559) 852-2366
doug.verboon@co.kings.ca.us

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

Respectfully,

Catherine Venturella,
Clerk to the Board of Supervisors

2021 BOARD OF SUPERVISORS MEMBERSHIPS

APPOINTMENTS ARE FOR ONE YEAR UNLESS INDICATED OTHERWISE

AGENCY	PRIMARY MEMBER	ALT MEMBER	TERM	CURRENT EXPIRATION (P)	CURRENT EXPIRATION (A)
Behavioral Health Board	Leticia Gonzalez	Robert Poythress		1/1/2022	1/1/2022
Review/evaluate mental health needs, insures appropriate and economical use of funds. Meets: 3rd Wednesday of every month, 11:30am-1:00pm					
CAL ID-Remote Access Committee (RAN)	Robert Poythress	David Rogers			
California Women's Facility Citizens Advisory Committee	David Rogers	Brett Frazier	2 Years	1/1/2023	1/1/2023
Can be a BOS member or a liaison from the Community at large. Meets: 1st Thursday of every other month, 3pm @ the Prison.					
California Development Block Grant Committee (CDBG)	Robert Poythress	Leticia Gonzalez			
Children & Families Commission (First 5)	Leticia Gonzalez	David Rogers	2 Years	1/1/2023	
Administration of Prop 10 (Tobacco) funds. Meets: 1st Wednesday of each month.					
Community Action Partnership of Madera County (CAPMC)	Leticia Gonzalez	Robert Poythress			
A social service agency: adminsters programs such as Headstart, Emergency Services, Victim Services. Meets: 2nd Thursday each month @5:30pm @1225 Gill Ave. Madera					
Community Corrections Partnership Committee	Robert Poythress	Brett Frazier			
Countywide Oversite Board of the Successor Agencies to the Redevelopment Agencies*	Robert Poythress	Leticia Gonzalez			
Per Resolution: Chairman and Chairman Pro Tem					
Courthouse Park Resotration Committee	Robert Poythress				
California State Assocation of Counties Policy Committees (CSAC)*	David Rogers	Leticia Gonzalez			
Appointment for 2020-2021 approved 11-10-2020					
Ag & Natural Resources	David Rogers		2 Years	1/1/2023	
Labor & Employment	Brett Frazier		2 Years	1/1/2023	
Government Finance & Operations	Robert Poythress		2 Years	1/1/2023	
Health & Welfare	Leticia Gonzalez		2 Years	1/1/2023	
Housing/Land Use/ Transportation (Native American Issues)	Tom Wheeler	Brett Frazier	2 Years	1/1/2023	
Administration of Justice	Robert Poythress		2 Years	1/1/2023	
CSAC Board of Directors (Sets Policy for CSAC)	David Rogers	Leticia Gonzalez	2 Years	1/1/2023	
Meets: Twice per year as determined by Committee Chairperson Conferences:	**Spring Conference & Annual Meeting**				
Crane Valley Project	Tom Wheeler				
Economic Development Commission	Brett Frazier	Leticia Gonzalez			
Promote Economic growth of Madera County. Meets: 2nd Wednesday of every month @3:00pm Conference: EDC Annual Planning Conference (Bass Lake)					
Fresno/Madera Area Agency on Aging Board of Directors (FMAAA)	Leticia Gonzalez	Brett Frazier			
Advocacy for elderly; Advance the aims of the Older American Act. Meets: 3rd Thursday @10am					
Fresno-Kings-Madera Regional Health Authority Commission	David Rogers	Brett Frazier	3 Years	1/1/2023	1/1/2023

Item #4

Attachment 4.A

Commission Minutes
Dated 11/19/2020

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
November 18, 2020

Meeting Location:
Teleconference Meeting due
to COVID-19 Executive Order
CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93711

	Commission Members		
	Sara Bosse, Director, Madera Co. Dept. of Public Health	✓●	**Aftab Naz**, Madera County At-large Appointee
✓●	**David Cardona**, M.D., Fresno County At-large Appointee	✓●	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
	Aldo De La Torre, Community Medical Center Representative	✓●	**Harold Nikoghosian**, Kings County At-large Appointee
✓●	**Joyce Fields-Keene,** Fresno County At-large Appointee	✓●	**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		**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
✓●	**Kerry Hydash**, Commission At-large Appointee, Kings County		
	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 via conference call in lieu of gathering in public per executive order signed	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of Commissioners' physical attendance at the public location or by teleconferencing.	
#2 Roll Call Cheryl Hurley, Clerk to the Commission	A roll call was taken for the current Commission Members.	*A roll call was taken*
#3 Consent Agenda a) Commission Minutes 10/15/2020 b) Finance Committee Minutes 9/17/2020 c) QIUM Committee Minutes dated 9/17/2020 d) Compliance Report Action D. Hodge, MD, Chair	All consent items were presented and accepted as read. *Joyce Fields-Keene not included in vote*	***Motion**: Approve Consent Agenda 10 – 0 – 0 – 7* *(Neves / Nikoghosian)* *A roll call was taken*
#4 CVH Website Demonstration Information D. Hodge, MD, Chair	Jeff Nkansah gave an in-depth demonstration via WebEx of the new CalViva Health (CVH) website. The updated/rebrand of the website is a result of solicited feedback provided from the CVH Public Policy Committee, other local health plans similar to CVH, and a local promotores community group from Madera county. The update was also a result of ADA Accessibility and Section 508 website compliance.	***No Motion***

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#5 Standing Reports • **Finance Report** Daniel Maychen, CFO	**<u>Finance</u>** **September 2020 Financials**: Total current assets were approximately $283.8M; total current liabilities were approximately $186.6M. Current ratio is 1.52. TNE as of September 30, 2020 was approximately $107.4M, which is approximately 724% above the minimum DMHC required TNE amount. For July 2020 through September 2020 actual premium capitation income recorded was approximately $320.5M which is approximately $4.25M below budgeted amounts, primarily due to MCO tax being less than what was projected, and rates being less than budgeted. The MCO tax loss is decreasing due to an increase in enrollment; however, is still creating a material loss to the Plan. From July 2020 to September 2020, the Plan has incurred an approximate $2.5M MCO tax loss. Furthermore, assuming enrollment remains relatively consistent, the projected tax loss of approximately $4.3M for the period of July 2020 through December 2020 is expected. DHCS has acknowledged and are keeping track of the MCO tax loss the Plans are experiencing, and are currently assessing potential solutions; the timing of any adjustments is yet to be determined. In addition, DHCS is in the process of creating their MCO tax revenue rate for the period of January 2021 through June 2021; those rates should be received late December 2020. Total cost of medical care expense recorded is approximately $269.2M which is approximately $1.7M less than budgeted due to rates being less than projected. All other expense line items are in line or below what is budgeted. For the first three months of fiscal year 2021, there is	***Motion**: Approve Standing Reports* *11 – 0 – 0 – 7* *(Nikoghosian / Frye)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	an approximate net loss of $1.3M, noting Net Income is approximately $2.5M less than budgeted, primarily due to the MCO tax loss. **<u>Medical Management</u>** **Appeals and Grievances Dashboard** Dr. Marabella presented the Appeals & Grievances Dashboard through the end of Q3 2020. The total number of grievances through Q3 has remained relatively consistent with Q2, but is noted to be lower than Q1 2020. The majority of grievances were due to Exempt grievances followed by Quality of Service issues. Quality of Care grievances have decreased from both Q1 and Q2 2020. The Exempt grievances for Q3 have remained consistent with Q2 2020. The two categories stated as "PCP Assignment/Transfer" that were labeled incorrectly have been modified to better reflect the issues. The total number of Appeals Received as of the end of Q3 2020 has demonstrated variation quarter to quarter with increased volumes compared to the prior year. Opportunities to further evaluate these appeals and educate providers have been identified, and training has been conducted.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Key Indicator Report Dr. Marabella presented the Key Indicator Report through Q3, 2020. In-hospital utilization rates have dipped in all areas in Q3. The lower admission numbers may be related to the spikes in COVID-19 cases throughout the year. Turn-around time compliance in Q3 was 100% Case Management results in 2020 continue to demonstrate positive trends in all areas. **QIUM Quarterly Report** Dr. Marabella provided the QI/UM Qtr. 4, 2020 update. One QI/UM meeting was held in Quarter 4 thus far, on October 15, 2020. The following guiding documents were approved at this meeting: • 2020 Culture & Linguistics (C&L) Work Plan Mid-Year Evaluation. • 2020 Health Education (HE) Work Plan Mid-Year Evaluation In addition, the following general documents were approved at the meetings: • Culture & Linguistics Language Assistance Program • CVH Preventive Screening Guidelines 2020	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Provider Appointment Availability and After-Hours Access Survey Results • Pharmacy Formulary • Medical Policies Q2 • UMCM Policy & Procedure Review The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard & Quarterly Reports, MHN Performance Indicator Report, SPD Health Risk Assessment (HRA), and Access Provider Office Wait Time Reporting. The Utilization Management & Case Management reports reviewed included the Key Indicator Report, Specialty Referral Report, MedZed Integrated Care Management Report, and additional UMCM reports. HEDIS® Activity: In Q4, HEDIS® related activities focused on analyzing the results for RY2020 under the new Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. The areas CalViva reported results below the 50th percentile MPL are: • Antidepressant Medication Management, for both the Acute Phase and the Continuation Phase, for all three counties. • Adolescent Well-Care Visit for Fresno County. • Breast Cancer Screening for Fresno County. • Chlamydia Screening for Madera County. • Childhood Immunization – Combo 10 for Fresno and Kings counties.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Well-Child Visits in the first 15 months of life for Fresno and Kings counties. Proposed Performance Improvement Projects (PIPs) consist of: • Childhood Immunizations – Combo 10 • Breast Cancer Screening On November 2nd CalViva submitted notification to DHCS of intent to re-establish Performance Improvement Projects (PIPs) for these two measures. New this year, each Plan is required to report on what is called the "COVID-19 Quality Improvement Plan (QIP)". This is a selection of 3 or more improvement strategies that demonstrate how the Plan has/will adapt to improve the health/wellness of its members during the COVID 19 Emergency. These interventions are to be associated with preventive services, chronic illness and/or behavioral health. The initial CalViva COVID-19 QIP report was submitted to DHCS on October 21st, 2020 and has been accepted by DHCS. The 3 improvement strategies include: **1.** Antidepressant Medication Management (AMM) Member Outreach effort by Behavioral Health Case Managers in Kings and Madera counties to encourage medication adherence. **2.** Adolescent Well-Care Visits will be addressed through a MemberConnections Outreach intervention for families in Fresno County.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	3. Pharmacy Outreach effort to encourage medication adherence for patients on blood pressure medications and/or anti-diabetic agents in Fresno County. **Credentialing Sub-Committee Quarterly Report** In Quarter 4, the Credentialing Sub-Committee met on October 15, 2020. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q2 2020 were reviewed for delegated entities, Q2 and Q3 for MHN, and Q3 2020 reports were reviewed for Health Net. There was one (1) ongoing case on the Quarter 3 2020 Credentialing Report from Health Net. This is related to ongoing monitoring of a case in Fresno County following a denial for re-entry into the network. Ongoing monitoring and reporting will continue. **Peer Review Sub-Committee Quarterly Report** The Peer Review Sub-Committee met on October 15, 2020. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2020 were reviewed for approval. There were no significant cases to report. The Q3 2020 Peer Count Report was presented with a total of 8 cases reviewed. There were three (3) cases closed and cleared. There were no cases pending closure for Corrective Action Plan compliance. There were five (5) cases pended for further information. Follow up will be initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Operations** J. Nkansah, COO • **Executive Report** G. Hund, CEO	No significant compliance issues have been identified. Oversight and monitoring processes will continue. **<u>Operations Report</u>** For IT Communications and Systems Active Presence of Failed Backups within Systems has been added and daily reports are being received. For Privacy and Security, a Risk Analysis was completed and presented to the confidential Compliance Committee. A grade of "A" was given for both Privacy Risk and Security Risk. In addition, the Active Business Associate Agreements was reduced from six (6) to five (5) due to the relationship end b/w CalViva Health and the Pharmacy consultant. In reference to the Member Call Center, the matrix for Behavioral Health is being monitored due to not meeting goal in Q3. Monitoring continues for Transportation as this category has been impacted in both Q2 and Q3 due to the COVID-19 pandemic. The CalViva Website was unveiled and discussed previously in agenda item #4. For all other areas, there are no significant items or issues to report **<u>Executive Report</u>** Membership as of the end of October increased to just over 370K members; highest in the history of CVH. Market share continues to decline at a slow rate. An action plan has been put in place to improve market share and improvement is expected by end of Q1 2021.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#6 Closed Session **A.** Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility – (*Confidential – Action Required*) B. Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility – (*Information Only*)	Jason Epperson, General Counsel, reported out of Closed Session. Commissioners discussed those items agendized for closed session discussion. Specifically, 1. Item 6.A Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility – • A motion was made and seconded to adopt a resolution by the Commission to conduct an election by all eligible employees regarding employee social security benefits. Motion was adopted unanimously by a vote of 10/0. 2. Item 6.B Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility – • Direction was given to staff. Closed Session concluded at 2:54 pm. *Harold Nikoghosian absent for Closed Session; not included in vote*	***6.A Motion**:* *10 – 0 – 0 – 7* *(Neves / Griffin)* *A roll call was taken* ***6.B No Motion; Information only***
#7 Final Comments from Commission Members and Staff	None.	
#8 Announcements	None.	
#9 Public Comment	None.	
#10 Adjourn	The meeting was adjourned at 2:55 pm The next Commission meeting is scheduled for February 18, 2021 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #4

Attachment 4.B

Finance Committee Minutes
dated 10/15/2020

CalViva Health
Finance
Committee Meeting Minutes

October 15, 2020

Meeting Location
Teleconference Meeting due
to COVID-19 Executive Order
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, Accounting Manager
✓•	Paulo Soares		
✓•	Joe Neves		
✓•*	Harold Nikoghosian		
✓•	David Rogers		
✓•	John Frye		
		✓	Present
		*	Arrived late/Left Early
		•	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 via conference call in lieu of gathering in public per executive order signed by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of Commissioners' physical attendance at the public location or by teleconferencing.	A roll call was taken.

#2 Finance Committee Minutes dated September 17, 2020 Attachment 2.A Action D. Maychen, Chair	The minutes from the September 17, 2020 Finance meeting were approved as read. *John Frye arrived at 11:31 am; not included in vote*	Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Nikoghosian / Soares)* A roll call was taken.
#3 Presentation of Fiscal Year 2020 Audit Results Action D. Maychen, Chair	Rianne Suico, representative from Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an unmodified opinion on the financial statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances were discussed. The required communications and the organization's accounting policies are in compliance with GAAP. After completing the work, it was found that the financial statements do not need to be adjusted and no issues were encountered when completing the work. *Harold Nikoghosian left meeting at 11:46 am; not included in vote*	Motion*: Approve Fiscal Year 2020 Audit Results* *6 – 0 – 0 – 1* *(Hund / Soares)* A roll call was taken.
#4 Financial Statements as of August 31, 2020 Action D. Maychen, Chair	Total current assets were approximately $351.9M; total current liabilities were approximately $254.7M. Current ratio is 1.38. TNE as of August 31, 2020 was approximately $107.5M, which is approximately 725% above the minimum DMHC required TNE amount. For the first two months of fiscal year 2021 premium capitation income actual recorded was approximately $211.5M which is approximately $4.9M below budgeted amounts, primarily due to rates being lower than anticipated, and the MCO tax being less than what was	Motion*: Approve Financials as of August 31, 2020* *6 – 0 – 0 – 1* *(Hund / Soares)* A roll call was taken.

	budgeted. In July 2020 the MCO tax loss was approximately $1M; whereas the MCO tax loss for August was approximately $755K. The decrease was due to additional enrollment in August. DHCS has stated they are taking into consideration the MCO tax loss and could potentially make an adjustment beginning January 2021 to make up for the loss for the period of July 2020 through December 2020. DHCS is scheduled to present the new MCO tax rate, covering the time period of January 2021 to June 2021, to Plans in December 2020. Total cost of medical care expense actual recorded is approximately $177.6M which is approximately $3M less than budgeted due to rates being less than projected. All other expense line items are in line or below what is budgeted. For the first two months of fiscal year 2021, there is an approximate net loss of $1.2M primarily due to the MCO tax loss.	
#5 Announcements		
#6 Adjourn	Meeting was adjourned at 11:50 am	

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

Dated: 11/19/2020

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 11/19/2020

Item #4

Attachment 4.C

QIUM Committee Minutes
dated 10/15/2020

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
October 15th, 2020

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

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

✓ = In attendance
* = Arrived late/left early
• = Attended via Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D, Chair	The meeting was called to order at 10:35 am. A quorum was present.	
#2 Approve Consent Agenda - Committee Minutes: September 17th, 2020 - Provider Preventable Conditions (PPC)(Q2) - CVH Preventative	The September 17th, 2020 QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. The full September Formulary (RDL) was available for review upon request.	Motion: Approve Consent Agenda (Verma/Cardona) 4-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Screening Guidelines 2020 - Standing Referrals Report - Medical Policies Provider Updates (Q2) - Full Formulary (September PDL) (Attachments A-E) Action Patrick Marabella, M.D Chair	Dr. Ayala and Dr. Lee both announced their attendance at 10:43 am. Dr. Marabella welcomed Dr. Ayala as a new member to the committee and each member introduced themselves.	
#3 QI Business - Appeals & Grievances Dashboard and Turnaround Time Report (August) (Attachment F) Action Patrick Marabella, M.D, Chair	Dr. Marabella presented the Appeals & Grievances Dashboard through August 2020. ➢ The total number of grievances ending August 2020 has decreased slightly, presumably due to less interactions with providers. ➢ The majority of grievances were due to Quality of Service. ➢ The Exempt grievances decreased in August. It has been determined that the category "PCP Assignment/Transfer – Incorrect PCP assigned-Health Plan Error" has been incorrectly labeled, as these were found to be a request to change the assignment. The category label will be modified to better reflect the issue. a. The total number of Appeals Received as of the end of July was noted to have decreased from recent months, however, the number increased again in August. Further evaluation of these appeals related to pharmacy and advanced imaging in progress. Based upon results of analysis providers will be educated and any other recommendations addressed. Activities are underway.	Motion: Approve - Appeals & Grievances Dashboard (August) (Foster/Lee) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business** - MHN Performance Indicator Report (Q2) (Attachment G) Action Patrick Marabella, M.D, Chair	The **MHN Performance Indicator Report for Behavioral Health Services** (Q2 2020) was presented. 15 out of the 15 metrics met or exceeded their targets. ➢ Authorization Decision Timeliness exceeded the target for Provider Disputes. Quarter 2 2020 resolution timeliness was above target by 5%. All 150 disputes were resolved within timeliness standards, resulting in a 100% compliance rate. A number of interventions have been implemented by the MHN Dispute Unit to improve performance. ➢ Member appointment access data revealed no (0) Life-threatening Emergent cases.; there were two (2) Non-life-threatening Emergent cases and the access standard was met; there were two (2) Urgent case and the appointment access standard was met. ➢ There were 2 PQI cases in Quarter 2 2020, one with minimal adverse effect. Both were resolved within timeliness standards.	Motion: Approve - MHN Performance Indicator Report (Q2) (Foster/Lee) 6-0-0-2
#3 **QI Business** - SPD HRA Outreach (Q2) (Attachment H) Action Patrick Marabella, M.D, Chair	The **SPD Health Risk Assessment** report for Q2 was presented. This is a state mandated member outreach activity which is summarized in this report quarterly. The intent of this new member outreach is to identify higher risk individuals and offer case management and other care coordination services and resources. DHCS requires a minimum of 3 outreach calls within 45 days for high risk individuals and three outreach calls to low risk individuals within 90 days of enrollment in the Plan. Results for Quarter 1 and Quarter 2 2020 include the following: ➢ All 5,421 members were outreached within the compliance due dates for Q2 2020. ➢ The focus of the regulation is timely outreach, which met 100% for all the records received back for Q2 2020. ➢ The percentage of members that completed a HRA for both high and low risk in Q2 2020 is 12.6% (709). To streamline calling and reporting a new call system will be implemented to provide an automated and more streamlined reporting solution. Additional outreach methods are being explored such as emailing and texting members. Updates will be provided.	Motion: Approve - SPD HRA Outreach (Q2) (Foster/Lee) 6-0-0-2
#3 **QI Business** - QIUM 2021 Meeting Schedule (Attachment I)	The **2021 QI/UM Committee Meeting schedule** was reviewed.	Informational: - QIUM 2021 Meeting Schedule

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#4 Culture & Linguistics/Health Education/QI Business - Culture & Linguistics Work Plan Mid-Year Evaluation & Executive Summary - Culture & Linguistics Language Assistance Program Report - Health Education Work Plan Mid-Year Evaluation & Executive Summary (Attachment J-L) Action Patrick Marabella, M.D, Chair	Dr. Marabella presented the **2020 Cultural & Linguistics Work Plan Mid-Year Evaluation and Executive Summary.** The 4 categories for the 2020 Work Plan are: • Language Assistance Services (LAP) • Compliance Monitoring • Communication, Training and Education • Health Literacy, Cultural Competency and Health Equity By June 30, 2020 all activities were on target. Some of the activities completed consist of: 1. Population Needs Assessment was completed in collaboration with Health Education and Quality Improvement. 2. C & L related grievances reviewed. Follow up completed when indicated. 3. Promoted Aunt Bertha platform as a member resource and included on Member Newsletter. 4. Four Call Center trainings conducted. 5. Collaborated on Breast Cancer Screening PIP intervention development. All of the Work Plan activities continue on target for completion by the end of calendar year 2020. **Culture & Linguistics Language Assistance Program Report** This Report provides information on the language service utilization by CalViva Health members for January 1st to June 30th, 2020. The Language Assistance Program incorporates MHN Services' Mental Health/Behavioral Health language utilization for the same reporting period. It also evaluates, telephonic and in-person interpretation services, Sign Language and document translations. ➢ C&L language reviewed 35 grievance cases with seven interventions identified. 2019 grievance trending report completed. ➢ In response to the CAP issued to A&G on incorrect application of C&L codes, the C&L grievance desktop was revised to ensure that A&G implemented and confirmed C&L code reclassifications. Virtual training was provided to A&G Case Coordinators on the desktop and quick reference guide.	Motion: Approve - Culture & Linguistics Work Plan Mid-Year Evaluation & Executive Summary - Culture & Linguistics Language Assistance Program Report - Health Education Work Plan Mid-Year Evaluation & Executive Summary (Cardona/Verma) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	➢ Aunt Bertha URLs for staff and member facing access completed. Promotion of Aunt Bertha/coronavirus resources included on the member newsletter. ➢ Four call center trainings conducted and training decks updated. ➢ English material review completed for a total of 65 materials. Of these, six came from MHN. ➢ Conducted eight staff trainings, attended by 191 staff on topic related to cultural competency, SDOH, Gender-neutral language, Health Literacy, ACE's, and Motivational Interviewing. ➢ Leading workgroup meetings with local CBO partner to plan component of BCS PIP. **Health Education Work Plan Mid-Year Evaluation & Executive Summary** Dr. Marabella presented the 2020 Health Education Work Plan Mid-Year Evaluation. Two areas of focus for 2020 consist of: 1. Programs and Services 2. Department Operations, Reporting and Oversight Of the 19 Program Initiatives, 12 are on track to meet year-end goals. These consist of: 1. Chronic Disease Education: Asthma 2. Community Health 3. Fluvention - Flu Vaccine Campaign 4. Health Equity Project 5. Immunizations 6. Member Newsletter 7. Mental Health 8. Pediatric Education 9. Perinatal Education 10. 10. Oversight and Reporting 11. Department Promotion and Materials Update, Development, Utilization and Inventory 12. 12. Operations: Geographic Information Systems The seven (7) initiatives that are off track or have been canceled due to the pandemic, consist of: 1. Chronic Disease: Diabetes.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2. Digital Health. 3. Member Engagement. 4. Obesity: Members and Community 5. Promotores Health Network: Diabetes Classes 6. Tobacco Cessation 7. Women's Health Barriers to full implementation of planned activities have been identified and are being addressed. 2020 initiatives will continue to be implemented in order to meet or exceed year end goals.	
#4 Culture & Linguistics/Health Education/QI Business - Quality Improvement Update Action Patrick Marabella, M.D, Chair	Dr. Marabella provided an update on HEDIS®: Managed Care Accountability Set (MCAS) Overall CalViva performed well on the new MCAS with the 50th percentile minimum performance level. Reporting Year 2020 (RY20) data reflects care and services provided during calendar year 2019. Some allowances were made for RY20 due to some of the limitations on data capture associated with the pandemic. All three counties were below the minimum performance levels (MPL) for Antidepressant Medication Management Acute Phase and Antidepressant Medication Continuation Phase. This is a new measure for this year. There is a new COVID-Quality Improvement Project (QIP) which will include a Member Outreach effort by Behavioral Health Case Managers in Kings and Madera counties to encourage medication adherence. Fresno County fell below the MPL for Adolescent Well-Care Visits. Fresno and Kings counties fell below for Well Child Visits-First 15 Months. This will also be addressed with our new COVID-Quality Improvement Project through a MemberConnections Outreach intervention. Fresno and Kings counties fell below the MPL for Breast Cancer Screening and Childhood Immunizations-Under 2 Years, two Performance Improvement Projects (PIPs) that were started approximately 1 year ago and placed on "pause" by the state due to the pandemic, will be restarted in the first quarter of 2021 to address these opportunities for improvement. Madera County fell below the MPL for Chlamydia Screening. A PDSA Improvement Project is being initiated with a high volume, low compliance provider in Madera County to improve compliance with this measure.	Motion: Approve - Quality Improvement Update (Lee/Foster) 6-0-0-2
#5 Access Business - Provider Office Wait Time Report (Q2)	**Provider Office Wait Time Report (Q2)** was presented. The **Provider Office Wait Time** report is required by DHCS to evaluate how long scheduled members are waiting to be seen in providers' offices. This Provider Office Wait Time report provided a summary of	Motion: Approve - Provider Office Wait Time Report (Q2)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Provider Appointment Availability and After-Hours Access Survey Results (Attachment M-N) Action Patrick Marabella, M.D, Chair	Quarter 2 2020 monitoring for Fresno, Kings, and Madera Counties. Results indicate that all counties were within the 30-minute office wait time threshold for both mean and median metrics. Outliers are tracked. ➢ CalViva Health Medical Management staff reviews written time logs from providers' offices submitted after the first Tuesday of each month to assess in-office patient wait times. The elements tracked are: 1) Time of arrival 2) Time of scheduled appointments 3) Time the patient was escorted to an exam room. Walk-in patients are excluded from the study. ➢ Office wait times per county have demonstrated variation over time however, average overall wait times have remained between 6 and 20 minutes for the past year for all counties. ➢ Three (3) providers were identified to have an overall average rate above the 30-minute standard. In Q2 with twenty-four (24) providers submitting samples, the State of Emergency associated with COVID 19 and its resultant clinic/office closures combined with the use of telehealth to perform urgent visits, caused a decline in office wait time submissions. We will continue to monitor in-office patient wait times to identify provider specific trends and report results to providers. <u>Provider Appointment Availability and After-Hours Access Survey Results</u> The annual 2019 Provider Appointment Availability Survey and Provider After-Hours Access Survey results were reviewed from the random sample of participating primary care physicians (PCPs), specialty care providers, ancillary providers, and non-physician mental health providers included in the survey. Data was gathered from August 2019 through December 2019. Then following DMHC appointment access metrics did not meet the performance goal of 90%: ➢ Urgent care appointment with PCP within 48 hours (70.9%). ➢ Urgent care appointment with a specialist within 96 hours (52.2%). ➢ Non-urgent care appointment with a specialist within 15 business days (75.14%). ➢ Preventive or well-child appointment with PCP (76.9%). ➢ Initial prenatal appointment with PCP (88.4%). DMHC regulations require that health plans investigate and request corrective action when timely access to care standards are not met. To comply with these requirements and meet the plan's compliance requirements, as delineated by CalViva Health's Accessibility of Providers and Practitioners policy, a CAP will be issued to contracted PPGs and provider offices who fail any of the urgent or non-urgent metrics.	- Provider Appointment Availability and After-Hours Access Survey Results (Ayala/Foster) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#6 **UM/CM Business** - Key Indicator Report (July) (Attachment O) Action Patrick Marabella, M.D, Chair	The Key Indicator Report reflects data for the month of July in 2020. This report includes key metrics for tracking utilization and case management activities. ➢ Membership through July has trended upward, potentially associated with COVID 19. ➢ In-hospital utilization rates have begun to rise in all areas with the exception of the SPD (Seniors and Persons with Disabilities) population. An evaluation of these populations has identified an increase in respiratory admissions in alignment with the COVID-19 health crisis which began in March. ➢ Turn-around time compliance improved in June to 100% and has continued at 100% through July 2020. ➢ Case Management results in 2020 thus far, continue to demonstrate positive trends in all areas.	Motion: Approve - Key Indicator Report (July) (Foster/Ayala) 6-0-0-2
#6 **UM/CM Business** - Specialty Referrals Report-HN (Q2) (Attachment P) Action Patrick Marabella, M.D, Chair	<u>Specialty Referrals Report – HN (Q2)</u> was presented. This report provides a summary of Specialty Referral Services that require prior authorization in the tri-county area (Fresno, Kings, Madera) for the second quarter of 2020. The report includes three areas: 1) key services that while within the service area and within the network, require clinical review; 2) those services recognized as out the tri-county service area, but within the provider network; and 3) out of network requests. This report provides evidence of a system-wide process for tracking and following up in member referrals requiring prior authorization, and includes a breakdown of SPD and Non-SPD Member Specialty Referral Requests. In Q2 volumes and denial rates have remained consistent.	Motion: Approve - Specialty Referrals Report-HN (Q2) (Foster/Ayala) 6-0-0-2
#6 **UM/CM Business** - MedZed Report (Attachment Q) Action Patrick Marabella, M.D, Chair	<u>MedZed Integrated Care Management Report was presented.</u> This is a new report for quarter 2 2020. This program is designed as a bridge and support for member stabilization and then engagement into a traditional PCP relationship. Results included in this first report covered year-end 2019 and 2020 monthly and quarterly data. Initial focus is on volumes and engagement of members referred to the program. Results were as follows: a. 640 cases being managed at this time. b. 2020 engagement rate of 33% is consistent with 2019 results. c. Decrease in referrals noted (Q1-466 referrals, Q2-7 referrals). There was a pause in new referrals in Q2 due to COVID-19 Emergency. There was also a pause in in-home services due to COVID with those resuming as of August 2020. Discussions are in progress regarding when	Motion: Approve - MedZed Report (Foster/Ayala) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	new referral acceptance will resume. d. Disenrollment continues to meet the goal of 5% or less. HEDIS® compliance and other outcome measures including readmissions and emergency department utilization for this population are in development.	
#7 **Policies and Procedures** - UMCM Policy Grid (Attachment R) Action Patrick Marabella, M.D, Chair	**Utilization Management and Case Management Annual Review Policy grid** was presented to the committee. The majority of policies were updated without changes or had minor edits. Thirteen (13) policies now have a new designation as Case Management (CM) policies instead of Utilization Management (UM) or Public Health (PH) policies. One new policy was included in the packetCM-125 Case Management and Members Under 21 Receiving Private Duty Nursing Services. The policy edits were discussed and the UM/CM policies were approved.	Motion: Approve - UMCM Policy Grid (Lee/Foster) 6-0-0-2
#8 **Compliance Update** - Compliance Regulatory Report (Attachment S) Action Patrick Marabella, M.D, Chair	Mary Beth Corrado presented the **Compliance Report**. **Oversight Meetings:** 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. **Oversight Audits:** The following annual audits are in-progress: Access & Availability, Utilization Management & Case Management, and Call Center. The following audits have been completed since the last report: 2019-2020 Claims & PDR Audit (CAPs). **Fraud, Waste & Abuse Activity:** For 2020 year to date, there have been a total of 14 cases reported to DHCS. Since the last report there was only one MC609 case filed. **Department of Health Care Services ("DHCS") Annual Network Certification:** DHCS completed its initial assessment of CalViva Health's 2020 ANC submission and issued two reports. One report covered ANC preliminary findings and the other report identified some deficiencies regarding alternate access determinations. The Plan submitted its responses to DHCS on 08/11/20 and 08/28/20. On 10/2/20, in response to the Plan's 08/28/20 filing, DHCS identified additional alternate access standard	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	deficiencies for which the Plan will provide a response. **COVID-19 Novel Coronavirus** On October 2, 2020, the Department of Health and Human Services (HHS0) issued a renewal of the COVID-19 public health emergency (PHE) for a full 90-day extension through January 21, 2021. The plan continues to receive All Plan Letters and other regulatory guidance from DMHC and DHCS and continues to report provider site closures, positive COVID-19 tests and hospitalizations on a daily basis. **Public Policy Committee:** The Public Policy Committee met on December 2, 2020 at 11:30AM in Fresno County via telephone conference due to the COVID-19 state of emergency.	
#9 **Public Comment**	None	
#10 **Adjourn** Patrick Marabella, M.D, Chair	Meeting was adjourned at 11:51AM.	

NEXT MEETING: November 19th, 2020

Submitted this Day: November 19, 2020

Submitted by: Amy K Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Item #4

Attachment 4.D

Public Policy Committee Minutes
dated 9/2/2020

Public Policy Committee
Meeting Minutes
September 2, 2020

Teleconference Meeting due
to COVID-19 Executive Order
CalViva Health
7625 N. Palm Ave. #109
Fresno, CA 93711

Committee Members		Community Base Organizations (Alternates)	
✓•	Joe Neves, Chairman		Jeff Garner, KCAO
✓•	David Phillips, Provider Representative	✓•	Roberto Garcia, Self Help
	Leann Floyd, Kings County Representative		**Staff Members**
✓•	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Community Relations Director
✓•	Kristi Hernandez, At-Large Representative	✓	Cheryl Hurley, Commission Clerk
✓•	Kevin Dat Vu, Fresno County Representative	✓	Greg Hund, CEO
✓*•	Norma Mendoza, At-Large Representative		Dr. Marabella, CMO
			Amy Schneider, RN, Director of Medical Management
		✓	Mary Lourdes Leone, Director of Compliance
		✓	Steven Si, Operations & Privacy Specialist
		✓	Lori Norman, Compliance Manager
		✓•	Jeff Nkansah, COO
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:32 am. A quorum was present via conference call in lieu of gathering in public per executive order signed by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	Commissioners' physical attendance at the public location or by teleconferencing.	
#2 Meeting Minutes from June 10, 2020 **Action** Joe Neves, Chair	The June 10, 2020 meeting minutes were reviewed. There were no discrepancies.	**Motion:** Approve June 10, 2020 Minutes 6-0-0-3 (R. Garcia / D. Phillips) A roll call was taken.
#3 Committee Membership Update **Information** Joe Neves, Chair	Kevin Dat Vu's membership has been extended for an additional 3-year term.	
#4 Proposed 2021 PPC Meeting Calendar **Action** Joe Neves, Chair	The 2020 proposed meeting calendar was presented to the PPC. No conflicts were noted.	**Motion:** Approve Public Policy 2021 Meeting Calendar to move to Commission for final approval. 6-0-0-3 (D. Phillips / S. Garcia) A roll call was taken.
#5 Enrollment Dashboard Information Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the enrollment dashboard through July 2020. Membership as of the end of July was 361,207. CalViva Health maintains a 70.68% market share.	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#6 Health Education *Member Incentive Programs – Semi-annual Report Q1 and Q2 2020* **Information** Steven Si, Operations & Privacy Specialist	A total of 765 CalViva Health (CVH) members participated in seven health education and quality improvement incentive programs during Q1 and Q2 in 2020. Of the 765 participants, 560 members received an incentive. In total, $16,935 worth in gift cards were given to CVH members. Of the 560 award recipients, (77%) were from Fresno County, (17%) from Madera County and (6%) from Kings County. For Q1 & Q2, 2020, CVH continued to fulfill member requests based on the 2019 Member Incentive Statewide Program. In 2020, CVH put on hold launching the plan-wide incentive program. COVID-19 shelter-in-place orders limited deployment of direct care programs, including PIPs and PDSA programs with an incentive component included. This influenced the number incentives distributed in Q1 and Q2 of 2020. As COVID-19 evolves, CVH will continue to follow CDC, state and local data to make informed decisions concerning outreach events and special projects.	**No motion**
#7 Health Education *Population Needs Assessment Report*	A comprehensive analysis of key findings for, along with action plans and stakeholder engagement, was reported to the Committee in the areas of Membership and Group Profile, Healthcare Effectiveness Data and Information Set (HEDIS), Chronic Health Conditions, Tobacco Cessation, Top Diagnoses, Behavioral Health, Access to Care, Health Disparities, and Health Education, Cultural and Linguistics, and Quality Improvement GAP Analysis.	**No Motion**
#8 Appeals, Grievances and Complaints	Mary Lourdes Leone presented the appeals, grievances and complaints report for Q2 2020. Total appeals and grievances for Q2 2020 were 444. Total appeals for Q2	**No motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Information Mary Lourdes Leone, Director of Compliance	2020 were 208. Total grievances for Q2 2020 were 236. Turnaround time compliance standard was met at 100%. The majority of appeals and grievances were from members in Fresno County which has the largest CalViva Health enrollment.	
#9 2019 DMHC Audit Update; and 2020 DHCS Audit Update **Information** Mary Lourdes Leone, Director of Compliance	CVH submitted Plan's response to DMCH regarding the 2019 DMHC audit final report. No response is expected until DMHC begins their 18-month desk audit which will be March 1, 2021. Regarding the 2020 DHCS audit, CVH received the final report from DHCS on July 1, 2020. The Plan's corrective action plan (CAP) was submitted July 31, 2020. DHCS has since closed one finding, and one remains open.	**No motion**
#10 Final Comments from Committee Members and Staff	R. Garcia provided an update on Habitat for Humanity activities. N. Mendoza provided an update on Promotores. D. Phillips provided an update on United Health Centers activities. G. Hund provided an update to the PPC committee regarding collaborative meetings with other Plans and local stakeholders regarding COVID issues. In addition, CVH continues to be closed to the public and the downtown satellite office location is still closed until further notice.	

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#11 Announcements	Next scheduled PPC meeting is scheduled for December 2, 2020.	
#12 Public Comment	None.	
#13 Adjourn	Meeting adjourned at 12:22 pm.	

NEXT MEETING **December 2, 2020 in Madera County**
11:30 am - 1:30 pm

Submitted This Day: December 2, 2020

Submitted By: _____
Courtney Shapiro, Director Community Relations

Approval Date: December 2, 2020

Approved By: _____
Joe Neves, Chairman

Item #4

Attachment 4.E

Compliance Report

RHA Commission Compliance – Regulatory Report

Regulatory Filings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020 YTD Total
# of DHCS Filings													
Administrative/ Operational	9	15	12	13	12	13	9	14	14	10	10	10	141
Member & Provider Materials	2	1	7	12	1	0	4	3	5	1	3	1	40
# of DMHC Filings	5	8	7	7	1	5	5	6	7	3	6	6	66

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

Fraud, Waste, & Abuse Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2020 YTD Total
# of New MC609 Cases Submitted to DHCS	2	1	3	0	4	1	0	2	0	1	0	0	14
# of Cases Open for Investigation (Active Number)	16	16	16	14	14	16	15	17	17	18	16	14	

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

Since the last report, there have not been any new MC609 cases filed. 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 to critical projects or transitions that may affect CalViva Health. Health Net is providing more detailed reports of vendor oversight audits and comprehensive reports of participating provider groups (PPG) activity – additional reporting enhancements were implemented in 2020. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances and appeals, etc.
Oversight Audits	The following annual audits are in-progress: Access & Availability, Utilization Management & Case Management, Credentialing, Q2 2020 PDR Audit, and Call Center. Since the November 19, 2020 Compliance Commission report, no additional audits have been completed.
Regulatory Reviews/Audits and CAPS	**Status**
Department of Health Care Services ("DHCS") Annual Network Certification	On November 25, 2020, the DHCS issued the Plan a CAP for failure to meet the 2020 Network Certification Requirements as it related to time and distance standards. However, prior to the CAP notice, on November 24, 2020, the Plan had already responded to the DHCS' Alternate Access Standards (AAS) request but had not yet received a formal response. On December 28, 2020, the Plan provided additional CAP materials such as updated policies and training materials related to provider accessibility and these were all approved. Associated with DHCS' CAP, DHCS conducted an Out-of-Network (OON) access validation call campaign to the Plan's call center. The call campaign is designed to ensure compliance with CAP requirements in providing members with accurate information regarding OON access and transportation services. On January 1, 2021, DHCS informed the Plan that it was 100% compliant. On February 8, 2021, DHCS sent a determination letter regarding the Plan's 2020 Annual Network Certification submission of AAS requests. This DHCS letter is currently being reviewed by the Plan. DHCS also stated they would be sending a separate email detailing the requirements of the AAS Validation process the Plan would have to undergo shortly.
New Regulations / Contractual Requirements	
Medi-Cal Rx Transition	DHCS postponed transition of pharmacy services from Medi-Cal managed care to FFS (Medi-Cal Rx) from January 1, 2021 to April 1, 2021. The Plan submitted all required policy deliverables by 1/29/21. The Plan is restarting its member outreach campaign to remind members about the Medi-Cal RX transition. The Plan is also revising and issuing provider communications that were on hold during the delay.

California's Section 1115(a) Medicaid waiver entitled Medi-Cal 2020 **California Advancing and Innovating Medi-Cal (CalAIM)**	On January 28, 2021, DHCS presented an overview of the recently re-launched CalAIM Proposal that was delayed due to the COVID-19 PHE. The following are some of the key initiatives and their proposed effective dates: • Major organ transplant carve-in – January 1, 2022 • In lieu of Services (ILOS) – January 1 2022 • Enhanced Care Management for mandatory target populations – July 1, 2022 • Institutional long-term care carve-in – January 1, 2023 • Population Health Management – January 1, 2023
Behavioral Health Integration (BHI) Incentive Program	The Trailer Bill implementing the 2019 Budget Act authorized DHCS to develop the Behavioral Health Integration (BHI) Incentive Program as part of its Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care. Interested, eligible Medi-Cal providers had to submit applications to managed care plans in order to promote behavioral health integration. The goal of this program is to improve physical and behavioral health outcomes for Medi-Cal beneficiaries with co-morbid disorders by increasing rates of prevention, conducting early detection and interventions, and providing treatment that is clinically efficient, while being culturally and linguistically informed. Originally applicants selected one or more BHI projects to implement over a 33-month period (April 2020 through December 31, 2022). Due to the COVID-19 PHE, the start date and time period was delayed and changed to January 1, 2021 through December 31, 2022. CalViva Health and DHCS approved two provider applicants covering three BHI programs for implementation.
Plan Administration	
COVID-19 **Novel Coronavirus**	The Plan continues to provide daily updates to DHCS for any facility closures/re-openings due to COVID-19, and is providing providers with updates on COVID-19, including vaccine distribution and administration. Our administrator has extended the delay in their return to office date and their staff will continue to carry out operations on a remote basis until at least September 2021.
Committee Report	
Public Policy Committee	The Public Policy Committee met on 12/2/20 at 11:30 AM in Fresno County *via* teleconference due to COVID-19 precautions. The following reports were presented: Q3 2020 Grievance and Appeals; the 2020 C&L Work Plan Mid-Year Evaluation; and the MY 2019 HEDIS Data Results. There were no recommendations for referral to the Commission. The next meeting will be held on March 3, 2021 in Fresno County *via* teleconference.

Item #5

Attachments 5.A – 5.B

- BL-002 Annual Administration
- Form 700

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Pomaville, Director
Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Ed Hill, Director
Public Health Department

Harold Nikoghosian- At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Brian Smullin
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: February 18, 2021

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Annual Administration

BL #: 21-002
Agenda Item 5
Attachment 5.A

Discussion Points:

Ethics Training:

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

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

Form 700:

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

Please complete and return to the Clerk, Cheryl Hurley, by April 1, 2021.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

STATEMENT OF ECONOMIC INTERESTS
COVER PAGE
A PUBLIC DOCUMENT

Date Initial Filing Received
Filing Official Use Only

Please type or print in ink.

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

1. Office, Agency, or Court

Agency Name *(Do not use acronyms)*

Division, Board, Department, District, if applicable

Your Position

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

Agency: Position:

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

☐ State

☐ Judge, Retired Judge, Pro Tem Judge, or Court Commissioner (Statewide Jurisdiction)

☐ Multi-County

☐ County of

☐ City of

☐ Other

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

☐ **Annual:** The period covered is January 1, 2020, through December 31, 2020.

-or-

The period covered is ____/____/_____, through December 31, 2020.

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

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

☐ The period covered is January 1, 2020, through the date of leaving office.

-or-

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

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

4. Schedule Summary (must complete) ► *Total number of pages including this cover page:* _____

Schedules attached

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

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

5. Verification

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

DAYTIME TELEPHONE NUMBER ( )

EMAIL ADDRESS

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

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

Date Signed *(month, day, year)*

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

Instructions
Cover Page

Enter your name, mailing address, and daytime telephone number in the spaces provided. **Because the Form 700 is a public document, you may list your business/office address instead of your home address.**

Part 1. Office, Agency, or Court

- Enter the name of the office sought or held, or the agency or court. Consultants must enter the public agency name rather than their private firm's name. (Examples: State Assembly; Board of Supervisors; Office of the Mayor; Department of Finance; Hope County Superior Court)
- Indicate the name of your division, board, or district, if applicable. (Examples: Division of Waste Management; Board of Accountancy; District 45). **Do not use acronyms.**
- Enter your position title. (Examples: Director; Chief Counsel; City Council Member; Staff Services Analyst)
- If you hold multiple positions (i.e., a city council member who also is a member of a county board or commission), you may be required to file statements with each agency. To simplify your filing obligations, you may complete an expanded statement.
    - To do this, enter the name of the other agency(ies) with which you are required to file and your position title(s) in the space provided. **Do not use acronyms.** Attach an additional sheet if necessary. Complete one statement covering the disclosure requirements for all positions. Each copy must contain an original signature. Therefore, before signing the statement, make a copy for each agency. Sign each copy with an original signature and file with each agency.

If you assume or leave a position after a filing deadline, you must complete a separate statement. For example, a city council member who assumes a position with a county special district after the April annual filing deadline must file a separate assuming office statement. In subsequent years, the city council member may expand his or her annual filing to include both positions.

Example:

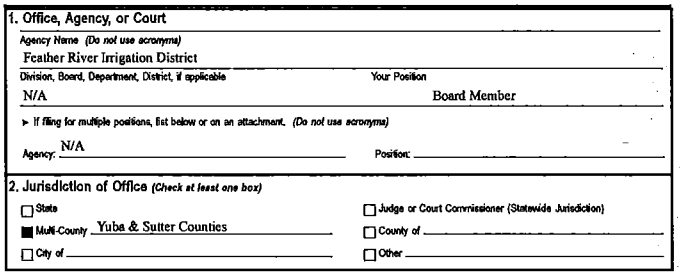
Brian Bourne is a city council member for the City of Lincoln and a board member for the Camp Far West Irrigation District – a multi-county agency that covers Placer and Yuba counties. Brian will complete one Form 700 using full disclosure (as required for the city position) and covering interests in both Placer and Yuba counties (as required for the multi-county position) and list both positions on the Cover Page. Before signing the statement, Brian will make a copy and sign both statements. One statement will be filed with City of Lincoln and the other will be filed with Camp Far West Irrigation District. Both will contain an original signature.

Part 2. Jurisdiction of Office

- Check the box indicating the jurisdiction of your agency and, if applicable, identify the jurisdiction. Judges, judicial candidates, and court commissioners have statewide jurisdiction. All other filers should review the Reference Pamphlet, page 13, to determine their jurisdiction.
- If your agency is a multi-county office, list each county in which your agency has jurisdiction.
- If your agency is not a state office, court, county office, city office, or multi-county office (e.g., school districts, special districts and JPAs), check the "other" box and enter the county or city in which the agency has jurisdiction.

Example:

This filer is a member of a water district board with jurisdiction in portions of Yuba and Sutter Counties.


1. Office, Agency, or Court
Agency Name (Do not use acronyms)
Feather River Irrigation District
Division, Board, Department, District, if applicable: N/A
Your Position: Board Member
▶ If filing for multiple positions, list below or on an attachment. (Do not use acronyms)
Agency: N/A
Position:
2. Jurisdiction of Office (Check at least one box)
☐ State
■ Multi-County Yuba & Sutter Counties
☐ City of
☐ Judge or Court Commissioner (Statewide Jurisdiction)
☐ County of
☐ Other

Part 3. Type of Statement

Check at least one box. The period covered by a statement is determined by the type of statement you are filing. If you are completing a 2020 annual statement, **do not** change the pre-printed dates to reflect 2021. Your annual statement is used for reporting the **previous year's** economic interests. Economic interests for your annual filing covering January 1, 2021, through December 31, 2021, will be disclosed on your statement filed in 2022. See Reference Pamphlet, page 4.

Combining Statements: Certain types of statements may be combined. For example, if you leave office after January 1, but before the deadline for filing your annual statement, you may combine your annual and leaving office statements. File by the earliest deadline. Consult your filing officer or the FPPC.

Part 4. Schedule Summary

- Complete the Schedule Summary after you have reviewed each schedule to determine if you have reportable interests.
- Enter the total number of completed pages including the cover page and either check the box for each schedule you use to disclose interests; **or** if you have nothing to disclose on any schedule, check the "No reportable interests" box. Please **do not** attach any blank schedules.

Part 5. Verification

Complete the verification by signing the statement and entering the date signed. All statements must have an original "wet" signature or be duly authorized by your filing officer to file electronically under Government Code Section 87500.2. **When you sign your statement, you are stating, under penalty of perjury, that it is true and correct.** Only the filer has authority to sign the statement. An unsigned statement is not considered filed and you may be subject to late filing penalties.

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

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/20___ ACQUIRED ___/___/20___ DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/20___ ACQUIRED ___/___/20___ DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/20___ ACQUIRED ___/___/20___ DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/20___ ACQUIRED ___/___/20___ DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/20___ ACQUIRED ___/___/20___ DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

___/___/20___ ACQUIRED ___/___/20___ DISPOSED

Comments: ______

Instructions – Schedules A-1 and A-2
Investments

"Investment" means a financial interest in any business entity (including a consulting business or other independent contracting business) that is located in, doing business in, planning to do business in, or that has done business during the previous two years in your agency's jurisdiction in which you, your spouse or registered domestic partner, or your dependent children had a direct, indirect, or beneficial interest totaling $2,000 or more at any time during the reporting period. (See Reference Pamphlet, page 13.)

Reportable investments include:

- Stocks, bonds, warrants, and options, including those held in margin or brokerage accounts and managed investment funds (See Reference Pamphlet, page 13.)
- Sole proprietorships
- Your own business or your spouse's or registered domestic partner's business (See Reference Pamphlet, page 8, for the definition of "business entity.")
- Your spouse's or registered domestic partner's investments even if they are legally separate property
- Partnerships (e.g., a law firm or family farm)
- Investments in reportable business entities held in a retirement account (See Reference Pamphlet, page 15.)
- If you, your spouse or registered domestic partner, and dependent children together had a 10% or greater ownership interest in a business entity or trust (including a living trust), you must disclose investments held by the business entity or trust. (See Reference Pamphlet, page 16, for more information on disclosing trusts.)
- Business trusts

You are not required to disclose:

- Government bonds, diversified mutual funds, certain funds similar to diversified mutual funds (such as exchange traded funds) and investments held in certain retirement accounts. (See Reference Pamphlet, page 13.) (Regulation 18237)
- Bank accounts, savings accounts, money market accounts and certificates of deposits
- Insurance policies
- Annuities
- Commodities
- Shares in a credit union
- Government bonds (including municipal bonds)
- Retirement accounts invested in non-reportable interests (e.g., insurance policies, mutual funds, or government bonds) (See Reference Pamphlet, page 15.)
- Government defined-benefit pension plans (such as CalPERS and CalSTRS plans)
- Certain interests held in a blind trust (See Reference Pamphlet, page 16.)

Use Schedule A-1 to report ownership of less than 10% (e.g., stock). Schedule C (Income) may also be required if the investment is not a stock or corporate bond. (See second example below.)

Use Schedule A-2 to report ownership of 10% or greater (e.g., a sole proprietorship).

To Complete Schedule A-1:

Do not attach brokerage or financial statements.

- Disclose the name of the business entity.
- Provide a general description of the business activity of the entity (e.g., pharmaceuticals, computers, automobile manufacturing, or communications).
- Check the box indicating the highest fair market value of your investment during the reporting period. If you are filing a candidate or an assuming office statement, indicate the fair market value on the filing date or the date you took office, respectively. (See page 20 for more information.)
- Identify the nature of your investment (e.g., stocks, warrants, options, or bonds).
- An acquired or disposed of date is only required if you initially acquired or entirely disposed of the investment interest during the reporting period. The date of a stock dividend reinvestment or partial disposal is not required. Generally, these dates will not apply if you are filing a candidate or an assuming office statement.

Examples:

Frank Byrd holds a state agency position. His conflict of interest code requires full disclosure of investments. Frank must disclose his stock holdings of $2,000 or more in any company that is located in or does business in California, as well as those stocks held by his spouse or registered domestic partner and dependent children.

Alice Lance is a city council member. She has a 4% interest, worth $5,000, in a limited partnership located in the city. Alice must disclose the partnership on Schedule A-1 and income of $500 or more received from the partnership on Schedule C.

Reminders

- Do you know your agency's jurisdiction?
- Did you hold investments at any time during the period covered by this statement?
- Code filers – your disclosure categories may only require disclosure of specific investments.

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

▶ 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

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

GENERAL DESCRIPTION OF THIS BUSINESS

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

IF APPLICABLE, LIST DATE:
__/__/20__ ACQUIRED
__/__/20__ DISPOSED

NATURE OF INVESTMENT
☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

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

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

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

☐ None or ☐ Names listed below

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

Check one box:
☐ INVESTMENT ☐ REAL PROPERTY

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

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

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

IF APPLICABLE, LIST DATE:
__/__/20__ ACQUIRED
__/__/20__ DISPOSED

NATURE OF INTEREST
☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership
☐ Leasehold _____ Yrs. remaining ☐ Other _____

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

---

▶ 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

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

GENERAL DESCRIPTION OF THIS BUSINESS

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

IF APPLICABLE, LIST DATE:
__/__/20__ ACQUIRED
__/__/20__ DISPOSED

NATURE OF INVESTMENT
☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

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

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

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

☐ None or ☐ Names listed below

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

Check one box:
☐ INVESTMENT ☐ REAL PROPERTY

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

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

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

IF APPLICABLE, LIST DATE:
__/__/20__ ACQUIRED
__/__/20__ DISPOSED

NATURE OF INTEREST
☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership
☐ Leasehold _____ Yrs. remaining ☐ Other _____

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

Comments: _____

Instructions – Schedule A-2
Investments, Income, and Assets of Business Entities/Trusts

Use Schedule A-2 to report investments in a business entity (including a consulting business or other independent contracting business) or trust (including a living trust) in which you, your spouse or registered domestic partner, and your dependent children, together or separately, had a 10% or greater interest, totaling $2,000 or more, during the reporting period and which is located in, doing business in, planning to do business in, or which has done business during the previous two years in your agency's jurisdiction. (See Reference Pamphlet, page 13.) A trust located outside your agency's jurisdiction is reportable if it holds assets that are located in or doing business in the jurisdiction. Do not report a trust that contains non-reportable interests. For example, a trust containing only your personal residence not used in whole or in part as a business, your savings account, and some municipal bonds, is not reportable.

Also report on Schedule A-2 investments and real property held by that entity or trust if your pro rata share of the investment or real property interest was $2,000 or more during the reporting period.

To Complete Schedule A-2:

Part 1. Disclose the name and address of the business entity or trust. If you are reporting an interest in a business entity, check "Business Entity" and complete the box as follows:

- Provide a general description of the business activity of the entity.
- Check the box indicating the highest fair market value of your investment during the reporting period.
- If you initially acquired or entirely disposed of this interest during the reporting period, enter the date acquired or disposed.
- Identify the nature of your investment.
- Disclose the job title or business position you held with the entity, if any (i.e., if you were a director, officer, partner, trustee, employee, or held any position of management). A business position held by your spouse is not reportable.

Part 2. Check the box indicating **your pro rata** share of the **gross** income received **by** the business entity or trust. This amount includes your pro rata share of the **gross** income **from** the business entity or trust, as well as your community property interest in your spouse's or registered domestic partner's share. Gross income is the total amount of income before deducting expenses, losses, or taxes.

Part 3. Disclose the name of each source of income that is located in, doing business in, planning to do business in, or that has done business during the previous two years in your agency's jurisdiction, as follows:

- Disclose each source of income and outstanding loan **to the business entity or trust** identified in Part 1 if your pro rata share of the **gross** income (including your community property interest in your spouse's or registered domestic partner's share) to the business entity or trust from that source was $10,000 or more during the reporting period. (See Reference Pamphlet, page 11, for examples.) Income from governmental sources may be reportable if not considered salary. See Regulation 18232. Loans from commercial lending institutions made in the lender's regular course of business on terms available to members of the public without regard to your official status are not reportable.
- Disclose each individual or entity that was a source of commission income of $10,000 or more during the reporting period through the business entity identified in Part 1. (See Reference Pamphlet, page 8.)

You may be required to disclose sources of income located outside your jurisdiction. For example, you may have a client who resides outside your jurisdiction who does business on a regular basis with you. Such a client, if a reportable source of $10,000 or more, must be disclosed.

Mark "None" if you do not have any reportable $10,000 sources of income to disclose. Phrases such as "various clients" or "not disclosing sources pursuant to attorney-client privilege" are not adequate disclosure. (See Reference Pamphlet, page 14, for information on procedures to request an exemption from disclosing privileged information.)

Part 4. Report any investments or interests in real property held or leased **by the entity or trust** identified in Part 1 if your pro rata share of the interest held was $2,000 or more during the reporting period. Attach additional schedules or use FPPC's Form 700 Excel spreadsheet if needed.

- Check the applicable box identifying the interest held as real property or an investment.
- If investment, provide the name and description of the business entity.
- If real property, report the precise location (e.g., an assessor's parcel number or address).
- Check the box indicating the highest fair market value of your interest in the real property or investment during the reporting period. (Report the fair market value of the portion of your residence claimed as a tax deduction if you are utilizing your residence for business purposes.)
- Identify the nature of your interest.
- Enter the date acquired or disposed only if you initially acquired or entirely disposed of your interest in the property or investment during the reporting period.

CALIFORNIA FORM **700**
FAIR POLITICAL PRACTICES COMMISSION

Name

SCHEDULE B
Interests in Real Property
(Including Rental Income)

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

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

IF APPLICABLE, LIST DATE:
__/__/20__ ACQUIRED __/__/20__ DISPOSED

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

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

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

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

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

IF APPLICABLE, LIST DATE:
__/__/20__ ACQUIRED __/__/20__ DISPOSED

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

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

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

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

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE TERM (Months/Years)

_____% ☐ None

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

☐ Guarantor, if applicable

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE TERM (Months/Years)

_____% ☐ None

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

☐ Guarantor, if applicable

Comments: _____

Instructions – Schedule B
Interests in Real Property

Report interests in real property located in your agency's jurisdiction in which you, your spouse or registered domestic partner, or your dependent children had a direct, indirect, or beneficial interest totaling $2,000 or more any time during the reporting period. Real property is also considered to be "within the jurisdiction" of a local government agency if the property or any part of it is located within two miles outside the boundaries of the jurisdiction or within two miles of any land owned or used by the local government agency. (See Reference Pamphlet, page 13.)

Interests in real property include:

- An ownership interest (including a beneficial ownership interest)
- A deed of trust, easement, or option to acquire property
- A leasehold interest (See Reference Pamphlet, page 14.)
- A mining lease
- An interest in real property held in a retirement account (See Reference Pamphlet, page 15.)
- An interest in real property held by a business entity or trust in which you, your spouse or registered domestic partner, and your dependent children together had a 10% or greater ownership interest (Report on Schedule A-2.)
- Your spouse's or registered domestic partner's interests in real property that are legally held separately by him or her

You are <u>not</u> required to report:

- A residence, such as a home or vacation cabin, used exclusively as a personal residence (However, a residence in which you rent out a room or for which you claim a business deduction may be reportable. If reportable, report the fair market value of the portion claimed as a tax deduction.)
- Some interests in real property held through a blind trust (See Reference Pamphlet, page 16.)
  - **Please note:** A non-reportable property can still be grounds for a conflict of interest and may be disqualifying.

To Complete Schedule B:

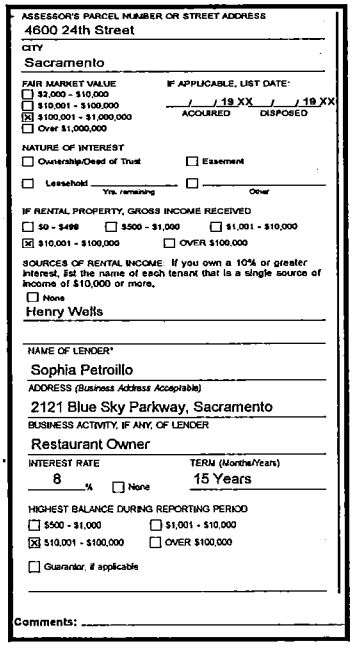
- Report the precise location (e.g., an assessor's parcel number or address) of the real property.
- Check the box indicating the fair market value of your interest in the property (regardless of what you owe on the property).
- Enter the date acquired or disposed only if you initially acquired or entirely disposed of your interest in the property during the reporting period.
- Identify the nature of your interest. If it is a leasehold, disclose the number of years remaining on the lease.
- If you received rental income, check the box indicating the gross amount you received.
- If you had a 10% or greater interest in real property and received rental income, list the name of the source(s) if your pro rata share of the gross income from any single tenant was $10,000 or more during the reporting period. If you received a total of $10,000 or more from two or more tenants acting in concert (in most cases, this will apply to married couples), disclose the name of each tenant. Otherwise, mark "None."
- Loans from a private lender that total $500 or more and are secured by real property may be reportable. **Loans from commercial lending institutions made in the lender's regular course of business on terms available to members of the public without regard to your official status are not reportable.**

  When reporting a loan:
  - Provide the name and address of the lender.
  - Describe the lender's business activity.
  - Disclose the interest rate and term of the loan. For variable interest rate loans, disclose the conditions of the loan (e.g., Prime + 2) or the average interest rate paid during the reporting period. The term of a loan is the total number of months or years given for repayment of the loan at the time the loan was established.
  - Check the box indicating the highest balance of the loan during the reporting period.
  - Identify a guarantor, if applicable.

If you have more than one reportable loan on a single piece of real property, report the additional loan(s) on Schedule C.

Example:

Allison Gande is a city planning commissioner. During the reporting period, she received rental income of $12,000, from a single tenant who rented property she owned in the city's jurisdiction. If Allison received $6,000 each from two tenants, the tenants' names would not be required because no single tenant paid her $10,000 or more. A married couple is considered a single tenant.


ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS
4600 24th Street
CITY
Sacramento
FAIR MARKET VALUE
☐ $2,000 - $10,000
☐ $10,001 - $100,000
☒ $100,001 - $1,000,000
☐ Over $1,000,000
IF APPLICABLE, LIST DATE:
ACQUIRED / / 19 XX
DISPOSED / / 19 XX
NATURE OF INTEREST
☐ Ownership/Deed of Trust ☐ Easement
☐ Leasehold ____ Yrs. remaining ☐ ____ Other
IF RENTAL PROPERTY, GROSS INCOME RECEIVED
☐ $0 - $499 ☐ $500 - $1,000 ☐ $1,001 - $10,000
☒ $10,001 - $100,000 ☐ OVER $100,000
SOURCES OF RENTAL INCOME: If you own a 10% or greater interest, list the name of each tenant that is a single source of income of $10,000 or more.
☐ None
Henry Wells
NAME OF LENDER*
Sophia Petroillo
ADDRESS (Business Address Acceptable)
2121 Blue Sky Parkway, Sacramento
BUSINESS ACTIVITY, IF ANY, OF LENDER
Restaurant Owner
INTEREST RATE
8 %
☐ None
TERM (Months/Years)
15 Years
HIGHEST BALANCE DURING REPORTING PERIOD
☐ $500 - $1,000 ☐ $1,001 - $10,000
☒ $10,001 - $100,000 ☐ OVER $100,000
☐ Guarantor, if applicable
Comments:

Reminders

- Income and loans already reported on Schedule B are not also required to be reported on Schedule C.
- Real property already reported on Schedule A-2, Part 4 is not also required to be reported on Schedule B.
- Code filers – do your disclosure categories require disclosure of real property?

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name _____

▶ 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

_____

ADDRESS *(Business Address Acceptable)*

_____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

_____

YOUR BUSINESS POSITION

_____

GROSS INCOME RECEIVED

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

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

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

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

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

☐ Loan repayment

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

_____ *(Describe)*

☐ Other _____ *(Describe)*

▶ 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

_____

ADDRESS *(Business Address Acceptable)*

_____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

_____

YOUR BUSINESS POSITION

_____

GROSS INCOME RECEIVED

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

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

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

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

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

☐ Loan repayment

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

_____ *(Describe)*

☐ Other _____ *(Describe)*

▶ 2. LOANS RECEIVED OR OUTSTANDING DURING THE REPORTING PERIOD

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

NAME OF LENDER*

_____

ADDRESS *(Business Address Acceptable)*

_____

BUSINESS ACTIVITY, IF ANY, OF LENDER

_____

HIGHEST BALANCE DURING REPORTING PERIOD

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

INTEREST RATE _____% ☐ None

TERM (Months/Years) _____

SECURITY FOR LOAN

☐ None ☐ Personal residence

☐ Real Property _____ *Street address*

_____ *City*

☐ Guarantor _____

☐ Other _____ *(Describe)*

Comments: _____

Instructions – Schedule C
Income, Loans, & Business Positions
(Income Other Than Gifts and Travel Payments)

Reporting Income:
Report the source and amount of gross income of $500 or more you received during the reporting period. Gross income is the total amount of income before deducting expenses, losses, or taxes and includes loans other than loans from a commercial lending institution. (See Reference Pamphlet, page 11.) You must also report the source of income to your spouse or registered domestic partner if your community property share was $500 or more during the reporting period.

The source and income must be reported only if the source is located in, doing business in, planning to do business in, or has done business during the previous two years in your agency's jurisdiction. (See Reference Pamphlet, page 13.) Reportable sources of income may be further limited by your disclosure category located in your agency's conflict of interest code.

Reporting Business Positions:
You must report your job title with each reportable business entity even if you received no income during the reporting period. Use the comments section to indicate that no income was received.

Commonly reportable income and loans include:
- Salary/wages, per diem, and reimbursement for expenses including travel payments provided by your employer
- Community property interest (50%) in your spouse's or registered domestic partner's income - **report the employer's name and all other required information**
- Income from investment interests, such as partnerships, reported on Schedule A-1
- Commission income not required to be reported on Schedule A-2 (See Reference Pamphlet, page 8.)
- Gross income from any sale, including the sale of a house or car (Report your pro rata share of the total sale price.)
- Rental income not required to be reported on Schedule B
- Prizes or awards not disclosed as gifts
- Payments received on loans you made to others
- An honorarium received prior to becoming a public official (See Reference Pamphlet, page 10.)
- Incentive compensation (See Reference Pamphlet, page 12.)

Reminders
- Code filers – your disclosure categories may not require disclosure of all sources of income.
- If you or your spouse or registered domestic partner are self-employed, report the business entity on Schedule A-2.
- Do not disclose on Schedule C income, loans, or business positions already reported on Schedules A-2 or B.

You are <u>not</u> required to report:
- Salary, reimbursement for expenses or per diem, or social security, disability, or other similar benefit payments received by you or your spouse or registered domestic partner from a federal, state, or local government agency.
- Stock dividends and income from the sale of stock unless the source can be identified.
- Income from a PERS retirement account.

(See Reference Pamphlet, page 12.)

To Complete Schedule C:

Part 1. Income Received/Business Position Disclosure
- Disclose the name and address of each source of income or each business entity with which you held a business position.
- Provide a general description of the business activity if the source is a business entity.
- Check the box indicating the amount of gross income received.
- Identify the consideration for which the income was received.
- For income from commission sales, check the box indicating the gross income received and list the name of each source of commission income of $10,000 or more. (See Reference Pamphlet, page 8.) **Note: If you receive commission income on a regular basis or have an ownership interest of 10% or more, you must disclose the business entity and the income on Schedule A-2.**
- Disclose the job title or business position, if any, that you held with the business entity, even if you did not receive income during the reporting period.

Part 2. Loans Received or Outstanding During the Reporting Period
- Provide the name and address of the lender.
- Provide a general description of the business activity if the lender is a business entity.
- Check the box indicating the highest balance of the loan during the reporting period.
- Disclose the interest rate and the term of the loan.
  - For variable interest rate loans, disclose the conditions of the loan (e.g., Prime + 2) or the average interest rate paid during the reporting period.
  - The term of the loan is the total number of months or years given for repayment of the loan at the time the loan was entered into.
- Identify the security, if any, for the loan.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

____

SCHEDULE D
Income – Gifts

▶ NAME OF SOURCE *(Not an Acronym)*

____

ADDRESS *(Business Address Acceptable)*

____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

____

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$_______	____________
___/___/___	$_______	____________
___/___/___	$_______	____________

▶ NAME OF SOURCE *(Not an Acronym)*

____

ADDRESS *(Business Address Acceptable)*

____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

____

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$_______	____________
___/___/___	$_______	____________
___/___/___	$_______	____________

▶ NAME OF SOURCE *(Not an Acronym)*

____

ADDRESS *(Business Address Acceptable)*

____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

____

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$_______	____________
___/___/___	$_______	____________
___/___/___	$_______	____________

▶ NAME OF SOURCE *(Not an Acronym)*

____

ADDRESS *(Business Address Acceptable)*

____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

____

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$_______	____________
___/___/___	$_______	____________
___/___/___	$_______	____________

▶ NAME OF SOURCE *(Not an Acronym)*

____

ADDRESS *(Business Address Acceptable)*

____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

____

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$_______	____________
___/___/___	$_______	____________
___/___/___	$_______	____________

▶ NAME OF SOURCE *(Not an Acronym)*

____

ADDRESS *(Business Address Acceptable)*

____

BUSINESS ACTIVITY, IF ANY, OF SOURCE

____

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
___/___/___	$_______	____________
___/___/___	$_______	____________
___/___/___	$_______	____________

Comments: ____________________

____

Instructions – Schedule D
Income – Gifts

A gift is anything of value for which you have not provided equal or greater consideration to the donor. A gift is reportable if its fair market value is $50 or more. In addition, multiple gifts totaling $50 or more received during the reporting period from a single source must be reported.

It is the acceptance of a gift, not the ultimate use to which it is put, that imposes your reporting obligation. Except as noted below, you must report a gift even if you never used it or if you gave it away to another person.

If the exact amount of a gift is unknown, you must make a good faith estimate of the item's fair market value. Listing the value of a gift as "over $50" or "value unknown" is not adequate disclosure. In addition, if you received a gift through an intermediary, you must disclose the name, address, and business activity of both the donor and the intermediary. You may indicate an intermediary either in the "source" field after the name or in the "comments" section at the bottom of Schedule D.

Commonly reportable gifts include:

- Tickets/passes to sporting or entertainment events
- Tickets/passes to amusement parks
- Parking passes not used for official agency business
- Food, beverages, and accommodations, including those provided in direct connection with your attendance at a convention, conference, meeting, social event, meal, or like gathering
- Rebates/discounts not made in the regular course of business to members of the public without regard to official status
- Wedding gifts (See Reference Pamphlet, page 16)
- An honorarium received prior to assuming office (You may report an honorarium as income on Schedule C, rather than as a gift on Schedule D, if you provided services of equal or greater value than the payment received. See Reference Pamphlet, page 10.)
- Transportation and lodging (See Schedule E.)
- Forgiveness of a loan received by you

Reminders

- Gifts from a single source are subject to a **$500** limit in **2020**. (See Reference Pamphlet, page 10.)
- Code filers – you only need to report gifts from reportable sources.

Gift Tracking Mobile Application

- FPPC has created a gift tracking app for mobile devices that helps filers track gifts and provides a quick and easy way to upload the information to the Form 700. Visit FPPC's website to download the app.

You are <u>not</u> required to disclose:

- Gifts that were not used and that, within 30 days after receipt, were returned to the donor or delivered to a charitable organization or government agency without being claimed by you as a charitable contribution for tax purposes
- Gifts from your spouse or registered domestic partner, child, parent, grandparent, grandchild, brother, sister, and certain other family members (See Regulation 18942 for a complete list.). The exception does not apply if the donor was acting as an agent or intermediary for a reportable source who was the true donor.
- Gifts of similar value exchanged between you and an individual, other than a lobbyist registered to lobby your state agency, on holidays, birthdays, or similar occasions
- Gifts of informational material provided to assist you in the performance of your official duties (e.g., books, pamphlets, reports, calendars, periodicals, or educational seminars)
- A monetary bequest or inheritance (However, inherited investments or real property may be reportable on other schedules.)
- Personalized plaques or trophies with an individual value of less than $250
- Campaign contributions
- Up to two tickets, for your own use, to attend a fundraiser for a campaign committee or candidate, or to a fundraiser for an organization exempt from taxation under Section 501(c)(3) of the Internal Revenue Code. The ticket must be received from the organization or committee holding the fundraiser.
- Gifts given to members of your immediate family if the source has an established relationship with the family member and there is no evidence to suggest the donor had a purpose to influence you. (See Regulation 18943.)
- Free admission, food, and nominal items (such as a pen, pencil, mouse pad, note pad or similar item) available to all attendees, at the event at which the official makes a speech (as defined in Regulation 18950(b)(2)), so long as the admission is provided by the person who organizes the event.
- Any other payment not identified above, that would otherwise meet the definition of gift, where the payment is made by an individual who is not a lobbyist registered to lobby the official's state agency, where it is clear that the gift was made because of an existing personal or business relationship unrelated to the official's position and there is no evidence whatsoever at the time the gift is made to suggest the donor had a purpose to influence you.

To Complete Schedule D:

- Disclose the full name (not an acronym), address, and, if a business entity, the business activity of the source.
- Provide the date (month, day, and year) of receipt, and disclose the fair market value and description of the gift.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name ______________________

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

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

► NAME OF SOURCE *(Not an Acronym)*
____

ADDRESS *(Business Address Acceptable)*
____

CITY AND STATE
____

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

DATE(S): ___/___/___ - ___/___/___ AMT: $________
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description ______________________

► If Gift, Provide Travel Destination ______________________

► NAME OF SOURCE *(Not an Acronym)*
____

ADDRESS *(Business Address Acceptable)*
____

CITY AND STATE
____

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

DATE(S): ___/___/___ - ___/___/___ AMT: $________
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description ______________________

► If Gift, Provide Travel Destination ______________________

► NAME OF SOURCE *(Not an Acronym)*
____

ADDRESS *(Business Address Acceptable)*
____

CITY AND STATE
____

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

DATE(S): ___/___/___ - ___/___/___ AMT: $________
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description ______________________

► If Gift, Provide Travel Destination ______________________

► NAME OF SOURCE *(Not an Acronym)*
____

ADDRESS *(Business Address Acceptable)*
____

CITY AND STATE
____

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

DATE(S): ___/___/___ - ___/___/___ AMT: $________
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description ______________________

► If Gift, Provide Travel Destination ______________________

Comments: ______________________

Instructions – Schedule E
Travel Payments, Advances, and Reimbursements

Travel payments reportable on Schedule E include advances and reimbursements for travel and related expenses, including lodging and meals.

Gifts of travel may be subject to the gift limit. In addition, certain travel payments are reportable gifts, but are not subject to the gift limit. To avoid possible misinterpretation or the perception that you have received a gift in excess of the gift limit, you may wish to provide a specific description of the purpose of your travel. (See the FPPC fact sheet entitled "Limitations and Restrictions on Gifts, Honoraria, Travel, and Loans" to read about travel payments under section 89506(a).)

You are <u>not</u> required to disclose:

- Travel payments received from any state, local, or federal government agency for which you provided services equal or greater in value than the payments received, such as reimbursement for travel on agency business from your government agency employer.
- A payment for travel from another local, state, or federal government agency and related per diem expenses when the travel is for education, training or other inter-agency programs or purposes.
- Travel payments received from your employer in the normal course of your employment that are included in the income reported on Schedule C.
- A travel payment that was received from a nonprofit entity exempt from taxation under Internal Revenue Code Section 501(c)(3) for which you provided equal or greater consideration, such as reimbursement for travel on business for a 501(c)(3) organization for which you are a board member.

  Note: Certain travel payments may not be reportable if reported via email on Form 801 by your agency.

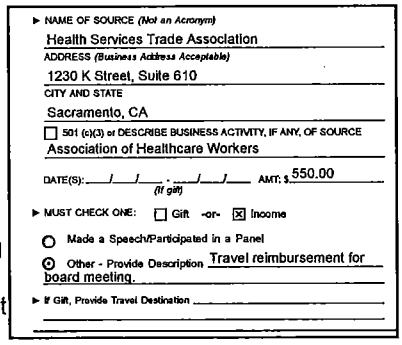
To Complete Schedule E:

- Disclose the full name (not an acronym) and address of the source of the travel payment.
- Identify the business activity if the source is a business entity.
- Check the box to identify the payment as a gift or income, report the amount, and disclose the date(s).
  - **Travel payments are gifts** if you did not provide services that were equal to or greater in value than the payments received. You must disclose gifts totaling $50 or more from a single source during the period covered by the statement.

    When reporting travel payments that are gifts, you must provide a description of the gift, the **date(s)** received, and the **travel destination.**
  - **Travel payments are income** if you provided services that were equal to or greater in value than the payments received. You must disclose income totaling $500 or more from a single source during the period covered by the statement. You have the burden of proving the payments are income rather than gifts. When reporting travel payments as income, you must describe the services you provided in exchange for the payment. You are not required to disclose the date(s) for travel payments that are income.

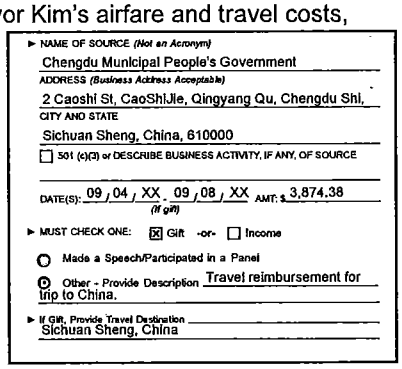
Example:

City council member MaryClaire Chandler is the chair of a 501(c)(6) trade association, and the association pays for her travel to attend its meetings. Because MaryClaire is deemed to be providing equal or greater consideration for the travel payment by virtue of serving on the board, this payment may be reported as income. Payments for MaryClaire to attend other events for which she is not providing services are likely considered gifts. Note that the same payment from a 501(c)(3) would NOT be reportable.


► NAME OF SOURCE *(Not an Acronym)*
Health Services Trade Association
ADDRESS *(Business Address Acceptable)*
1230 K Street, Suite 610
CITY AND STATE
Sacramento, CA
☐ 501 (c)(3) or DESCRIBE BUSINESS ACTIVITY, IF ANY, OF SOURCE
Association of Healthcare Workers
DATE(S): __/__/__ , __/__/__ *(If gift)* AMT: $ 550.00
► MUST CHECK ONE: ☐ Gift -or- ☒ Income
○ Made a Speech/Participated in a Panel
⊙ Other - Provide Description Travel reimbursement for board meeting.
► If Gift, Provide Travel Destination

Example:

Mayor Kim travels to China on a trip organized by China Silicon Valley Business Development, a California nonprofit, 501(c)(6) organization. The Chengdu Municipal People's Government pays for Mayor Kim's airfare and travel costs, as well as his meals and lodging during the trip. The trip's agenda shows that the trip's purpose is to promote job creation and economic activity in China and in Silicon Valley, so the trip is reasonably related to a governmental purpose. Thus, Mayor Kim must report the gift of travel, but the gift is exempt from the gift limit. In this case, the travel payments are not subject to the gift limit because the source is a foreign government and because the travel is reasonably related to a governmental purpose. (Section 89506(a)(2).) Note that Mayor Kim could be disqualified from participating in or making decisions about The Chengdu Municipal People's Government for 12 months. Also note that if China Silicon Valley Business Development (a 501(c)(6) organization) paid for the travel costs rather than the governmental organization, the payments would be subject to the gift limits. (See the FPPC fact sheet, Limitations and Restrictions on Gifts, Honoraria, Travel and Loans, at www.fppc.ca.gov.)


► NAME OF SOURCE *(Not an Acronym)*
Chengdu Municipal People's Government
ADDRESS *(Business Address Acceptable)*
2 Caoshi St, CaoShiJie, Qingyang Qu, Chengdu Shi,
CITY AND STATE
Sichuan Sheng, China, 610000
☐ 501 (c)(3) or DESCRIBE BUSINESS ACTIVITY, IF ANY, OF SOURCE
DATE(S): 09/04/XX , 09/08/XX *(If gift)* AMT: $ 3,874.38
► MUST CHECK ONE: ☒ Gift -or- ☐ Income
○ Made a Speech/Participated in a Panel
⊙ Other - Provide Description Travel reimbursement for trip to China.
► If Gift, Provide Travel Destination Sichuan Sheng, China

Restrictions and Prohibitions

The Political Reform Act (Gov. Code Sections 81000-91014) requires most state and local government officials and employees to publicly disclose their personal assets and income. They also must disqualify themselves from participating in decisions that may affect their personal economic interests. The Fair Political Practices Commission (FPPC) is the state agency responsible for issuing the attached Statement of Economic Interests, Form 700, and for interpreting the law's provisions.

Gift Prohibition

Gifts received by most state and local officials, employees, and candidates are subject to a limit. In 2021-2022, the gift limit increased to $520 from a single source during a calendar year. In 2019 and 2020, the gift limit was $500 from a single source during a calendar year.

Additionally, state officials, state candidates, and certain state employees are subject to a $10 limit per calendar month on gifts from lobbyists and lobbying firms registered with the Secretary of State. See Reference Pamphlet, page 10.

State and local officials and employees should check with their agency to determine if other restrictions apply.

Disqualification

Public officials are, under certain circumstances, required to disqualify themselves from making, participating in, or attempting to influence governmental decisions that will affect their economic interests. This may include interests they are not required to disclose. For example, a personal residence is often not reportable, but may be grounds for disqualification. Specific disqualification requirements apply to 87200 filers (e.g., city councilmembers, members of boards of supervisors, planning commissioners, etc.). These officials must publicly identify the economic interest that creates a conflict of interest and leave the room before a discussion or vote takes place at a public meeting. For more information, consult Government Code Section 87105, Regulation 18707, and the Guide to Recognizing Conflicts of Interest page at *www.fppc.ca.gov.*

Honorarium Ban

Most state and local officials, employees, and candidates are prohibited from accepting an honorarium for any speech given, article published, or attendance at a conference, convention, meeting, or like gathering. (See Reference Pamphlet, page 10.)

Loan Restrictions

Certain state and local officials are subject to restrictions on loans. (See Reference Pamphlet, page 14.)

Post-Governmental Employment

There are restrictions on representing clients or employers before former agencies. The provisions apply to elected state officials, most state employees, local elected officials, county chief administrative officers, city managers, including the chief administrator of a city, and general managers or chief administrators of local special districts and JPAs. The FPPC website has fact sheets explaining the provisions.

Late Filing

The filing officer who retains originally-signed or electronically filed statements of economic interests may impose on an individual a fine for any statement that is filed late. The fine is $10 per day up to a maximum of $100. Late filing penalties may be reduced or waived under certain circumstances.

Persons who fail to timely file their Form 700 may be referred to the FPPC's Enforcement Division (and, in some cases, to the Attorney General or district attorney) for investigation and possible prosecution. In addition to the late filing penalties, a fine of up to $5,000 per violation may be imposed.

For assistance concerning reporting, prohibitions, and restrictions under the Act:

- Email questions to advice@fppc.ca.gov.
- Call the FPPC toll-free at (866) 275-3772.

Form 700 is a Public Document Public Access Must Be Provided

Statements of Economic Interests are public documents. The filing officer must permit any member of the public to inspect and receive a copy of any statement.

- Statements must be available as soon as possible during the agency's regular business hours, but in any event not later than the second business day after the statement is received. Access to the Form 700 is not subject to the Public Records Act procedures.
- No conditions may be placed on persons seeking access to the forms.
- No information or identification may be required from persons seeking access.
- Reproduction fees of no more than 10 cents per page may be charged.

Questions and Answers

General

Q. What is the reporting period for disclosing interests on an assuming office statement or a candidate statement?

A. On an assuming office statement, disclose all reportable investments, interests in real property, and business positions held on the date you assumed office. In addition, you must disclose income (including loans, gifts and travel payments) received during the 12 months prior to the date you assumed office.

On a candidate statement, disclose all reportable investments, interests in real property, and business positions held on the date you file your declaration of candidacy. You must also disclose income (including loans, gifts and travel payments) received during the 12 months prior to the date you file your declaration of candidacy.

Q. I hold two other board positions in addition to my position with the county. Must I file three statements of economic interests?

A. Yes, three are required. However, you may complete one statement listing the county and the two boards on the Cover Page or an attachment as the agencies for which you will be filing. Report your economic interests using the largest jurisdiction and highest disclosure requirements assigned to you by the three agencies. Make two copies of the entire statement before signing it, sign each copy with an original signature, and distribute one original to the county and to each of the two boards. Remember to complete separate statements for positions that you leave or assume during the year.

Q. I am a department head who recently began acting as city manager. Should I file as the city manager?

A. Yes. File an assuming office statement as city manager. Persons serving as "acting," "interim," or "alternate" must file as if they hold the position because they are or may be performing the duties of the position.

Q. My spouse and I are currently separated and in the process of obtaining a divorce. Must I still report my spouse's income, investments, and interests in real property?

A. Yes. A public official must continue to report a spouse's economic interests until such time as dissolution of marriage proceedings is final. However, if a separate property agreement has been reached prior to that time, your estranged spouse's income may not have to be reported. Contact the FPPC for more information.

Q. As a designated employee, I left one state agency to work for another state agency. Must I file a leaving office statement?

A. Yes. You may also need to file an assuming office statement for the new agency.

Investment Disclosure

Q. I have an investment interest in shares of stock in a company that does not have an office in my jurisdiction. Must I still disclose my investment interest in this company?

A. Probably. The definition of "doing business in the jurisdiction" is not limited to whether the business has an office or physical location in your jurisdiction. (See Reference Pamphlet, page 13.)

Q. My spouse and I have a living trust. The trust holds rental property in my jurisdiction, our primary residence, and investments in diversified mutual funds. I have full disclosure. How is this trust disclosed?

A. Disclose the name of the trust, the rental property and its income on Schedule A-2. Your primary residence and investments in diversified mutual funds registered with the SEC are not reportable.

Q. I am required to report all investments. I have an IRA that contains stocks through an account managed by a brokerage firm. Must I disclose these stocks even though they are held in an IRA and I did not decide which stocks to purchase?

A. Yes. Disclose on Schedule A-1 or A-2 any stock worth $2,000 or more in a business entity located in or doing business in your jurisdiction.

Q. The value of my stock changed during the reporting period. How do I report the value of the stock?

A. You are required to report the highest value that the stock reached during the reporting period. You may use your monthly statements to determine the highest value. You may also use the entity's website to determine the highest value. You are encouraged to keep a record of where you found the reported value. Note that for an assuming office statement, you must report the value of the stock on the date you assumed office.

Q. I am the sole owner of my business, an S-Corporation. I believe that the nature of the business is such that it cannot be said to have any "fair market value" because it has no assets. I operate the corporation under an agreement with a large insurance company. My contract does not have resale value because of its nature as a personal services contract. Must I report the fair market value for my business on Schedule A-2 of the Form 700?

A. Yes. Even if there are no *tangible* assets, intangible assets, such as relationships with companies and clients are commonly sold to qualified professionals. The "fair market value" is often quantified for other purposes, such as marital dissolutions or estate planning. In addition, the IRS presumes that "personal services corporations" have a fair market value. A professional "book of business" and the associated goodwill that generates income are not without a determinable value. The Form 700 does not require a precise fair market value; it is only necessary to check a box indicating the broad range within which the value falls.

Q. I own stock in IBM and must report this investment on Schedule A-1. I initially purchased this stock in the early 1990s; however, I am constantly buying and selling shares. Must I note these dates in the "Acquired" and "Disposed" fields?

A. No. You must only report dates in the "Acquired" or "Disposed" fields when, during the reporting period, you initially purchase a reportable investment worth $2,000 or more or when you dispose of the entire investment. You are not required to track the partial trading of an investment.

Q. On last year's filing I reported stock in Encoe valued at $2,000 - $10,000. Late last year the value of this stock fell below and remains at less than $2,000. How should this be reported on this year's statement?

A. You are not required to report an investment if the value was less than $2,000 during the **entire** reporting period. However, because a disposed date is not required for stocks that fall below $2,000, you may want to report the stock and note in the "comments" section that the value fell below $2,000. This would be for informational purposes only; it is not a requirement.

Q. We have a Section 529 account set up to save money for our son's college education. Is this reportable?

A. If the Section 529 account contains reportable interests (e.g., common stock valued at $2,000 or more), those interests are reportable (not the actual Section 529 account). If the account contains solely mutual funds, then nothing is reported.

Income Disclosure

Q. I reported a business entity on Schedule A-2. Clients of my business are located in several states. Must I report all clients from whom my pro rata share of income is $10,000 or more on Schedule A-2, Part 3?

A. No, only the clients located in or doing business on a regular basis in your jurisdiction must be disclosed.

Q. I believe I am not required to disclose the names of clients from whom my pro rata share of income is $10,000 or more on Schedule A-2 because of their right to privacy. Is there an exception for reporting clients' names?

A. Regulation 18740 provides a procedure for requesting an exemption to allow a client's name not to be disclosed if disclosure of the name would violate a legally recognized privilege under California or Federal law. This regulation may be obtained from our website at *www.fppc.ca.gov.* (See Reference Pamphlet, page 14.)

Q. I am sole owner of a private law practice that is not reportable based on my limited disclosure category. However, some of the sources of income to my law practice are from reportable sources. Do I have to disclose this income?

A. Yes, even though the law practice is not reportable, reportable sources of income to the law practice of $10,000 or more must be disclosed. This information would be disclosed on Schedule C with a note in the "comments" section indicating that the business entity is not a reportable investment. The note would be for informational purposes only; it is not a requirement.

Q. I am the sole owner of my business. Where do I disclose my income - on Schedule A-2 or Schedule C?

A. Sources of income to a business in which you have an ownership interest of 10% or greater are disclosed on Schedule A-2. (See Reference Pamphlet, page 8.)

Q. My husband is a partner in a four-person firm where all of his business is based on his own billings and collections from various clients. How do I report my community property interest in this business and the income generated in this manner?

A. If your husband's investment in the firm is 10% or greater, disclose 100% of his share of the business on Schedule A-2, Part 1 and 50% of his income on Schedule A-2, Parts 2 and 3. For example, a client of your husband's must be a source of at least $20,000 during the reporting period before the client's name is reported.

Q. How do I disclose my spouse's or registered domestic partner's salary?

A. Report the name of the employer as a source of income on Schedule C.

Q. I am a doctor. For purposes of reporting $10,000 sources of income on Schedule A-2, Part 3, are the patients or their insurance carriers considered sources of income?

A. If your patients exercise sufficient control by selecting you instead of other doctors, then your patients, rather than their insurance carriers, are sources of income to you. (See Reference Pamphlet, page 14.)

Q. I received a loan from my grandfather to purchase my home. Is this loan reportable?

A. No. Loans received from family members are not reportable.

Q. Many years ago, I loaned my parents several thousand dollars, which they paid back this year. Do I need to report this loan repayment on my Form 700?

A. No. Payments received on a loan made to a family member are not reportable.

Real Property Disclosure

Q. During this reporting period we switched our principal place of residence into a rental. I have full disclosure and the property is located in my agency's jurisdiction, so it is now reportable. Because I have not reported this property before, do I need to show an "acquired" date?

A. No, you are not required to show an "acquired" date because you previously owned the property. However, you may want to note in the "comments" section that the property was not previously reported because it was used exclusively as your residence. This would be for informational purposes only; it is not a requirement.

Q. I am a city manager, and I own a rental property located in an adjacent city, but one mile from the city limit. Do I need to report this property interest?

A. Yes. You are required to report this property because it is located within 2 miles of the boundaries of the city you manage.

Q. Must I report a home that I own as a personal residence for my daughter?

A. You are not required to disclose a home used as a personal residence for a family member unless you receive income from it, such as rental income.

Q. I am a co-signer on a loan for a rental property owned by a friend. Since I am listed on the deed of trust, do I need to report my friend's property as an interest in real property on my Form 700?

A. No. Simply being a co-signer on a loan for property does not create a reportable interest in real property for you.

Gift Disclosure

Q. If I received a reportable gift of two tickets to a concert valued at $100 each, but gave the tickets to a friend because I could not attend the concert, do I have any reporting obligations?

A. Yes. Since you accepted the gift and exercised discretion and control of the use of the tickets, you must disclose the gift on Schedule D.

Q. Julia and Jared Benson, a married couple, want to give a piece of artwork to a county supervisor. Is each spouse considered a separate source for purposes of the gift limit and disclosure?

A. Yes, each spouse may make a gift valued at the gift limit during a calendar year. For example, during 2020 the gift limit was $500, so the Bensons may have given the supervisor artwork valued at no more than **$1,000**. The supervisor must identify Jared and Julia Benson as the sources of the gift.

Q. I am a Form 700 filer with full disclosure. Our agency holds a holiday raffle to raise funds for a local charity. I bought $10 worth of raffle tickets and won a gift basket valued at $120. The gift basket was donated by Doug Brewer, a citizen in our city. At the same event, I bought raffle tickets for, and won a quilt valued at $70. The quilt was donated by a coworker. Are these reportable gifts?

A. Because the gift basket was donated by an outside source (not an agency employee), you have received a reportable gift valued at $110 (the value of the basket less the consideration paid). The source of the gift is Doug Brewer and the agency is disclosed as the intermediary. Because the quilt was donated by an employee of your agency, it is not a reportable gift.

Q. My agency is responsible for disbursing grants. An applicant (501(c)(3) organization) met with agency employees to present its application. At this meeting, the applicant provided food and beverages. Would the food and beverages be considered gifts to the employees? These employees are designated in our agency's conflict of interest code and the applicant is a reportable source of income under the code.

A. Yes. If the value of the food and beverages consumed by any one filer, plus any other gifts received from the same source during the reporting period total $50 or more, the food and beverages would be reported using the fair market value and would be subject to the gift limit.

Q. I received free admission to an educational conference related to my official duties. Part of the conference fees included a round of golf. Is the value of the golf considered informational material?

A. No. The value of personal benefits, such as golf, attendance at a concert, or sporting event, are gifts subject to reporting and limits.

Item #8

Attachment 8.A

2020 Annual QI Work Plan Evaluation
Executive Summary

REPORT SUMMARY TO COMMITTEE

TO:	QI/UM Committee Members Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Amy Wittig, Quality Improvement Department
COMMITTEE DATE:	February 18, 2021
SUBJECT:	Quality Improvement End of Year Work Plan Evaluation Executive Summary 2020

Summary:
CalViva Health's 2020 Quality Improvement (QI) Program monitors improvement in clinical care and service using a range of indicators. These key performance indicators are found in service, clinical, and utilization reports from QI and various other departments. Based on these reports, areas of improvement are identified, and interventions implemented and monitored. In 2020, quality improvement initiatives are focused on (but not limited to) improving preventative care, disease management outcomes, continuity and coordination of patient care, patient safety metrics, member access to care, and supporting provider initiatives.

Due to COVID-19 public health emergency CalViva Health was unable to implement and test the 2020 performance improvement projects (PIP) and plan-do-study-act (PDSA) strategies with the targeted providers. DHCS did not require submission of the final 2020 PDSA and ended the projects on June 22, 2020. DHCS also elected to end the 2020 PIPs as of June 30, 2020.

Purpose of Activity:
The QI Work Plan Evaluation Executive Report provides evidence of monitoring of the overall effectiveness of the QI activities and processes, and identifies barriers and opportunities for improvement.

Work Plan Initiatives:
Details for the End of Year outcomes are included in the 2020 QI End of Year Work Plan Evaluation. Key End of Year highlights include:

1. Access, Availability, and Service

1.1 Improve Access to Care: CalViva monitors appointment access annually through the Provider Appointment Availability Survey (PAAS). After Hours Access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS). Between MY 2018 and MY 2019 improvement was noted for Non-urgent PCP and Specialist appointments. Madera county saw an increases of 7.3 percentage points (PP) for the Non-Urgent PCP appointment measure. The Non-Urgent Specialist overall score increased by 7.3 PP with Madera county posting a notable increase of 31.1 PP.

Rates for Urgent PCP appointments were similar to MY 2018 with a slight dip of 0.5 PP in the overall score.as compared to MY 2018. Overall specialists scores showed a notable decline.

For the After-Hours (PAHAS) survey, a new survey vendor was used and overall results indicate both metrics were met. Statistically significant improvement at the overall and county levels were noted for both metrics.

When deficiencies are identified through analysis of the survey results, Corrective Action Plan (CAP) packets are distributed to PPGs who fail one or more of the timely access or after-hours measures. For MY 2019, a revised CAP process was implemented using a targeted PPG approach to address non-compliance and a refined escalation process for non-responding PPGs. Seven priority PPGs were identified and CAP packets were sent on 7/31/20. A request to complete an Improvement Plan was included in the CAP packet with a due date of 9/1/20.

All IPs were received by 9/1/20 with the exception of Adventist Health. Due to a data issue, a revised CAP was sent on 10/1/20 and a completed Improvement Plan was received on 11/2/20.

All Improvement Plans were validated and requests sent for supporting documentation as applicable. The majority of the CAPs were closed out by 12/31/20. Two CAPs remain open for supporting documentation and are being closely monitored.

Non-compliant FFS groups/clinics (16) and Direct Network providers (26) were sent Education packets on 7/29/20. The packets outlined the non-compliant measures and included resource materials.

Additionally in 2020, the Access & Availability team conducted 10 timely access provider webinars with 51 attendees present. Low attendance was impacted by the COVID-19 and wildfire situations that occurred in 2020.

1.2 I**mprove Member Satisfaction**: CAHPS Metrics evaluate the following: getting needed care, getting care quickly, rating of all health care, rating of personal doctor, and how well doctors communicate. Although RY2020 rates were below the national benchmark, the majority of measures saw improvement from the last set of results (RY2017).
The 2020 Annual Access Survey revealed that overall, CVH members are able to get care within an adequate timeframe (both for children and adult membership). However, the following areas saw a YOY decrease and thus became areas of focus for 2020 improvement efforts:
1. Access to Specialist Appointments (adults)
2. Ease of Getting Care, Tests, and Treatment (adults)
3. Wait Time for Care, Tests, and Treatment (children)

A PPG Webinar was held in Q3 over 2 days (2 separate sessions) to educate attendees on the importance of CAHPS, review impacts due to COVID-19, and a Q&A session to address any inquiries. Quarterly root cause analyses were done to highlight member pain points and better identify areas that need additional focus.

Root Cause Analyses were done on a quarterly basis to identify CAHPS leading indicators using other sources of member pain point data (A&G). Top pain point trends in 2020 were around the following areas: Access to Care, Transportation, and Admin. Issues – Referrals. Findings were shared with the appropriate HN stakeholder departments to highlight the issues, as well as brainstorm ways to properly address and improve.

CAHPS Action Plan Meetings continue to take place on a regular basis as a way to stay connected with partner departments who have launched member experience improvement efforts, as well as track progress. Monitoring of improvement efforts and gathering feedback from stakeholders will continue through 2021.

2. Quality and Safety of Care

2.1 HEDIS® Minimum Performance Level (MPL) Default Measures (50th percentile)

Cervical Cancer Screening (CCS)	All counties exceeded MPL of 60.65%.
Childhood Immunization Combo 10 (CIS-10)	One county (Madera) exceeded MPL of 34.79%. Kings and Fresno counties fell below the MPL. The Performance Improvement Project that has been implemented to improve

	rates in Fresno County has been put on hold due to the pandemic.
Comprehensive Diabetes Care HbA1c Testing (CDC – Testing)	For Final RY20 two out of three (Kings & Madera) counties exceeded the 50th percentile (88.55%). Fresno County fell below the MPL at 87.83%.
Controlling High Blood Pressure (CBP)	All three counties exceeded MPL 61.04%
Timeliness of Prenatal Care (PPC-Pre)	All three counties exceeded MPL of 83.76%
Well Child Visits 3-6 years (W34)	All three counties exceeded MPL of 72.87%

2.2 Non-Default HEDIS® Minimum Performance Level (MPL) Measures – Additional measures Below the MPL in RY 2020

Antidepressant Medication Management - Acute Phase (AMM)	All counties fell below the MPL of 52.33%.
Antidepressant Medication Management - Continuation Phase (AMM)	All counties fell below the MPL of 36.51%.
Adolescent Well-Care Visits (AWC)	Fresno County fell below the MPL of 54.26% with a rate of 53.77%.
Breast Cancer Screening (BCS)	Two of the three counties (Fresno & Kings) fell below the DHCS MPL of 58.67%. A Disparity PIP was implemented for Fresno County, and was placed on hold due to the pandemic..
Chlamydia Testing – TOTAL (CHL)	Madera County fell below the MPL of 58.34% with a rate of 55.42%.
Well-Child Visits in the First 15 Months of Life (W15)	Two counties (Kings & Fresno) fell below the MPL of 65.83%.

3. Performance Improvement Projects

Two new PIPs, in Fresno County have begun and the first modules have been submitted to HSAG/DHCS:

- Breast Cancer Screening (BCS) disparity
- Childhood Immunizations, Combination 10 (CIS-10) project

3.1 Childhood Immunization (CIS-10):

In Q4, 2020 CalViva Health Medical Management staff expanded the CIS-3 Performance Improvement Project to a CIS-10 project in collaboration with one high volume, low compliance clinic in Fresno County. Due to the COVID-19 restrictions, the Performance Improvement Project was put on pause by DHCS. A new PIP Topic Proposal was submitted and approved by DHCS. CalViva Health Medical Management staff is currently in discussions with the clinic to determine appropriate interventions due to COVID-19. Per DHCS guidelines, CVH will be resubmitting the Modules with a revised baseline and goal rate.

3.2 Breast Cancer Screening (BCS) Disparity

In Q4, 2020 CalViva Health Medical Management staff began a Breast Cancer Screening (BCS) Performance Improvement Project in collaboration with one high volume, low compliance clinic, a women's radiology center and a community based organization that supports the Hmong population in Fresno County. CalViva Health, the clinic, and a radiology center met to develop and finalize the process map to identify gaps in care for potential interventions.

Due to the COVID-19 restrictions, the Performance Improvement Project was put on pause by DHCS. A new PIP Topic Proposal was submitted and approved by DHCS. CalViva Health Medical Management staff is currently in discussions with the clinic to determine appropriate interventions due to COVID-19. Per DHCS guidelines, CVH will be resubmitting the Modules with a revised baseline and goal rate.

Due to COVID-19 public health emergency CVH was unable to implement and test the 2020 strategies with the targeted provider. DHCS did not require submission of final 2020 PDSA for Diabetes.

Item #8

Attachment 8.B

2020 Annual QI Work Plan Evaluation
Year End Evaluation

CalViva Health
Quality Improvement
End of Year Work Plan Evaluation
2020

02.08.21

CalViva Health 2020 Quality Improvement End of Year Work Plan Evaluation

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CalViva Health 2020 Quality Improvement End of Year Work Plan Evaluation

Submitted by:

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CalViva Health 2020 Quality Improvement End of Year Work Plan Evaluation

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 End of Year Work Plan Evaluation encompasses quality improvement activities for 2020. The development of this document requires resources of multiple departments.

CalViva Health 2020 Quality Improvement End of Year Work Plan Evaluation

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances	**HPL:**	High Performance Level
A&I:	Audits and Investigation	**HN:**	Health Net
AH:	After Hours	**HSAG:**	Health Services Advisory Group
AWC:	Adolescent Well-Care	**IHA:**	Initial Health Assessment
BH:	Behavioral Health	**ICE:**	Industry Collaborative Effort
C&L:	Cultural and Linguistic	**IP:**	Improvement Plan
CAHPS:	Consumer Assessment of Healthcare Providers and Systems	**IVR:**	Interactive Voice Response
		MCL:	Medi-Cal
CAP:	Corrective Action Plan	**MH:**	Mental Health
CCHRI:	California Cooperative Healthcare Reporting Initiative	**MMCD:**	Medi-Cal Managed Care Division
CDC:	Comprehensive Diabetes Care	**MPL:**	Minimum Performance Level
CM:	Case Management	**PCP:**	Primary Care Physician
CP:	Clinical Pharmacist	**PIP**:	Performance Improvement Project
CVH:	CalViva Health	**PMPM:**	Per Member Per Month
DHCS:	Department of Health Care Services	**PMPY:**	Per Member Per Year
DM:	Disease Management	**PNM:**	Provider Network Management
DMHC:	Department of Managed Health Care	**PRR:**	Provider Relations Representative
DN:	Direct Network	**PTMPY:**	Per Thousand Members Per Year
FFS:	Fee-for-Service	**QI:**	Quality Improvement
HE:	Health Education	**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 90% for all measures. Success will be evaluated at the end of the survey period. Timely Appointment Access is monitored using the DMHC PAAS Tool and the CVH PAAS Tool.
Timely Appointment Access to Ancillary Providers is measured through two metrics. The goal is 90% for all metrics. Timely Appointment Access is monitored using the DMHC PAAS Tool.
After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey. This survey is conducted to assess provider compliance with required after-hours emergency instructions for members and that members can expect to receive a call-back from a qualified health professional within 30 minutes when seeking urgent care/services by telephone. The results are made available to all applicable provider organizations through annual provider updates. When deficiencies are identified, improvement plans are requested of contracted providers and provider groups as described in CVH policy PV-100-007 Accessibility of Providers and Practitioners. These measures assess whether 90% of providers have appropriate emergency instructions whenever their offices are closed/after-hours, and if 90% of providers are available for members to contact them during after-hours for urgent issues within the 30-minute timeframe standard.

Planned Activities

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

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

• PAAS & PAHAS surveys slated to kick off 8/17/20 by Sutherland.
• Provider Updates:
  ○ MY 2019 CalViva PAAS & After-Hours Results – draft being prepared for CalViva Health's review.
  ○ MY 2020 PAAS & After-Hours Survey Prep – draft being prepared for CalViva Health's review.
• Telephone Answer surveys on hold Q1 & Q2 due to COVID-19. Reinstatement is TBD.
• Provider Trainings conducted on June 16, 18 & 19. Total of 13 provider offices attended. Attendance expected to increase in Q3 & Q4 once CAP packets and Education packets are distributed. Attendance is required for all PPGs receiving a CAP and strongly encouraged for those receiving an Education packet.
	• MY 2020 PAAS & PAHAS surveys completed 12/24/20 ahead of the 12/31/20 deadline. Surveys conducted by Sutherland.
	• Provider Communications:
	  ○ MY 2019 PAAS & After-Hours results Provider Update sent out 8/14/20.
	  ○ MY 2020 PAAS & After-Hours Survey Prep Provider Update sent out 8/21/20.
	  ○ Provider Training Flyers sent June 2020, August 2020 and November 2020.
	• Provider Trainings :
	  ○ Q1- no trainings scheduled due to COVID-19
	  ○ Q2 – conducted 6/16, 6/18 & 6/19 with 20 attendees (REVISED attendee count from mid-year update)
	  ○ Q3 – conducted 9/15, 9/17 & 9/23 with 15 attendees
	  ○ Q4 – conducted 12/2, 12/3, 12/8 & 12/9 with 16 attendees

• Access & Availability P&P currently under review by CalViva Health for additions of LTSS and revised CAP process.
• MY 2019 CAP:
  ○ CAP process revised for MY 2019 with a targeted focus on priority PPGs. Includes follow-up on Improvement Plan completion, Action Plan validation and escalation process for non-responses.
  ○ CAP packets will be sent out no later than 7/31/20 with completed Improvement Plans due back from PPGs by 8/31/20.
  ○ Education packets will be sent out no later than 7/31/20.
• Review of resource materials conducted.
  ○ Update of Timely Appointment Access flyer to reflect change of "First Prenatal Appt – PCP & SCP" standard from 10 business days to 2 weeks as directed by DHCS.
  ○ Update of Timely Access Report Card flyer to reflect 2019 dates and updated First Prenatal standard of 2 weeks.
• Suggest revamp of tables in Section B for 2021 to remove duplicative data and to align reporting with DMHC's format.
	○ Attendance for Q3 and Q4 not as high as expected due to COVID and wildfire situation.
	• Telephone Answer Surveys:
	  ○ Q1-Q3 surveys not conducted due to the COVID-19 situation.
	  ○ Q4 surveys were conducted in December 2020 and concluded on December 24th.
	• Access & Availability P&P reviewed at the 10/6/20 CalViva Access Work Group meeting.
	• MY 2019 CAP:
	  ○ Seven Priority PPGs identified and CAP packets sent out via email on 7/31/20.
	  ○ Provider Ed packets sent to 16 other FFS/Clinics and 26 Direct Network providers via email/mail on 7/29/20.
	  ○ Improvement Plans (IP):
	  ▪ All IPs received by 9/1 due date with the exception of Adventist Health Kings County. Revised CAP sent 10/1/20 and competed IP received 11/2/20.
	  ▪ Validations of all Improvement Plans completed within 10 business days of IP receipt and supporting documentation requested as needed.
	  ▪ Five Improvement Plans closed out as of 12/31/20.
	  ▪ Adventist Health Community Care Clinics requested an extension until 12/31/20 to submit supporting documentation of Improvement Plan activities. This PPG was escalated to the assigned PNA and is being monitored closely.
	  ▪ Central Valley Medical Providers requested an extension until 3/2021 to submit supporting documentation of Improvement Plan activities due to staff turnover. This PPG was escalated to the assigned PNA and is being monitored closely.
	• Review of resource materials:
	  ○ Improve Your Patients' Experience with Timely Access flyer updated in January 2020 and sent as part of the CAP/Provider Ed packet.

	○ Timely Appointment Access & After-Hours Report Card flyer updated in July 2020 and sent as part of the CAP/Provider Ed packet. • Revamp of table in Section B for 2021 reporting. Table will now include combined results line and will show three years of data. Approved by Amy Schneider and Dr. Marabella on 12/23/20.

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

Measure(s)	Performance Goal[#]	Rate (%) RY 2020 (MY 2019) (populated mid-year)	Rate (%) RY 2019 (MY 2018)	Baseline Value Source	Baseline Value (%) RY 2018 (MY 2017)
Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	90%	Overall=84.7 Fresno=85.5 Kings= 84.9 Madera= 79.5	Overall=82.1** Fresno=85.7** Kings=85.2** Madera=62.5 **	CVH Performance RY 2018 (MY 2017)	Overall=90.1 Fresno=87.7 Kings=97.7 Madera=94.9
Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	90%	Overall=75.4 Fresno=77.1 Kings=64.3 Madera=74.2	Overall= 68.1** Fresno=72.2** Kings= 73.7** Madera=43.1**	CVH Performance RY 2018 (MY 2017)	Overall=64.0 Fresno=68.8 Kings=65.2 Madera=55.5
Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request	90%	Overall=70.9^ Fresno=71.9 Kings=67.3 Madera=70.3	Overall= 71.4** Fresno=74.2** Kings=59.3 Madera=81.3	CVH Performance RY 2018 (MY 2017)	Overall=82.9 Fresno=82.9 Kings=81.4 Madera=84.6
Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	90%	Overall=52.2^ Fresno=53.8 Kings=42.3 Madera=50.9	Overall=62.8** Fresno=68.0** Kings=44.4** Madera=53.2**	CVH Performance RY 2018 (MY 2017)	Overall=60.7 Fresno=68.3 Kings=52.3 Madera=50.8
First Prenatal Visit (PCP) – Within 2 weeks of request	90%	Overall=88.4 Fresno=90.0 Kings=91.3 Madera=70.0	Overall=90.3 ** Fresno=94.4** Kings=90.0** Madera=66.7**	CVH Performance RY 2018 (MY 2017)	Overall=100 Fresno=100 Kings=100 Madera=NR
First Prenatal Visit (SCP) – Within 2 weeks of request	90%	Overall=91.2 Fresno=90.3 Kings=100* Madera=NR	Overall=88.9** Fresno=87.5** Kings=100** Madera=100**	CVH Performance RY 2018 (MY 2017)	Overall=80.0 Fresno=100 Kings=NR Madera=33.3

Well-Child Visit with PCP – within 10 business days of request	90%	Overall=76.9 Fresno=77.5 Kings=79.6 Madera=70.3	Overall=73.6** Fresno=69.8** Kings=85.2** Madera=68.8**	CVH Performance RY 2018 (MY 2017)	Overall=84.1 Fresno=86.9 Kings=60.0 Madera=66.7
Physical Exams and Wellness Checks – within 30 calendar days of request	90%	Overall=87.8 Fresno=88.1 Kings=91.5^ Madera=81.6	Overall=88.5** Fresno=85.2** Kings=92.6** Madera=93.8**	CVH Performance RY 2018 (MY 2017)	Overall=91.3 Fresno=93.4 Kings=60.0 Madera=100
Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	90%	Overall=93.3 Fresno=90.9 Kings=100* Madera=100*	Overall=66.7 Fresno=60.0 Kings=100 Madera= NR	CVH Performance RY 2018 (MY 2017)	Overall=89.0 Fresno=83.3 Kings=100 Madera=NR
Appropriate After-Hours (AH) emergency instructions	90%	Overall=97.9 ↑ Fresno=97.9 ↑ Kings=99.0 Madera=96.1 ↑	Overall=93.9 Fresno=95.2 Kings=95.0 Madera=80.5	CVH Performance RY 2018 (MY 2017)	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=99.4 ↑ Fresno=99.4 ↑ Kings=99.0 ↑ Madera=100 ↑	Overall=82.0 Fresno=82.3 Kings=77.8 Madera=85.0	CVH Performance RY 2018 (MY 2017)	Overall=78.7 Fresno=76.7 Kings=87.0 Madera=82.1

^Rate for MY 2019 cannot be compared to MY 2018 due to change in the sampling methodology.

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

↑↓ Statistically significant difference between RY 2019 vs RY 2018, p<0.05

NR – No reportable data

** Change in DMHC survey tool for all PCP and specialist urgent and non-urgent metrics - rates should be interpreted with caution

Performance Goal was 80% for MY 2017 & MY 2018

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Overall Effectiveness:** • PAAS & After-Hours Surveys: ○ Urgent Care – PCP overall scores were relatively the same as the prior measurement year with a slight dip of 0.5 percentage points (PP) as compared to MY 2018. Overall Specialists scores continue to be low with a notable decline in MY 2019. ○ Non-Urgent Care – PCP overall scores improved slightly as compared to MY 2018 with Fresno and Kings county scores similar to MY 2018. Madera County saw an increase of 7.3 PP as compared to the prior measurement year. ○ After-Hours: Statistically significant improvement was noted for overall and county level scores in MY 2019 as compared to MY 2018.

	• Provider Training: ○ A total of 10 Timely Access provider webinars were conducted for 2020 with 51 attendees from the CalViva area. **Barriers:** • PAAS & After-ours Surveys: DMHC methodology makes it difficult to truly assess provider timely access, as it is not reflective of real-life scenarios (other providers within the same group who may be able to see the patient sooner, part-time providers, use of extenders, etc.). • Provider Training: Ability to track accurate CalViva attendance at Timely Access provider webinars continues to be challenging due to registration template restrictions.
Initiative Continuation Status (Populate at year end)	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

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

Rationale and Aim(s) of Initiative

Member Experience for CalViva is monitored in two ways:

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

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

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

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

- Rating of Health Plan

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

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

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

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

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

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Annually review, update, distribute and promote the Patient Experience(PE) Toolkit to providers	P	Q2 2020	CVH/HN
Annually, review update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide	P	Q1-Q2 2020	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 2020	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 2020	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services	M	Q2 2020	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 2020	CVH/HN
Update and conduct scaled-back member survey (annual Access Survey) to assess effectiveness of interventions implemented. Share and review results once they are made available.	M	Q1 – Q2 2020	CVH/HN
PPG CAHPS Webinar held bi-annually. Webinar covers recommendations and best practices on how provider/provider staff can improve patient satisfaction throughout all patient interactions, as well as the importance of CAHPS.	P	Q3, Q4 2020	CVH/HN
Quarterly root cause analysis on appeals and grievances data to highlight member pain points, trends and opportunities for improvement.	P	Quarterly basis	CVH/HN

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

• The Patient Experience Toolkit has evolved and become part of the Provider Tool Kit. The Provider Tool Kit includes various resources/materials around the following topics: Overall Patient Experience, CAHPS Survey, Online Provider Resources, Timely Access to Care, Interpreter Services. 500 copies of the tool kit were provided to distribute to interested doctors/clinics. .
• The CalViva Access Survey was completed timely. Overall, the vast majority of members were typically able to get both urgent care and routine care as soon as needed – members waiting on average 2.8 days, 6.1 days for an appointment.76% of respondents stated that it was always/usually easy to get care, a 1 percentage point drop from 2019. Efforts will continue through various access, availability, and member experience projects to push directional improvement in all access measures.
• Launched the Annual Member Newsletter to 163,377 member households, highlighting the following topics: access standards, interpreter services, Nurse Advice Line
	• Patient Experience Toolkit
	  ○ Evolved to become a part of the Provider Tool Kit, which includes various resources
	  ○ 500 copies sent out to interested provider clinics in Q1
	• Reviewed the following resources to ensure all content was up-to-date and relevant; posted and made available on Provider Library Website
	  ○ Appointment Tip Sheet & Guide
	  ○ “Talking with my Doctor” Resource
	  ○ Interpreter Services 24/7 materials
	• Member Newsletter
	  ○ Q2 articles educate members on the acceptable wait times/turnaround time for various care access; available interpreter and translation services available to them
	  ○ Newsletter was sent to 163,777 households in late June 2020
	• Nurse Advice Line
	  ○ Promoted Nurse Advice Line in member newsletter that was launched late June 2020.
	• Annual Access Survey

	○ Based on results, the top areas of improvement for 2020 were identified (all three saw decline in comparison to RY2019 rates): 1. Access to specialist appointments – adults 2. Ease of getting care, tests and treatment - adults 3. Wait time for care, tests and treatment - children • PPG CAHPS Webinar ○ The Q3 PPG CAHPS Webinar was conducted over two sessions in August 2020. The webinar included a presentation on the CAHPS Survey – updates, COVID-19 impacts, the importance of CAHPS, etc. – as well as a Q&A session. ○ Due to the limited availability in Q4, the PPG CAHPS Webinar did not take place in Q4. CAHPS information and details were added to the Q4 PNM PPG Quarterly Training Deck to cover the CAHPS topic for the similar audience. • Quarterly Root Cause Analyses ○ Used to identify top member pain points in 2020: Access To Care, Transportation, and Admin. Issues – Referral Process. ○ Trends and findings were shared with the appropriate HN stakeholder departments so that areas could be properly address and worked on.

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 2020	RY Rate 2019	Baseline Source	Baseline Value
Got urgent care as soon as needed	Improve YOY	78%	76%	RY 2018 Rate	81%
Got routine care as soon as needed	Improve YOY	67%	65%	RY 2018 Rate	68%
Ease to get specialist appointment	Improve YOY	59%	59%	RY 2018 Rate	55%
Ease of getting care/test/treatment	Improve YOY	76%	77%	RY 2018 Rate	74%

CAHPS Survey Measures	Specific Goal	RY 2020 Rate MY 2019 (% always/usually)	RY 2017 Rate (MY 2016) (% always/usually)	Baseline Source (RY 2020)	Baseline Value
Getting Needed Care	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 81.11%	69.10%	69%	National Benchmark (50th Percentile)	83.12%
Getting Care Quickly	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 80.52%	73.31%	73%	National Benchmark (50th Percentile)	82.48%
How well doctors communicate	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 90.96%	86.57%	87%	National Benchmark (50th Percentile)	91.62%
Customer Service	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 87.45%	NA	NA	National Benchmark (50th Percentile)	88.52%
Shared Decision Making	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 79.70%	77.00%	77.00%	National Benchmark (50th Percentile)	79.84%
Rating of All Health Care	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 74.06%	63.41%	63%	National Benchmark (50th Percentile)	74.80%
Rating of Personal Doctor	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 80.58%	75.46%	75%	National Benchmark (50th Percentile)	81.76%

Rating of Health Plan	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 75.70%	73.35%	73%	National Benchmark (50th Percentile)	77.47%
Rating of Specialist	Exceed RY2017 All Plans Medicaid Average 50th Nat'l = 80.75%	74.44%	74%	National Benchmark (50th Percentile)	82.39%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Overall Effectiveness:** • CAHPS activities completed in 2020 continued to expose internal departments and partners of the importance of CAHPS and member experience overall. • CAHPS Webinar conducted to support providers in their improvement efforts around patient satisfaction. • Results from Access Survey helped to identify areas that need additional focus on: 1. Access to specialist appointments – adults, 2. Ease of getting care, tests and treatment – adults, 3. Wait time for care, tests and treatment – children **Barriers:** • The majority of CAHPS measures continue to be below the national benchmark (50th percentile). • CAHPS can be very nuanced and difficult to pinpoint since results are anonymous. Routine CAHPS Action Plan meetings will carry on into 2021 as a way to stay connected with the various departments across the organization that impact member experience, as well as track progress across improvement efforts. Will continue to monitor both internal and external feedback on how to best improve member experience activities and outreach for members, providers, and staff.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

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

Rationale and Aim(s) of Initiative

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

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

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

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

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

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

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

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1 & Q2 2020, CalViva Health Medical Management collaborated with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c) testing. • CalViva Health Medical Management continued to conduct bi-weekly meetings with the multidisciplinary Diabetes Improvement team in order to receive updates on progress with activities and make modifications as needed.	• In Q2, CalViva Health Medical Management continued to work with a high volume, low compliance provider in Fresno County to improve CDC rates for Hemoglobin A1c (HbA1c). • In Q2, CalViva Medical Management staff continued to conduct regular meetings with the Fresno County provider to improve the CDC rates for HbA1c Testing. • The clinic utilized the Planned Care Visit flowchart to assist members in completing their labs, receive education, and

• In Q1, Medical Management completed its first PDSA cycle in which members either completed their testing or had an appointment scheduled to complete testing with the use of the Provider Profile and a member incentive. • CalViva Medical Management Team found that using the Planned Care for a longer duration of time, confirmed the effectiveness of the script in persuading patients to complete their HbA1c testing. CVH plans to build upon the Planned Care Visit, the first step in our efforts to implement a Chronic Disease Self-Management program. The clinic is implementing a Chart Prep program throughout their clinics that is similar to the Planned Care Visit; this will allow our Diabetes Team to continue to expand and test the Planned Care Visits while we develop new components. • Through this intervention, 65/71 members remained on the phone to hear the full Diabetes Call Script reflecting a high engagement rate of 92%. Of those 65 engaged patients, 40 completed their HbA1c testing. The completion rate for patients who heard the call script was 62% which is well above the 50% goal we established for the population overall. • The clinic scheduled members/patients for labs (HbA1c Testing) along with nursing education using the "Stoplight tool." A standard guide comes with the "Stoplight tool" and asks patients "what barriers exist and how can we help them the most." • Members are eligible to receive a $25 Visa gift card for completing an HbA1c testing or having their HbA1c under control (<9%). If they completed an HbA1c testing and have their HbA1c under control (<9%), they will receive two $25 Visa gift card. Due to COVID-19 public health emergency CVH was unable to implement and test the 2020 strategies with the targeted provider. DHCS did not require submission of final 2020 PDSA for Diabetes. • In Q2 of 2020, the in-home screening program MedXM to complete CDC HbA1C testing was put on hold due to the COVID-19 pandemic.	scheduling an appointment with the provider to improve their HbA1C rates. • <u>The PDSA Improvement Project ended due to COVID-19 restrictions from DHCS.</u>

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1) Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3) Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)					
Measure(s)	**Specific Goal**	**Rate RY2020**	**Rate RY2019**	**Baseline Source**	**Baseline Value**
HEDIS® Comprehensive Diabetes Care – HbA1c Testing	Meet or Exceed DHCS 50th Percentile update 87.83% (RY2019)	Fresno: 88.56%	84.43%	RY 2019 CVH Results	Fresno: 83.43%
HEDIS® Comprehensive Diabetes Care – HbA1c Poor Control (>9%)	Meet or Exceed DHCS 50th Percentile 38.20%	Fresno: 34.06%	41.61%	RY 2019 CVH Results	Fresno:41.61%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	**Successes**: • Collaboration with a motivated staff and proactive provider resulted in members completing their required testing for HbA1c. • The implementation of the Provider Profile along with the Planned Care Visit increased HbA1c Testing and provided the clinic with resources to help educate members on the need for comprehensive care. • Planned Care Visits consist of Utilization of the Diabetes Call Script, CDC HEDIS® Nephropathy Workflow, and the Orange and Butler Planned Care Visit Workflow. **Barriers**: • Members did not always understand the significance in maintaining blood sugars for overall health. • COVID-19 restrictions; members were afraid to come to the clinic. **Lessons Learned**: • A clinical champion, such as the Panel Manager and support of the clinic's Quality Improvement leadership improves the success of implementation. • Obtaining staff feedback is crucial to successful intervention implementation. CalViva Health Medical Management staff scheduled bi-weekly meetings to hear staff successes, challenges, and implement solutions to barriers to maximize improvement efforts.
Initiative Continuation Status	☒ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
2-2: Chlamydia Screening (CHL)				
☒ 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: The overall aim is to improve the reproductive health of young women in Madera County and thereby reduce infertility and other morbidity later in life.

Rationale: Chlamydia is the most common infection reported in the United States, with more than 1.5 million cases reported in 2015. The actual number of infections probably exceeds 3 million annually, because most chlamydial infections are asymptomatic and go undetected. Persons between 15 and 24 years of age have the highest reported rates of infection. Chlamydia screening is widely promoted as an intervention to prevent reproductive tract morbidity, including infertility, in women by reducing chlamydia transmission. (Wiesenfeld, 2017). The rates of chlamydial infection are higher among young women than among men, which reflects screening programs that primarily target women. Chlamydial infections are a public health concern in both metropolitan centers and smaller communities. (MMWR, 2015). The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection. (HealthyPeople, 2020)

HealthyPeople 2020 (2020). HealthPeople.gov Evidence-based Resource Summary. https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/chlamydia-screening-in-women.

Wiesenfeld, Harold. (2017). Screening for Chlamydia trachomatis Infections in Women. The New England Journal of Medicine 2017; 376:765-73. https://medicinainternaelsalvador.com/wp-content/uploads/2017/03/nejmcp1412935.pdf
DOI: 10.1056/NEJMcp1412935

Morbidity and Mortality Weekly Report. (2015). Sexually transmitted Guidelines. MMWR Recommend Rep 2015; 64(RR-03):1-137. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6403a1.htm

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

The percentage of women 16-24 years of age who were screened for chlamydia.

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 Madera County to improve CHL Screening rates.	P	Q3-Q4	CVH/HN
Conduct regular meetings with Madera County provider to improve CHL Screening rates.	P	Q3-Q4	CVH/HN
Initiate an EMR flag/alert for women ≥ 16 < 25 years of age for inclusion on Daily Huddle sheet to facilitate completion of the screening test in collaboration with the provider.	P/M	Q3-Q4	CVH/HN
Develop a Provider Profile in collaboration with the clinic leadership/staff in order to identify the members that require screening.	P/M	Q3-Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
Intervention was added at End of Year Evaluation.	Intervention was added at End of Year Evaluation. • In Q3, CalViva Health Medical Management collaborated with a high volume, low compliance provider in Madera County to improve CHL Screening rates. • In Q3, CalViva Medical Management staff continue to conduct bi-weekly meetings with the multidisciplinary CHL Screening Improvement team in order to receive updates on progress with activities and make modifications as needed. • In Q4, the clinic initiated an EMR flag/alert for women >16 <25 years of age for inclusion on a Daily Huddle sheet to facilitate completion of the screening test. • In Q4, CalViva Health developed a Provider Profile in collaboration with the clinic/staff and identified the members that require screenings.

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

Measure(s)	Specific Goal	Rate RY2019	Rate RY2020	Baseline Source	Baseline Value

HEDIS® Chlamydia Screening in Women (CHL)	Meet or Exceed DHCS 50th Percentile 58.33%	Madera: 53.05%	55.42%	RY 2020 CVH Results	Madera: 53.05%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	**Successes**: • Collaboration with a motivated staff and proactive provider to complete CHL Screenings. • Initiation of an EMR flag/alert for women ≥ 16 < 25 years of age **Barriers**: • Patients are not being screened when they are seen by their PCP or other clinic provider. • Lack of knowledge on the importance of CHL Screenings. • COVID-19; members are afraid to come to provider's office. • Language barriers **Lessons Learned:** • A clinical champion supports the clinic's Quality Improvement leadership improve the success of implementation. • Obtaining staff feedback is crucial to successful intervention implementation.
Initiation Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

II. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)				
2-3: Addressing Breast Cancer Screening Disparities				
☐ **New Initiative** ☒ **Ongoing Initiative from prior year**				
Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**		☐ **Safety Clinical Care**
Reporting Leaders	**Primary**	**CalViva Health Medical Management**	**Secondary**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

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

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

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

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

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

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

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

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

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

The HEDIS measure, Breast Cancer Screening (BCS) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. The baseline HEDIS result for RY 2019 was 58.08%. Increase the breast cancer screening rate among the Hmong speaking population at the targeted clinic site from a baseline of 19.2% to a goal rate of 28.8%.

Planned Activities

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

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1 and Q2 2020, CalViva Health Medical Management team was able to build upon a previous strategy for improving BCS rates in Fresno County that utilized mobile mammography as a primary intervention. This project was established in	• In Q2, this project was closed by DHCS due to COVID-19 restrictions.

collaboration with one clinic with 2 sites, (Greater Fresno Health Organization) which is a high volume, low compliance clinic, an imaging center, and a Hmong cultural center in Fresno County. The partner organizations and CalViva Health established multidisciplinary BCS improvement Team that met bi-weekly to determine the current process, identify potential barriers, and establish a plan for improvement to address potential barriers to the project. • Through a barrier identification process, an Educational Event which includes a video in Hmong language was developed to address health literacy barriers among the Hmong population. In addition to the event, the CalViva Health Provider Engagement staff plan to collaborate with the radiology center to establish appointment slots/block scheduling for mammograms for attendees of the educational event. CalViva will integrate the member friendly approach that addresses cultural and language issues, as well as transportation and other potential barriers. A member incentive for completion of breast cancer screening will also be offered to members who complete their screening. • Modules 1, 2, and 3 were submitted to DHCS, however, we will take a brief pause, update our baseline and goal rates, and resubmit these modules per DHCS guidance. Due to the public health crisis associated with COVID-19, DHCS has elected to end the current PIPs as of June 30, 2020 and DHCS will have the MCPs and PSPs start new PIPs as soon as the new EQRO contract is in place in mid to late summer. • All Providers in Fresno County will be offered an incentive to encourage outreach to members and completion of their breast cancer screening. • Provider Tip Sheets will be developed in Q3 2020 and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended screening guidelines.	• In Q4, a PIP Topic Proposal was submitted and approved by DHCS. CalViva Health Medical Management team will continue to collaborate with the Greater Fresno Health Organization, which is a high volume, low compliance clinic, an imaging center, and a Hmong cultural center in Fresno County. • Due to COVID-19 restrictions, the interventions are currently in the planning phases with the clinic. • In Q4, trainings at the Hmong cultural center were completed by: Quality Improvement which encompassed the Performance Improvement Process as outlined by DHCS/HSAG; Cultural and Linguistic discussed cultural competency awareness and social determinants of Health, Aunt Bertha-Community Connect, and Interpreter Services. Health Education Department discussed transportation services, Know Your Number Health Screenings and available Health Education materials, (Fit Families for Life and Healthy Habits for Healthy People Weight Control Programs, pregnancy education, breastfeeding and nutrition support, and Healthy Hearts, Healthy Lives Program).
Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1) **Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)**	

Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2020)					
Measure(s)	**Specific Goal**	**Rate RY2020**	**Rate RY2019**	**Baseline Source**	**Baseline Value**
HEDIS® Breast Cancer Screening	Meet or Exceed SMART Aim Goal of 28.8%	Fresno: 55.26%	58.08%	RY 2020 CVH results	Fresno: 51.12%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • It is critical to provide health education material to the members, and offer interpreter services in various settings. • Multidisciplinary teams continue to be critical to the success of the project. • Effective collaboration with clinic partners. **Barriers:** • COVID-19 restrictions. • Language barriers exist and it may require several attempts to fully communicate to a member what a mammogram is and why it is important. **Lessons Learned:** • Including Culture & Linguistic, Health Education, and Provider Relations on our team allowed us to address potential barriers ahead of time. • Flexibility is important, often members do not arrive at their scheduled time and the team needs to be prepared to adjust the schedule to fit them in. • Further explore ways to engage members who refuse exams in dialogue to help them understand the importance of BCS and how it is done.
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)				
2-4: Improving Childhood Immunizations (CIS-10)				
☐ **New Initiative** ☒ **Ongoing Initiative from prior year**				
Initiative Type(s)	☐ **Quality of Care**	☒ **Quality of Service**	☐ **Safety Clinical Care**	
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative
Overall Aim: To improve child health in Fresno County. **Rationale**: Childhood vaccination has proven to be one of the most effective public health strategies to control and prevent disease (Ventola, 2016). [1] In an effort to reduce childhood morbidity and mortality, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) issues annual recommendations and guidelines for childhood immunizations (Poland, Schaffner, Hopkins, 2013). [2] However, some parents decline or delay vaccinating their children or follow alternative immunization schedules because of medical, religious, philosophical, or socioeconomic reason (Ventola, 2016). Health care provider-based interventions have been suggested to overcome such vaccine noncompliance, including patient counseling; improving access to vaccinations; maximizing patient office visits; and offering combination vaccines. Community and government-based interventions to improve parent and patient adherence include public education and reminder/recall strategies, and financial incentives for vaccinations (CDC, 2017).[3] Despite the established guidelines and documented benefits and risks associated with childhood immunization, a gap in coverage still exists. A small but increasing number of children in the United States are not getting some or all of their recommended vaccinations. The percentage of children under 2 years old who haven't received any vaccinations has quadrupled in the last 17 years, according to federal health data (Health & Science, 2018). Approximately 300 children in the United States die each year from vaccine preventable diseases (NCQA, 2019).[4] Infants also comprise the largest share of pertussis-related death. Half of the infants who contract pertussis also known as whooping cough, will be hospitalized and one in 100 will die (CDC, 2017). With the addition of new vaccines in recent years, and more in development, there is an even greater potential to save millions of more lives. Unfortunately, continuing disease outbreaks across the U.S. remain a public health concern. Lack of access to vaccines, combined with people who are not taking full advantage of opportunities to protect themselves, their families, and their communities, leaves people susceptible to preventable diseases (State of the Immunion, 2018).[5] America's future rests in the hands of our young; here in the U.S., we have the technology to prevent suffering among our most vulnerable citizens, our newborns (State of Immunion, 2018). Through public health efforts and working together to ensure access to and delivery of vaccines, we can prevent the suffering of families who could otherwise lose their precious newborns to vaccine-preventable diseases (State of Immunion, 2018). _____ 1 Ventola C. L. (2016). Immunization in the United States: Recommendations, Barriers, and Measures to Improve Compliance: Part 1: Childhood Vaccinations. *P & T: a peer-reviewed journal for formulary management*, *41*(7), 426–436. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4927017/

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

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

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

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

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

The HEDIS measure, Childhood Immunization Status - Combination 10 (CIS-10), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of members who turn 2 years old who have been identified for completing the following vaccinations: four diphtheria, tetanus, and acellular pertussis (DTap); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four (pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

The baseline rate of 32.4% was determined based on the RY 2019 HEDIS hybrid data for one high volume, low preforming clinics in Fresno County to a goal rate of 39.0%.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Collaborate with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 2)	P	Q1-Q4	CVH/HN
Health Education to implement educational activities on the importance of childhood immunizations.	M	Q1-Q4	CVH/HN
Member newsletter article: Childhood Immunizations	M	Q1-Q4	CVH/HN

Implement direct member incentive for completion of childhood immunizations series to improve rates	M	Q1-Q4	CVH/HN
Implement Provider Incentives to close the Care Gaps and Improve HEDIS rates for Childhood Immunizations.	P	Q1-Q4	CVH/HN
Provider Tip Sheets will be developed and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines.	P	Q1-Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1 and Q2, CalViva Health led a Childhood Immunizations (CIS-10), Performance Improvement Team in collaboration with one high volume, low compliance clinic in Fresno County. • Based on the barriers identified through the Module 2 quality improvement activities (i.e. Process Mapping, Failure Modes and Effects Analysis, Failure Mode Priority Ranking, and a Key Driver Diagram activities) the team determined that an intervention focused on education was needed to improve immunization completion rates. An educational activity could include a video about the importance of childhood immunizations while the member is waiting to see the provider. • Modules 1 and 2 were submitted to DHCS,; Module 3 is in development, however, we will take a brief pause to update our baseline and goal rates and resubmit these modules per DHCS guidance. • The second intervention is a $25 per member/per visit gift card incentive at point of service. Due to the public health crisis associated with COVID-19, DHCS has elected to end the current PIPs as of June 30, 2020 and DHCS will have the MCPs and PSPs start new PIPs as soon as the new EQRO contract is in place in mid to late summer. • The member newsletter will be distributed to members in Q3 of 2020 to educate them on the importance of childhood immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations (to be paid in Q3).	• In Q3, this project was closed by DHCS due to COVID-19 restrictions. • In Q4, a PIP Topic Proposal was submitted and approved by DHCS. CalViva Health Medical Management team will continue to collaborate with one high volume, low compliance clinic in Fresno County. • Due to COVID-19 restrictions, the interventions are currently in the planning phases with the clinic.

• Provider Tip Sheets will be developed in Q3 2020 and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended immunization guidelines.	

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

Measure(s)	Specific Goal	Rate RY2020	Rate RY2019	Baseline Source	Baseline Value
Childhood Immunization Combo 10	Meet or Exceed SMART Aim Goal of 39.0%	Fresno: 33.82%	25.19 %	RY 2020 CVH results	Fresno: 27.74%

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

Analysis: Intervention Effectiveness w Barrier Analysis	**Successes:** • Effective collaboration and clinic engagement contributed to the success of the project. • The clinic is well-established with sufficient human resources to engage and participate on the team. • The clinic is affiliated with a Pediatric Residency Program, which provides the opportunity to influence and collaborate with new physicians in order to engage parents to promote timely and complete immunizations for our youngest members. **Barriers:** • Members did not always understand the significance of receiving their immunizations. • Children missing one or more vaccines. • No immunization records received. • No immunizations were given. • Language barriers that may require several attempts to fully communicate to parents why immunizations are important. • COVID-19 restrictions; members were afraid to come to the clinic. **Lessons Learned:** • It is critical to provide health education materials to the members.
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	Continuing. It is in the new member welcome packet.	☒	12/31/2020	This is an on-going resource that is in the new member packet.
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	Clinical Practice Guidelines were updated and disseminated in April 2020.	☒	04/2020	
3. Implement CalViva Pregnancy Program and identify high risk members by Case Management	CVH/HN	The CalViva Pregnancy Program remains in place. Preliminary YTD through May 2020 590 members have been managed in this program. Outcomes continue to demonstrate greater compliance with prenatal and postpartum visits and fewer preterm deliveries of members managed vs those not managed.	☒	Ongoing	Preliminary YTD through December 2020, 948 members have been managed in this program. This program is ongoing for 2021.
4. Promote CA Smokers' Helpline (CSH) to smokers	CVH/HN	Continuing. Plan to conduct a text messaging campaign pending DHCS approval.	☒		Plan texting campaign had to be halted because DHCS prohibited using member phone numbers from 834 files to text members without their prior consent. Sent a mailing promoting CSH in December to 484 members who smoke.
5. Launch a Diabetes Prevention Program	CVH/HN	In the process of contracting with new vendor to offer DPP.	☒	Ongoing	Health Net's DPP program submitted to DHCS for approval. Pending approval for HN before submitting to CalViva to submit to DHCS for approval.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for appropriate member outreach	CVH/HN	Traditional DM: telephonic outreach and education activities continue through the Traditional DM program, which helps members, manage their chronic health conditions. Chronic conditions addressed in this program include Asthma, Diabetes and Heart Failure. On.Demand Diabetes: CalViva Leadership is currently reviewing the feasibility of a proximate launch. On.Demand Diabetes is an opt-in DM program that provides cellular-enabled blood glucose meters and all testing supplies including test strips, lancets, lancing device and control solution, to testing diabetics.	☒ ☒	Ongoing 12/31/2020	Program offering is ongoing. On Demand program did not pass proposal stages. Early findings showed low continuous engagement with the On Demand program among a similar Medi-Cal population. The health plan did not move forward with the On Demand Diabetes program.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	CVH/HN	Completed and received approval on the following C&L reports during this reporting period: 2019 end of year work plan, 2019 end of year LAP report and year over year LAP trending, 2020 program description, and 2020 work plan. Also	☒	5/21/2020	

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
		completed a report on the Cultural and Linguistic Services Results of the MY 2019 Provider Satisfaction Survey for Timely Access to Care.			
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or CCHRI	CVH/HN	PAAS & PAHAS surveys slated to kickoff 8/17/20. Surveys being conducted by Sutherland.	☒	12/31/20	Surveys completed timely.
3. Complete and submit DMHC Timely Access Reporting (TAR) by April 30 filing due date	CVH/HN	TAR reports completed and filed timely.	☒	4/1/20	TAR filed timely
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	CVH/HN	Provider Updates: MY 2019 CalViva PAAS & After-Hours Results – draft being prepared for CalViva Health's review. MY 2020 PAAS & After-Hours Survey Prep – draft being prepared for CalViva Health's review. CAP packets and Education packets will be distributed no later than 7/31/20.	☒	11/15/20	MY 2019 PAAS & After-Hours results Provider Update sent out 8/14/20. MY 2020 PAAS & After-Hours Survey Prep Provider Update sent out 8/21/20. Timely Access provider webinar flyers sent June 2020, August 2020 and November 2020. CAP packets sent out 7/31/20 Provider Ed packets sent out 7/29/20.
5. ACCESS PROVIDER TRAINING: Conduct webinars quarterly	CVH/HN	Webinar conducted on June 16, 17, & 19. Total of 13 provider offices attended.	☒	12/9/20	Total of 10 Timely Access provider webinars conducted for 2020 with 51 attendees.

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		Attendance expected to increase in Q3 & Q4 once CAP packets and Education packets are distributed. Attendance is required for all PPGs receiving a CAP and strongly encouraged for those receiving an Education packet.			Revamp of registration template for better tracking of CalViva attendees will be explored for 2021.
6. TELEPHONE ANSWER SURVEY: Conduct quarterly and issue CAPs to noncompliant providers.	CVH/HN	Q1 & Q2 surveys were not completed due to COVID-19 Q4 reinstatement is TBD.	☒	12/24/20	Q1-Q3 surveys not conducted due to the COVID-19/wildfire situation. Q4 surveys were conducted in December 2020 and concluded on December 24th.
7. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN	A&G continues to assist members with obtaining timely access appointments and facilitate referrals as needed. These trends are monitored through monthly Dashboard and quarterly UMQI reporting.	☒	Ongoing	A&G has worked with providers and internal departments as needed to help resolve member appeals and grievances. Data is a consistent component of UM/QI and tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.
8. Population Needs Assessment Update– Evaluating membership's health risks and identifying their health care needs will help to prioritize, develop and implement Cultural & Linguistics, Health Education and Quality Improvement (QI) programs.	CVH/HN	Population needs assessment (previously known as group needs assessment) completed by HE, C&L and QI departments and provided to CVH for submission to DHCS on	☒	6/30/2020	

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
		6/30/20 and approved on 7/17/20.			
9. 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.	CVH/HN	Shared the 2019 C&L Geo Access Report and identified gaps by zip code, language and provider type with Provider Network Management (PNM). PNM completed follow up in an effort to identify opportunities for network improvement in response to the language access needs identified. A report with the outcomes/ updates was completed by C&L and presented on 3/24/2020.	☒	3/24/2020	
10. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN	Revising approach to CAP and preparing a revised response. Established IHA Workgroup to identify process improvements and resolve issues.	☒	Ongoing	CVH received a CAP for IHA, and has met with a high performing clinic to learn best practice, as well as a high volume low performing clinic. CVH continues to meet with the low performing clinic to improve processes and improve IHA compliance. The IHA Workgroup meets regularly to review process improvement and evaluate and analyze report data. A new logic to reporting was introduced to more closely reflect the exclusions and requirements set by the DHCS APL 20-004.

Activity	Activity Leader	Mid-Year Update	Complete?	Year End (YE) Date	YE Update or Explanation *(if not complete)*
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: ○ Readmission rates ○ ED utilization ○ Overall health care costs ○ Member Satisfaction	CVH/HN	The ImpactPro data has been incorporated into the Population Health Management Report used to identify high risk members. Outcomes demonstrate lower readmission rates, ED utilization, and health care costs post CM vs pre CM for members managed. Overall members were satisfied with the help they received from the CM and reported improvement in ability to care for self/family post CM. Outcomes are evaluated quarterly in the CM quarterly report.	☒	Ongoing	This is ongoing and will continue into 2021.
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN	On target for Credentialing and Recredentialing goals.	☒	12/31/2020	Completed and compliant for year 2020.
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	CVH/HN	MHN QI continues to monitor and report quarterly performance to CVH QI/UM and Access Workgroups in 2020. The Q1 Open Practice target is the only target MHNS has missed in 2020, so far. The Q1 Open Practice	☒	Ongoing	MHN QI continues to monitor and present performance to CVH QI/UM and Access Workgroups and will present satisfaction survey results and Q4 2020 key performance indicator results in early 2021.

Activity	Activity Leader	Mid-Year Update	Complete?	Year End (YE) Date	YE Update or Explanation *(if not complete)*
		rate was an improvement over the Q4 2019 but still hadn't reached the target. MHNS' improvement trajectory has continued and the Q2 Open Practice rate now exceeds the target.			MHN met the Open Practice target in Q2 and Q3 and expects to meet it for Q4 as well.
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	On target up to shelter in place order and APL20-011 suspending any in-person onsite provider visits until further notice.	☐	Ongoing	Still under APL 20-011 for suspended on-site visits, no ETA on when that will lift due to the public health emergency.
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	CVH/HN	Ongoing. QI continues to complete Work Plan evaluation at mid year as well as annually.	☒	9/17/2020	QI Mid-year Evaluation Workplan and Executive Summary was approved on September 17, 2020. End of year Workplan will be submitted in Q1 2021.
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	Due to COVID-19, provider resources were not distributed in Q1/Q2. A temporary hold started March 2020 to allow internal teams and communications to focus on COVID-19. Will continue in Q3/Q4 with a provider communication and tip sheet.	☒	12/30/2020	Provider Communications completed the tip sheet on depression screenings (FLY044002EH00) on 12/30/20. The tip sheet will be sent to be remediated and posted on the Provider Library in Q1 2021, along with a communication

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
					highlighting the tip sheets available on the Provider Library.

Item #9

Attachment 9.A

2020 Annual UMCM Work Plan Evaluation
Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Jennifer Lloyd, Vice President Medical Management
COMMITTEE DATE:	February 18, 2021
SUBJECT:	2020 CalViva Utilization Management/Case Management Work Plan End of Year Evaluation Executive Summary

Summary:

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

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

- 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance

Purpose of Activity:

CalViva Health has delegated responsibilities for utilization management and case management (UM/CM) activities to Health Net Community Solutions. CalViva Health's UM/CM activities are handled by qualified staff in Health Net's State Health Program (SHP) division.

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

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

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

Analysis/Findings/Outcomes:

I. Compliance with Regulatory & Accreditation Requirements

All Compliance activities met objectives for this end of year evaluation. No barriers have been identified.

II. Monitoring the Utilization Management Process

Monitoring of the utilization management process activities met objectives in 2020.

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

The Plan monitored TAT as planned throughout 2020. The benchmark of 100% TAT was not met in all months. An opportunity for improvement was identified to address holiday and weekend coverage in the first half of 2020. The process was strengthened in June 2020 so that cases are more closely monitored over holidays and weekends. The TAT outcomes improved to the point that the formal Corrective Action Plan (CAP) regarding TAT that was issued in 2019 was closed in Q3-2020. In the 4th Quarter the TAT 100% benchmark was missed by one case falling out of TAT.

III. Monitoring Utilization Metrics

Monitoring of Utilization Metrics activities met objectives in 2020 with the exception of work plan element 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance.

a. **Improve Medi-Cal shared risk and FFS UM acute in-patient performance** (Workplan element 3.1)

The Plan continued care management initiatives for all members including involvement with the medical directors and interdisciplinary teams throughout 2020. Due to the COVID-19 pandemic, we experienced increased inpatient admissions. Skilled nursing facilities experienced longer stays due to isolation and limited resources for transfers. Initial focus on the admissions for the top 10 admitting diagnoses and long length of stays was expanded to incorporate involvement in all diagnoses. The result of our goals to reduce admissions and length of stay by 10% were not able to be measured to validate a reduction or increase.

IV. Monitoring Coordination with Other Programs and Vendor Oversight

All Coordination with Other Programs and Vendor Oversight activities met objectives in 2020.

a. **Behavioral Health Performance Measures** (Work plan element 4.7)

Barriers were identified related to a not enough Psychiatrists in practice who are willing to treat the Medi-Cal population as well as provider dissatisfaction with current contract rates. Network availability and adequacy interventions were identified in 2020 and continue in order to achieve desired results by increasing adequacy and access to services.

V. Monitoring Activities for Special Populations

All Monitoring Activities for Special Populations activities met objectives in 2020.

a. **Monitor of California Children's Services (CCS) identification rate.** (Work plan element 5.1)

The annual average of CCS eligible members in 2020 was 1.3% higher than 2019. CCS monitoring and identification process experienced the following barriers in 2020:

i. The CA Central Valley was hit hard by COVID-19, resulting in
    1. fewer scheduled in-patient visits in 2020,
    2. CCS staff reduction to move clinical teams to treat COVID patients in hospitals,
    3. 30% less authorizations were submitted to the UM <21 Team.

ii. Members aging-out of CCS lose program benefits on their 21st birthday. Members transition to other providers with Plan and need "hand holding" in some cases to minimize lapses in care.

Public Programs team built different CCS case escalation processes for independent and dependent counties:

i. For Fresno (independent), PP worked more closely with the CCS county staff and provided aged case lists to improve CCS determination TAT, especially for NICU SAR

ii. For Madera and Kings (dependent), PP escalated all cases aged 30+ days to DHCS. PP worked directly with CCS medical directors as well

Aging-out and aged-out call programs were established in 2019 and maintained in 2020 to track aged-out member progress. Of the 110 CVH aged out members called after their 21st birthday, only four needed additional CM support.

Next Steps:

We are continuing monitoring of 2020 activities and will be continuing appropriate activities into 2021.

Item #9

Attachment 9.B

2020 Annual UMCM Work Plan Evaluation
Year End Evaluation

CalViva Health
2020
Utilization Management (UM)/ Case Management (CM)
End of Year Work Plan Evaluation

Last updated: February 11, 2021

CalViva Health
2020 UM/CM Work Plan

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1. Compliance with Regulatory & Accreditation Requirements

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. 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

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in the first half of 2020 • Jan: Genetic Testing and Molecular Profiling—Impact on Clinical Decisions for Patients with Cancer • February: Improving Women's Cardiovascular Disease • March: Palliative Care Update • March: Inappropriate Primary C-section, PNIP, PNP and PP Depression • May: Social Determinates of Health • May: Evidence-based Communication Strategies for Promoting Vaccination and Addressing Vaccine Hesitancy • June: Covid-19 • June: Cardiovascular Disease and Diabetes New hire overview training is offered monthly for all new hires. Medical management onboarding classes are offered and completion is monitored through our online learning management system. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform).	None identified	CME standing is not monitored, only licensure.	Ongoing

CalViva Health
2020 UM/CM Work Plan

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in 2020 • Jan: Genetic Testing and Molecular Profiling—Impact on Clinical Decisions for Patients with Cancer • February: Improving Women's Cardiovascular Disease • March: Palliative Care Update • March: Inappropriate Primary C-section, PNIP, PNP and PP Depression • May: Social Determinates of Health • May: Evidence-based Communication Strategies for Promoting Vaccination and Addressing Vaccine Hesitancy • June: Covid-19 • June: Cardiovascular Disease and Diabetes • August: Solving for Quality – HEDIS® 2021 • September: Social Determinants of Health Part 2 • October : Strategies to Prevent, Treat and Manage Opioid Use Disorder and Overdose • November: Non-Western Botanical Practices for Symptom Relief New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered and completion was monitored through our online learning management system. Training materials were reviewed and revised as needed. IRR training and testing was completed. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform).	None identified	CME standing is not monitored, only licensure.	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. 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

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, received from the Compliance Department and/or the Regulatory and Legislative Implementation committee including response to the COVID-19 National and State Emergency. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing Ongoing Ongoing

CalViva Health
2020 UM/CM Work Plan

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

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and annually thereafter through Cornerstone. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and annually thereafter. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None identified	None	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. 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 2020, July 2020, October 2020, January 2021

Health Net

CalViva HEALTH

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues of 30 sample size per Metric. When a variance from compliance standards are identified, sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented Program Metrics Reporting (PMR) meeting.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards are identified, CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented to the Program Metrics Reporting (PMR) meeting.	None identified	None	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ 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 2020. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters in the year.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for quarters in the year.	None	None	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually.	☒ Medi-Cal	Reviews/ revises Medi-Cal UM/CM Program Description and UMCM Policies and Procedures to be in compliance with regulatory and legislative requirements.	Core group comprised of State Health Programs Chief Medical Director (CMD), Regional Medical Directors, Director of Medical Management and Medical Management Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2020 UMCM Program Description. Write and receive CalViva approval of 2019 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2020 UMCM Work Plan. Write and receive CalViva approval of 2020 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 2020 Q 1 2020 Q 1 2020 Q 3 2020 Ongoing Ongoing

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2019 Year End UM/CM Work Plan Evaluation, 2020 UMCM Work Plan, 2020 UM Program Description and the 2020 CM Program Description were submitted and approved. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	The 2020 UMCM Work Plan Mid-Year Evaluation was submitted and approved in Q3. CalViva continues to monitor and revise policies and procedures based on DHCS, DMHC and other regulatory requirements.	None identified	None	Ongoing

2. Monitoring the UM Process

CalViva Health
2020 UM/CM Work Plan

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

CalViva Health
2020 UM/CM Work Plan

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

☒ ACTIVITY ON TARGET

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

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

Authorization volume began to decrease in late March due to the COVID-19 pandemic and began to rebound in June.
<table>
<tr><th></th><th colspan="3">Authorization Volume</th></tr>
<tr><th>Months</th><th>Approved</th><th>Modified</th><th>Denied</th></tr>
<tr><td>January</td><td>7,400</td><td>19</td><td>1,279</td></tr>
<tr><td>February</td><td>6,934</td><td>31</td><td>1,224</td></tr>
<tr><td>March</td><td>6,700</td><td>20</td><td>1,394</td></tr>
<tr><td>April</td><td>4,945</td><td>20</td><td>794</td></tr>
<tr><td>May</td><td>5,332</td><td>10</td><td>845</td></tr>
<tr><td>June</td><td>6,362</td><td>16</td><td>984</td></tr>
<tr><td>Totals</td><td>37,673</td><td>116</td><td>6,520</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2021</td>
<td>Authorization volumes in Quarter 3 and 4 continued to be lower when compared to Quarters 1 and 2 and previous year, most likely due to the COVID-19 pandemic (office closures, social distancing, and procedure availability in the outpatient settings.

See authorization volumes on table below:</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

CalViva Health
2020 UM/CM Work Plan

	Authorization Volume		
Months	**Approved**	**Modified**	**Denied**
January	7,400	19	1,279
February	6,934	31	1,224
March	6,700	20	1,394
April	4,945	20	794
May	5,332	10	845
June	6,362	16	984
July	5,703	48	984
August	5,657	28	929
September	5,978	69	969
October	5,954	37	1,067
November	5,149	39	853
December	5,402	32	914
2020 Totals	**71,516**	**369**	**12,236**

Prior year for comparison:

2019 Totals	**75,473**	**506**	**15,073**

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 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

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

☐ ACTIVITY ON TARGET

☒ TOO SOON TO TELL</td>
<td>The Plan monitored TAT as planned in the first half of 2020. The benchmark of 100% TAT was not met in all months. A formal CAP for TAT was established in 2019 and is ongoing.
<table>
<tr><th></th><th></th><th>Q1 2020</th><th>Q2 2020</th></tr>
<tr><th>Metric</th><th>Target</th><th>% Scored</th><th>% Scored</th></tr>
<tr><td>CalViva Pre-Service Routine Authorizations TAT with Extension/Deferral</td><td>100%</td><td>100.00%</td><td>100.00%</td></tr>
<tr><td>CalViva Pre-Service Expedited Authorizations TAT</td><td>100%</td><td>98.46%</td><td>99.23%</td></tr>
<tr><td>CalViva Pre-Service Expedited Authorizations TAT with Extension/Deferral</td><td>100%</td><td>100.00%</td><td>100.00%</td></tr>
<tr><td>CalViva Post-Service Authorization TAT</td><td>100%</td><td>100.00%</td><td>99.09%</td></tr>
<tr><td>CalViva Post-Service Review Authorization TAT with Extension/Deferral</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
<tr><td>CalViva Concurrent Authorization TAT</td><td>100%</td><td>100.00%</td><td>100.00%</td></tr>
</table>
</td>
<td>Opportunity for improvement in weekend/holiday coverage identified.</td>
<td>Weekend/holiday process was tightened up (June 2020) so that cases were more closely monitored over holiday weekends. Over/under 21 weekend process was also tightened up to include more oversight.</td>
<td>12/31/2020</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2021</td>
<td>The Plan monitored TAT as planned throughout 2020. The benchmark of 100% TAT was not met in all months but improved to the point that the formal CAP regarding TAT that was issued in 2019 was closed in Q3-2020. In the 4th Quarter the TAT benchmark was missed by one case falling out of TAT.
<table>
<tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Pre-Service Routine</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Pre-Service Expedited</td><td>98%</td><td>99%</td><td>100%</td><td>99%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service</td><td>100%</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service with Extension/Deferral</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Concurrent</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
</td>
<td>Opportunity for improvement in weekend/holiday coverage identified.</td>
<td>Weekend/holiday process was tightened up (June 2020) so that cases were more closely monitored over holiday weekends. Over/under 21 weekend process was also tightened up to include more oversight.</td>
<td>Ongoing</td>
</tr>
</table>

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. 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 2020. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using McKesson InterQual® IRR tool in Q3-4 2020.	Q3-4 2020 Q3-4 2020

Health Net

CalViva HEALTH

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	IRR Testing and training will be held Q3-4 2020	None identified	None	12/31/2020

Annual Evaluation
 	
☒ **MET OBJECTIVES**
 	
☒ **CONTINUE ACTIVITY IN 2021**
	An action plan was implemented in 2020 to re-educate and retest individuals whose minimum testing scores were not achieved in 2019. With the re-education, retesting and monitoring, all staff passed required retesting achieving the overall score of 98%.
	
	Following InterQual IRR prep training, the Change Health (formerly McKesson) InterQual IRR modules were administered to the Physician Reviewers and the non-physician clinical staff requiring a minimum score of 90% to pass.
	
	Overall pass score was 93%
		None Identified	• 2020 Tests were administered via links directly sent from Change Health
			• Reports were generated by corporate training.
			  • New Summary of Changes modules were introduced in the 2020 version and presented on Centene University
			  • Refresher Trainings were provided by the corporate training team	

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

CalViva Health
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<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

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

Turnaround Time Compliance for resolved expedited and standard appeals = 100% or 521 out of 521 cases.
<table>
<tr><th colspan="3">2020 Semi-Annual Count of Appeal Type</th></tr>
<tr><td>Appeal Type</td><td>Case Count</td><td>Percentage</td></tr>
<tr><td>Overturn</td><td>224</td><td>42.99%</td></tr>
<tr><td>Partial Uphold</td><td>8</td><td>1.54%</td></tr>
<tr><td>Uphold</td><td>284</td><td>54.51%</td></tr>
<tr><td>Withdrawal</td><td>5</td><td>0.96%</td></tr>
<tr><td>Case Total</td><td colspan="2">521</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2021</td>
<td>Appeals data is a consistent component of UM/QI and is tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.

Appeals of UM Appeal determinations for time frame January – December 2020. Turnaround Time Compliance for standard and expedite appeals = 99.90% or 1030 out of 1031 cases.
<table>
<tr><th colspan="3">2020 Annual Count of Appeal Type</th></tr>
<tr><td>Appeal Type</td><td>Case Count</td><td>Percentage</td></tr>
<tr><td>Overturn</td><td>432</td><td>41.90%</td></tr>
<tr><td>Partial Uphold</td><td>12</td><td>1.16%</td></tr>
<tr><td>Uphold</td><td>577</td><td>55.97%</td></tr>
<tr><td>Withdrawal</td><td>10</td><td>0.97%</td></tr>
<tr><td>Case Total</td><td colspan="2">1031</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

3. Monitoring Utilization Metrics

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance	☒ Medi-Cal	Health Net Central Medical Directors and Medical Management manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. 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 2020 Goals: • 10% reduction in admissions over prior year • 10% reduction in LOS overall	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. 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 2020; 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

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2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	The Plan continued care management initiatives for all members. Interdisciplinary meetings occur weekly with CVH & Daily with Case Management and Public Programs teams.	COVID-19 increased inpatient admissions SNF longer stays due to isolation, and limited resources for transfers due to COVID-19 pandemic.	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	The Plan continued care management initiatives for all members including involvement with the medical directors and interdisciplinary teams throughout 2020. Due to the pandemic, results of our goals to reduce admissions and LOS by 10% were not accurately measurable secondary to the admissions and readmissions related to the pandemic. Accurate measurements were unattainable due to the variable diagnosis's members treated for while admitted and incidental COVID-19 symptoms, diagnosis, and exposure requiring increase LOS and alternate LOC settings post inpatient discharge.	COVID-19 increased inpatient admissions. SNF longer stays due to isolation and limited resources for transfers due to COVID-19 pandemic.	We continued to focus on the top 10 admitting diagnoses and incorporated involvement in all diagnoses due to the COVID influx. There were plans to hire non clinical discharge navigators in Q4 but was placed on hold due to the pandemic.	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. 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 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 2020 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. Results of the reviews will be reported to CVH leadership at least quarterly.	Ongoing

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	The CVH PPG specific data Dashboard Reports are produced quarterly. The data is presented at the CalViva Management Oversight meeting. The reports are derived from claims data and have a time lag of approximately four to five months. Statewide utilization shows decreased office visits and elective surgeries. Awaiting Q2 data to see PPG specific UM performance, meanwhile encounter volume overall has significantly decreased throughout central valley with most PPGs performing in the median range for the region.	None identified	Utilizations patterns have greatly shifted due to COVID-19 and are being reviewed and tracked with the PPGs on a quarterly basis.	12/31/2020
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Quarterly PPG UM data presented at CalViva Management Oversight Meetings. Quarterly JOMs with PPGs reviewed COVID-19 shifts in utilizations. Central Valley had consistent COVID-19 related UM patterns, with PPGs performing equally and no outliers. Each PPG showed a downturn on all utilization metrics, which closely followed the comparison downturn. ER utilization improved overall, but remains high as a region.	COVID-19 shifted both utilization patterns and PPG UM resources.	A new best practices checklist for UM shared with PPGs at JOMs along with a toolkit of resources.	12/31/2020

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

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Q1 2020 PPG Profile and Narrative was provided 5/26/2020 and will be reviewed at MOM on 7/14/2020. Data analysis for claims and authorizations reflected expected operation variations due to COVID. No major outliers were identified and trends demonstrate consistent results. CalViva PPG profile reports are made available quarterly. Q2 - 8/31/2020, Q3 - 11/30/2020, Q4 - 2/28/2021 CAPS are monitored by the Delegation Oversight team to insure actions are implemented, documented and followed to completion. Q1 & Q2 Annual Reviews - La Salle Medical Providers had no CAPs - Central Valley Medical Providers had no CAPs Pending Annual Reviews for Q3 & Q4 - Adventist Health Plan - First Choice Medical Group - Independence Medical Group - Santé Community Physicians	None identified	• Added quarterly review of denial review letter per PPG. • Tracking top 80% denial types by PPG. • Separating PPG risk and Health Net risk for out of network services. • Added trending for top 10 specialty referrals. • Provided additional analytical data in the narrative for monitoring purposes.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Q3 2020 PPG Profile and Narrative was provided 11/19/2020 and was reviewed at MOM on 1/12/2021. Data analysis for claims and authorizations reflected expected operation variations due to COVID. No major outliers were identified and trends demonstrate consistent results. CalViva PPG profile reports are made available quarterly. Q4 – 2/22/2021, Q1 2021 – 05/24/2021, Q2 2020 – 08/30/2021	None identified	Auditor evaluates CalViva monthly denials through DOIT (Delegation Oversight Interactive Tool)	Ongoing

	CAPS are monitored by the Delegation Oversight team to insure actions are implemented, documented and followed to completion. Q3 & Q4 Annual Reviews - Adventist Health Plan had 2/2 CAPs resolved. - First Choice Medical Group had 3/5 CAPs resolved - Independence Medical Group had 5/5 CAPs resolved - Santé Community Physicians had 7/7 CAPs resolved Pending Annual Reviews for Q1 & Q2 2021 - Central Valley Medical Providers - La Salle Medical Associates			

4. Monitoring Coordination with Other Programs and Vendor Oversight

CalViva Health
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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
4.1 Case Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. 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

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2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Number of HIFs completed in January -June by member and returned or EPC outreach was 3,146. 242 members subsequently referred to CM through June. Total members managed through Q2 across physical, behavioral health, and TCM programs was 1,160. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2019 & 12/31/2019 & remained eligible 90 days after case open date. 601 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 9.6% difference • Volume of ED claims/1000/year decreased by 539 • Total health care costs reduction primarily related to reduction in inpatient costs, some decrease in outpatient services and increase in pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 106 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the CM and reported the goals they worked on improved understanding of their health • Quality of Life Section 23.7% improvement in ability to care for self/family post CM (70.9%) vs pre CM (57.3%); 93.1% (95/102) of respondents reported CM exceed their expectations	None	None identified	Ongoing

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Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Number of HIFs completed in January – December 2020 by member and returned or EPC outreach was 4,976; 371 members subsequently referred to CM. Total members managed through Q4 2020 across physical, behavioral health, and TCM programs was 2,622. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Results reported through Q3 include members with active or closed case on or between 1/1/2020 & 9/30/2020 & remained eligible 90 days after case open date. 842 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 5.9% difference (15% decrease) • Volume of ED claims/1000/year decreased by 219 • Total health care costs reduction primarily related to reduction in inpatient costs, some decrease in outpatient services and increase in pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 256 members were successfully contacted Q1 through Q4 • Care Team Satisfaction - overall members were satisfied with the help they received from the CM and reported the goals they worked on improved understanding of their health • Quality of Life - 24.1% increase in ability to care for self/family post CM (56.6%) vs pre-CM (45.6%); 94.8% (235/248) of respondents reported CM exceeded their expectations	None identified	None	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program. 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

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals decreased from 787 in Q1 to 562 in Q2. Through Q2 660 members managed in PCM program, exceeding number managed in 2019 (503). Quarterly average engagement rate increased from 29%in Q1 to 38% in Q2 with YTD average 33%. Texting portion of program on hold while texting policy under review. Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. In addition the rate of pre-term delivery of high risk members managed is compared to high risk members not managed. Results reported in Q1 for 2019 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 133 members met the outcome inclusion criteria fo visits; 67 members met preterm delivery criteria • Members enrolled in the High Risk Pregnancy Program demonstrated: o 7.3% greater compliance in completing the first prenatal visit within their first trimester5.2% greater compliance in completing their post-partum visit o 5.2% less pre-term deliveries in high risk members	None	None	Ongoing

CalViva Health
2020 UM/CM Work Plan

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Referrals – 2,307 Q1-Q4 2020 with average engagement rate 31%. Through Q4 943 members managed in PCM program; exceeding number managed in 2019 (503). Texting portion of program on hold while texting policy under review. Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 7 & 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition the rate of pre-term delivery of high risk members managed is compared to high risk members not managed. Results reported through Q3 2020 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 501 members met the outcome inclusion criteria for visits; 199 members met preterm delivery criteria • Members enrolled in the Pregnancy Program demonstrated: o 4.2% greater compliance in completing the first prenatal visit within their first trimester o 5.8% greater compliance in completing their post-partum visit o 4.8% less pre-term deliveries in high risk members Pregnancy Program mailings: January through December • NOP mailings 15,139 • Pregnancy mailings 2,583 Post-delivery packets 762	None identified	None	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. 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

Health Net

CalViva HEALTH

CalViva Health
2020 UM/CM Work Plan

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Data reported is a subset of information provided in 4.1.Referrals to behavioral health program increased from 124 in Q1 to 326 in Q2. The increase in referrals was due to behavioral health case management receiving referrals from Fresno County behavioral health department (that were previously worked by MHN) for members seeking services. Total members managed increased from 75 in Q1 to 154 in Q2. Total members managed through Q2 was 203. CY engagement rate 38%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2019 & 12/31/2019 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Data reported is a subset of information provided in 4.1.Referrals to behavioral health program Q1-Q4 2020 1,100. Total members managed increased in 2020 to 496 compared to 181 in 2019. Overall engagement rate 42%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Results reported through Q3 include members with active or closed case on or between 1/1/2020 & 9/30/2020 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	None identified	Modify report intervention From: "Use of ImpactPro as the predictive modeling tool to identify high risk members for referral to CM." To: "The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM."	Ongoing

CalViva Health
2020 UM/CM Work Plan

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 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 2020 Ongoing

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Disease Management program continues for asthma, diabetes and heart failure: • send educational materials and information about the program to enrolled CVH members. • conduct outbound telephonic interventions and • make referrals to case management for CVH members identified as being at high risk for hospitalizations or poor outcomes, or in need of assistance with behavioral health issues. Ongoing program monitoring is taking place to assure that member needs are met.	None identified	The disease management program insourcing completed in October 2019.	Ongoing Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Disease Management program continues for asthma, diabetes and heart failure: • educational materials and information about the program sent • outbound telephonic interventions continue • referral processes continue Ongoing program monitoring continues to assure that member needs are met.	None identified	The disease management program insourcing completed in October 2019.	Ongoing

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2020 Planned Interventions	Target Completion Date
4.5 MD interactions with Pharmacy	☒ Medi-Cal	Medi-Cal formulary is a closed formulary consisting of primarily generic medications. 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 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

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly PA statistics are tracked and reported quarterly in the UM/QI meeting. Active engagement with Pharmacy and existing narcotic prior authorization requirements continue as planned. Narcotic Limits enacted 10/2019 based on CDC guidelines and results from Q4 2019 and Q1 2020 show decreased utilization. PDL changes halted in April 2020 due to MCAL RX implementation Current SHP Quarterly meeting topics include • Medi-Cal RX • AB1114 – Pharmacist services • A&G trends and concerns • Interrater Reliability of Envolve PA team	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	• All PA, IRR, A&G trending reports submitted on time to UMQI for 2020 and no outstanding issues were identified • Formulary changes still halted until Medi-Cal RX transition on 4/1/2021 • Narcotic pain medication restrictions remain in place. PA volume still high for these requests. • Medi-Cal RX implementation delayed until 4/1/2021 by DHCS. Standard UMQI reporting for Q1 2021 will be completed	None	• New APL for AB1114 released January 2021 with follow up needed for final implementation • Revised UMQI reporting for pharmacy data in Q2-Q4 of 2021 will be required due to the Medi-Cal RX transition. • A&G and PA related issues will be based on medical benefit	Ongoing in 2021 with some program modifications TBD

CalViva Health
2020 UM/CM Work Plan

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

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	MHN continues the bidirectional referral process with Fresno, Kings and Madera counties. Referrals were based on acuity of clinical presentation and member need for particular behavioral health services. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. During the period January through June, 2020, MHN received 373 referrals from Fresno, Kings and Madera counties. MHN referred 7 members to the county for Specialty Mental Health or Substance Abuse Services.	None Identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	The bidirectional referral process for CalViva counties continued to serve members in 2020, both via fax using the clinical screening tool and telephonically. Clinical rounds with MHN psychiatrists as well as HN medical physicians occurred weekly to ensure that members were receiving good coordinated and integrated care. PCPs continue to be offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. 789 calls were received from members 1/1/20–12/31/20. Of those calls, 161 were sent to clinical care managers. Of those, 14 were referred to County Specialty Mental Health Services. The remainder were	None Identified	None	Ongoing

	assisted with referrals to MHN providers or case management services. Behavioral health care managers continue to attend medical concurrent review rounds to ensure that member mental health and substance abuse needs are met. BHCMs also conduct rounds with plan psychiatrists to obtain clinical consultation on complex cases as well as decisions regarding denials and modifications.			

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measureable Objective(s)	2020 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: 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

CalViva Health
2020 UM/CM Work Plan

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

☐ ACTIVITY ON TARGET

☒ TOO SOON TO TELL</td>
<td>Performance was below target in Q1 2020 for network adequacy for Psychologist.
Instances where the target is not met are shown in bold red.
<table>
<tr><th>Metric</th><th>Target</th><th>Q1-2020</th><th>Q2-2020</th></tr>
<tr><td>Appointment Accessibility by Risk Rating</td><td></td><td></td><td></td></tr>
<tr><td>Life-Threatening Emergent (requires immediate care)</td><td>100%</td><td>0 cases</td><td>0 cases</td></tr>
<tr><td>Non Life-Threatening Emergent (requires care within 6 hours)*[1]</td><td>90%</td><td>100%</td><td>100%</td></tr>
<tr><td>Urgent (requires care within 48 hours)</td><td>90%</td><td>100%</td><td>100%</td></tr>
<tr><td>Authorization Decision Timeliness</td><td></td><td></td><td></td></tr>
<tr><td>% of Authorization Decisions in Compliance - Non ABA</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>% of Authorization Decisions in Compliance - ABA</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Potential Quality Issues</td><td></td><td></td><td></td></tr>
<tr><td>% of PQIs Resolved Within 30 Days</td><td>95%</td><td>100%</td><td>100%</td></tr>
<tr><td>% of Untoward Events Resolved Within 60 Days</td><td>95%</td><td>0 cases</td><td>0 cases</td></tr>
<tr><td>Provider Disputes</td><td></td><td></td><td></td></tr>
<tr><td>% of Provider Disputes Resolved within 45 days</td><td>95%</td><td>100%</td><td>100%</td></tr>
<tr><td>Network Availability</td><td></td><td></td><td></td></tr>
<tr><td>1 BHP (including high volume BHPs) within 45 miles and 75 minutes from residence</td><td>90%</td><td>100%</td><td>100%</td></tr>
<tr><td>1 QAS provider (BCBA provider) within 45 miles and 75 minutes from residence</td><td>90%</td><td>100%</td><td>100%</td></tr>
<tr><td>2 QAS Professionals and Paraprofessionals (BCaBA/Paraprofessional) within 45 miles and 75 minutes from residence</td><td>90%</td><td>100%</td><td>100%</td></tr>
<tr><td>BHP Open Practice</td><td>85%</td><td>82%</td><td>95%</td></tr>
</table>
<u>MY 2019 MHN Provider Appointment Availability Survey and Autism Provider Accessibility Survey:</u>
- Access to urgent appointments fell below 90% target
- Routine non-urgent appointments, met the 90% standard but all other results are below standard.
- CVH non-physician mental health providers met the compliance rate target, over 90%.

<u>Autism Provider Accessibility Survey results</u>:
<table>
<tr><th colspan="7">MY 2019 Provider Appointment Availability Survey: Compliance Results</th></tr>
<tr><th rowspan="2">Reporting Population</th><th rowspan="2">Provider Type</th><th colspan="2">Compliance: 96 Hour Urgent</th><th colspan="2">Compliance: 48 Hour Urgent</th><th colspan="2">Compliance: Routine**</th></tr>
<tr><th>MY 2018</th><th>MY 2019</th><th>MY 2018</th><th>MY 2019</th><th>MY 2018</th><th>MY 2019</th></tr>
<tr><td rowspan="2">CalViva Health</td><td>Psychiatrists</td><td>75%</td><td>53%</td><td>75%</td><td>41%</td><td>80%</td><td>78%</td></tr>
<tr><td>NPMH Providers</td><td>66%</td><td>75%</td><td>32%</td><td>70%</td><td>86%</td><td>91%</td></tr>
</table>
</td>
<td>• Psychiatry is an underserved specialty in California, particularly for the Medi-Cal population. There are not enough Psychiatrists in practice who are willing to treat this population.
• Provider dissatisfaction with current contract rates.</td>
<td>2020-Network Availability and Adequacy interventions identified:
• Grow telemedicine network and promote use of telemedicine
• Reviewing the current Provider contract rates for rate increases.
• Improved reimbursement for newly contracted providers with stipulations including acceptance of new patients.
• Contacting SCA Providers SCA's and trying to bring them in network.
• Increased FQHC network participation</td>
<td>Ongoing</td>
</tr>
</table>

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Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	In Q3 and Q4 2020, 15 of the 15 metrics with targets met or exceeded their targets. Even though ABA authorization timeliness did not meet the 100% target, it exceeded the threshold for action of 95%. In Q3 and Q4 the appointment access standards for "Life-Threatening Emergent", "Non Life-Threatening Emergent" and "Urgent" were met.	• Psychiatry is an underserved specialty in California, particularly for the Medi-Cal population. There are not enough Psychiatrists in practice who are willing to treat this population. • Provider dissatisfaction with current contract rates.	Network availability and adequacy interventions identified in 2020, continue in order to achieve desired results by increasing adequacy and access to services.	Ongoing

5. Monitoring Activities for Special Populations

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2020 Planned Interventions	Target Completion Date
5.1 Monitor of California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Health Net identifies 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, 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

CalViva Health
2020 UM/CM Work Plan

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Comparing Q2 2019 with 2020, while the overall under-21 CVH population has decreased 0.7%, the subset of under-21 membership identified as CCS-Eligible and subsequently tracked in the DHCS PEDI system has increased 1.5%.

2020 Monthly CCS Identification Rates
<table>
<tr><th></th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>20-Jan</td><td>8.65%</td><td>7.20%</td><td>7.26%</td><td>8.36%</td></tr>
<tr><td>20-Feb</td><td>8.53%</td><td>7.10%</td><td>7.23%</td><td>8.25%</td></tr>
<tr><td>20-Mar</td><td>8.71%</td><td>7.22%</td><td>7.34%</td><td>8.42%</td></tr>
<tr><td>20-Apr</td><td>8.53%</td><td>7.08%</td><td>7.17%</td><td>8.24%</td></tr>
<tr><td>20-May</td><td>8.42%</td><td>7.00%</td><td>7.17%</td><td>8.15%</td></tr>
<tr><td>20-Jun</td><td>8.55%</td><td>7.26%</td><td>7.38%</td><td>8.30%</td></tr>
</table>
</td>
<td>• Due to COVID-19, facilities and providers stopped scheduling non-emergent surgeries and procedures, so the overall number of prior authorization submissions to the plan decreased. Potentially CCS-eligible authorizations for under-21 membership also went down:
o May 2019 vs May 2020, under-21 PA & IP auth volume decreased 100% (from 3,325 to 1,661)
• Misdirected provider claims were being sent to the Fresno CCS office in late 2019, early 2020. Targeted education and communication to providers was completed to address the issues and provide Plan resources.</td>
<td>Measurable objective staff title edited from “Public Programs Coordinators” to “Public Programs Specialists”.

Planned Interventions:
• Removed reference to 2018 interventions
• Provider letters moved from quarterly to ad hoc
• Continued outreach out to members aging-out of CCS six months prior to their 21st birthday.
• Continue to follow-up with aged-out members three months after their 21st birthday to ensure on-going quality of care.

Using the Health Places Index risk score metric to identify members most at-risk due to COVID-19, Public Programs team identified and called 3,848 CalViva members to address needs.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2021</td>
<td>Comparing 2019 with 2020:
<table>
<tr><th>Quarter</th><th>2019</th><th>2020</th></tr>
<tr><td>Q1</td><td>8.07%</td><td>8.34%</td></tr>
<tr><td>Q2</td><td>8.10%</td><td>8.23%</td></tr>
<tr><td>Q3</td><td>8.19%</td><td>8.22%</td></tr>
<tr><td>Q4</td><td>8.28%</td><td>8.27%</td></tr>
</table>
Looking at annual average, the 2020 percent CCS eligible was 1.3% higher than 2019.
By county, 2019 through 2020, Fresno saw 1% growth</td>
<td>1. The CA Central Valley was hit hard by COVID-19, resulting in fewer scheduled in-patient visits in 2020 and a CCS staff reduction to move clinical teams to treat COVID patients in hospitals. Even with providers sent 30% less PA/IP authorizations to the UM <21 Team.

2. Members aging-out of CCS lose program benefits on their 21st birthday. Members transition to other providers with Plan and</td>
<td>1. Public Programs built different CCS case escalation processes for independent and dependent counties:
• For Fresno (independent), PP worked more closely with the CCS county staff and provided aged case lists to improve CCS determination TAT, especially for NICU SAR</td>
<td>On-going (maintaining processes established in 2020 into 2021 while pandemic persists)</td>
</tr>
</table>

	in its percent CCS eligible membership, Kings 2%, Madera 5%	need “hand holding” in some cases to minimize lapses in care	• For Madera and Kings (dependent), PP escalated all cases aged 30+ days to DHCS. PP worked directly with CCS medical directors as well Aging-out and aged-out call programs were established in 2019 and maintained in 2020 to track aged-out member progress. Of the 110 CVH aged out members called after their 21st birthday, only four needed additional CM support.	

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Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2020 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. 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

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Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 419 SPD members (SSI Dual and Non Dual) have been managed 2020 through Q2. This includes PH CM, BH CM, TCM & OB CM, as well as both complex and non-complex cases. All members (100%) were outreached within the compliance due date for Q1 2020 (Reported July 2020). The percentage of members that completed a HRA for both high and low risk in Q1 2020 is 15%, which is slightly higher than Q3 2019 at 13%. Timely HRA outreach reported for CalViva SPD members as of June 2020: 100%	Vendor reporting does not summarize call attempts. Currently the health plan utilizes individual call records to validate call attempts.	EPC plans to implement a new outbound call process called Performance Outreach Manager (POM). The new call system will provide an automated reporting solution for vendor call attempts.	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2021**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 931 SPD members (SSI Dual and Non Dual) have been managed Q1-Q4 2020. This includes PH CM, BH CM, TCM & OB CM, as well as both co 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 mplex and non-complex cases. Timely HRA outreach reported for CalViva SPD members YTD 2020: 100%	None None	None None	Ongoing Ongoing

Item #9

Attachment 9.C

2021 Utilization Management
Program Description

REPORT SUMMARY TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Marianne Armstrong Utilization Management

COMMITTEE DATE: February 18, 2021

SUBJECT: Utilization Management Program Description Change Summary

UM Redline Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Updated year from 2020 to 2021
ii-iii	Table of Contents	Page numbering updated
3	Confidentiality	Edited learning system name
4	Information Systems and Analysis	Removed “National” from Medical Advisory Council reference.
6	Health Net Mission	Updated Health Net Mission and Purpose statement
10	Preauthorization/ Prior Authorization	Removed “home health” from reference to services requiring prior authorization
11 and 12	Inpatient Facility Concurrent Review and Discharge Planning	Removed MHN references to inpatient management. MHN only manages mild to moderate behavioral health services for CalViva.
18	Continuity and Coordination of Care; Primary Care Physician responsibility	Changed Nurse Advice to lower case, removed “and Triage” reference.
18	Health Promotion Programs; Be In Charge!SM	Changed Preventative to Preventive, Removed Nurse Advice Line.
18/19	Nurse Advice Line and Disease Management	Revised and reordered the Disease management and Nurse Advice Line sections
22	Utilization Decision Criteria	Updated Decision Criteria references under E. 4-6
27	Communication Services	Changed Nurse Advice to lower case, removed “and Triage” reference
29	Organizational Structure and Resources	Removed MHN Resources references; duplicative of references on page 32
31	Health Net Clinical Staff and Additional Resources	Reorganized resources references
32	MHN Medical Director And MHN Medical Staff	Removed “Western Region” reference to MHN Medical Director
34	Delegation	Changed Delegation team member reference from CCA to UM Compliance Auditors. Clarified monthly reports are required in addition to quarterly.
35	Sub-delegation	Removed “Onsite” reference to review of the contracted delegates.

20202021

Health Net Community Solutions, Inc.
CalViva Health
Utilization Management (UM) Program Description

Health Net

CalViva HEALTH

TABLE OF CONTENTS

Commented [MA1]: Table of contents updated in final

Section 1

Introduction and Background

Introduction and Background

Introduction

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

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

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

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

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

Background

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

Provider Network

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

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

- Practitioners and providers contracted directly with Health Net or CalViva Health.

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 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~~Centene University".

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

Information Systems and Analysis

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

- 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 departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical support resources include Actuary, Finance, Provider Network Management, ~~National~~ Medical Advisory Council, Customer Service~~s~~ 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 Mission and Purpose

The mission of Health Net is:

"Better health outcomes at lower costs~~To help people be healthy, secure and comfortable~~."

The purpose of Health Net is:

"Transforming the health of our communities, one person at a time"

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State Health Programs UM Vision

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

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

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary 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
- Assess 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 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 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
- 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 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 Management Program is under the clinical supervision of the Health Net Chief Medical Officer who has substantial involvement in developing and implementing the Program.

Scope of Utilization 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 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. The plan separates its medical decisions from 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 Programs adhere to all applicable requirements set forth by CMS, DHCS, DMHC and MRMIB for Utilization Management and Care Coordination activities.

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

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 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.

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 Management section of the UM 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-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 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) Educate the Member's healthcare team on the Member's benefit structure and resources,
3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate 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 and~~,~~ 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 staff supports pre-service and concurrent review 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 in the event the member experiences a health status change. This is done through work and advocacy with the PPG, member and/or the interdisciplinary care team to 1) ensure services are accessed timely, 2) educate to the member's healthcare team on the member's benefit structure and resources, 3) facilitate expeditious authorization of services when appropriate, and 4) facilitate 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 discharge plan of care based on short-term medical/psychosocial needs.
- Coordination and implementation of services requested in the plan of care.

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 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 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 the behavioral health subsidiary of HNCS and HNCA 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-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.

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 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 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 incorporates the unique perspectives and skills of behavioral health disciplines.
- A systems orientation views the patient as a member of his/her family, job, social system, and community network, all of which may be involved in the treatment plan.
- The MHN utilization management program provides clinical 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 licensed Care Managers and Medical Directors. MHN staff providing services to CalViva members are located at MHN 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, LLC Health Net Pharmaceutical Services, administers and manages the prescription drug benefit including select injectable for Health Net'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.

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 n~~N~~urse a~~A~~dvice ~~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 ~~T~~triage services.

Health Promotion Programs

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 preven~~ta~~tive wellness, and chronic care* disease management in accordance with national peer-reviewed published guidelines. Preven~~ta~~tive 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~~
- Weight Management Programs
- 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.

Nurse Advice Line

In addition to *Be in Charge!*℠ programs, the nurse advice line provides immediate symptom assessment and member education 24 hours a day, seven days a week. In addition to educating members how to better manage their health, the service recommends callers seek the appropriate level of care, within the appropriate timeframe and at the proper setting. The service is available in English and Spanish with interpreter services for other languages. Only California-licensed nurses assess, evaluate, triage or advise regarding the condition of an enrollee.

Disease Management

The *Be In Charge!*℠ Disease Management Program increases awareness of self-care strategies and empowers participants to better manage their disease. The program targets high-risk members identified with chronic asthma, diabetes and heart failure conditions and encourages them to participate in the disease management program. This program includes a population-based identification process, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to disease management are multichannel and come through provider, Case Management and member self-referrals. ~~Members with asthma, diabetes, and chronic heart failure are enrolled into *Be In Charge!*℠ 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.~~

~~**Nurse Advice Line**~~

~~The Nurse Advice Line (NAL) service is a member-centric nurse triage program that combines, 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 interpreter services available for other languages. Only California-licensed nurses assess, evaluate, triage or advise regarding the condition of an enrollee.~~

~~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~~

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~~timeliness of care. The NAL is URAQ accredited and has also received the Health Information Line NCQA Certification.~~

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. 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 center, community based organizations and provider clinics located in areas where CalViva Health members reside. The community classes are free to all CalViva Health members and the community. Providers should complete and fax a copy of the Fit Families for Life - *Be In Charge!℠* Program Referral Form to the CalViva Health's Health Education Department to refer members to the Home Edition program.

Health Education Programs, Services and Resources

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:

- 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 yearlong evidence-based, lifestyle change program that promotes and focuses on emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.
- Healthy Hearts Healthy Lives Program - Members have access to a health heart prevention toolkit (educational booklet, tracking journal and fitness DVD) and access to 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 depression, anxiety, stress, substance use, pain management, and insomnia.
- Health Promotion Incentive Programs - The Health Education Department (HED) 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 - The HED 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 educational resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, dental health, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Member Request Form – Members complete a pre-stamped form to request free health education materials available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line or view some materials online at www.CalVivaHealth.org. They can also get CalViva Health's print resources at contracted providers and health education classes.

- Health Education Programs and Services Flyer – This flyer contains information on all health education programs and services offered to members and information on how to access services.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in English, Spanish and Hmong.
- Member Newsletter – Newsletter is mailed to members on a regular basis and covers various health topics and the most up-to-date information on health education programs and services.

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 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:

A. State law/guidelines (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 (including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria);
C. Centene clinical policy (including Centene clinical policies in InterQual as custom content);
D. 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;
E. In the case of no guidance from A-D, 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; such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.;
    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, including in UpToDate;
    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

When state Medicaid coverage provisions conflict with the coverage provisions in Plan- or Centene-specific clinical policy, state Medicaid coverage provisions take precedence. Refer to the state Medicaid manual for any coverage provisions. Clinical policies, benefit provision, guideline, protocol or criteria are available upon request per Federal and State regulatory guidelines.

Separation of Medical Decisions from Fiscal and Administrative Management

In Health Net's UM 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,
- 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 Vice President 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, 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 UMQI Committee where recommendations for corrective action are made. Member and practitioner satisfaction information is reported at the 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~~ nurse ~~Advice~~ advice ~~and Triage L~~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 Program Description and the UM Policies and Procedures

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

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

Health Net's Chief Medical Officer has direct responsibility for the Utilization 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,

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 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.

Vice President Medical Director, State Health Programs

The Vice President Medical Director, State Health Programs (SHP), is responsible for Utilization Management and Case Management activities for Medi-Cal. In addition, the Vice President Medical Director is responsible for QI activities for these programs. The Vice President 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 Vice President 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 Management Program for all product lines.

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

Additionally, each Medical Director recommends policy/program changes to improve performance and enhance the Quality Improvement Programs as well as serving as

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.

Senior Vice President of Medical Management (VPMM)

The Senior VPMM is a registered nurse with experience in utilization management and case management activities. The Senior VPMM is responsible for overseeing the activities of the Plan's Utilization Management and Case Management Programs. The Senior VPMM reports to the Plan Chief Operating Officer. The Senior VPMM, in collaboration with the Vice President Medical Director (SHP), assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

Healthcare Services (UM/CM) Resources

Vice President, Medical 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 Program and:

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

Health Net UM Clinical Staff

HN UM clinical nursing staff (i.e. Review Nurses) has responsibilities, which may include but are not limited to:

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,

- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Case/Disease Management when appropriate,
- Management of out-of-area cases, and
- Monitoring effectiveness of delegated entities and contracted providers.
- All UM LVN, LCSW and RN staff is under the direct supervision of a Manager, HCS or UM, who is an RN.

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Additional~~ly for State Health Plan Members in California~~Resources

- Additional licensed and clerical staff supports UM activities.
- 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

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

~~Additional licensed and clerical staff supports UM 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.

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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.

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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 Utilization Management (UM) Compliance Auditors ~~Clinical Care Administrators (CCA) who are registered nurses specially trained~~ to perform this evaluation. UM Compliance Auditors~~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, UM Compliance Auditors~~CCAs~~ are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, UM Compliance Auditors~~CCAs~~, in conjunction with the Regional Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors~~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 monthly/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. Assessing and determining the appropriateness of delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

B. Performing 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 activities and recommendations of the DOW 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, initiates 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~~ A 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.

_____ _____

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

_____ _____

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

Health Net Medi-Cal Utilization Management Program Approval

The Chief Medical Officer and Vice President of Medical Management have reviewed and approved this Program Description.

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Jennifer Lloyd
Vice President of Medical Management

Item #10

Attachment 10.A

2020 Annual Compliance Evaluation

CALVIVA HEALTH
2020 ANNUAL REGULATORY AFFAIRS & COMPLIANCE EVALUATION

I. EXECUTIVE SUMMARY

The Fresno-Kings-Madera Regional Health Authority ("RHA") dba CalViva Health ("CalViva" or the "Plan") operates as a public agency, Local Initiative Medi-Cal managed care plan covering the counties of Fresno, Kings and Madera. The Plan does not offer commercial or other product lines. CalViva Health is committed to maintaining its business operations in compliance with ethical standards, Department of Health Care Services ("DHCS") Medi-Cal contractual obligations, Department of Managed Health Care ("DMHC") requirements, and all-applicable state and federal statutes, regulations and rules. CalViva Health's compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners.

CalViva Health has an Administrative Services Agreement ("ASA") with Health Net Community Solutions ("Health Net") to provide certain administrative and operational services on the Plan's behalf. CalViva Health also has a Capitated Provider Services Agreement ("CPSA") with Health Net for the provision of health care services to CalViva Health members through Health Net's network of contracted providers and subcontracted health plans. CalViva Health also has direct contracts with three (3) Federally Qualified Health Centers. A primary responsibility of the Plan is to ensure Health Net and their subcontractors perform delegated services and activities in compliance with CalViva Health standards, contractual requirements and state and federal regulatory requirements.

The Compliance Program is guided by the Plan's mission "To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners." The Compliance Program is implemented by all Plan Departments: Compliance, Medical Management, Finance and Operations. Compliance Program results are the collective achievements of dedicated Plan staff members, the Plan's administrator, providers and community-based organizations working together to meet the needs of CalViva members and the community we serve. As will be presented below, in 2020, the Plan continued efforts to update its policies to be in compliance with new regulations and guidance as well as improve its oversight of delegates/subdelegates, maintain its network adequacy, and timely access standards. Going forward, the Compliance Program will focus on meeting new regulatory challenges in 2021 and beyond, improving performance by addressing issues identified through Corrective Action Plans (CAPs) as well as maintaining overall operational effectiveness and regulatory compliance.

Health plan operations and compliance activities were significantly impacted in 2020 by the declaration of a public health emergency (PHE) due to the Novel Coronavirus Disease (COVID-19). On January 31, 2020 the Secretary of the U.S. Department of Health and Human Services (HHS) declared a PHE had existed since January 27, 2020. On March 4, 2020, Governor Newsom declared a state of emergency exists in California due to COVID-19. As the COVID-19 pandemic spread, the California and Federal PHE declarations were renewed and extended and remain in place as the Plan goes into 2021.

II. REGULATORY AFFAIRS

A. Administrative and Operational Regulatory Reporting

As a licensed health plan, CalViva Health is required to submit a wide variety of information and data for review and approval to the DMHC in compliance with Knox-Keene regulations, and to the DHCS in compliance with its contract, Medi-Cal regulations and All Plan Letters. Regulatory filing activities include but are not limited to: material modification and amendment filings, annual timely access submissions, annual network certification, fraud waste and abuse case review and submissions, member-informing materials, new benefit-associated deliverables, changes in commission/committee members, key policies and procedures, etc. In 2020, CalViva Health made over 200 regulatory filings to DMHC and DHCS. These filings do not include the various "routine" monthly/quarterly data reports or audit-related information that are sent to the two agencies. In addition to regulatory filings and report submissions, the Plan undergoes annual audits by DHCS, triennial medical and financial audits by DMHC, annual HEDIS® audits and implements and addresses regulatory agency CAPs as needed.

B. Summary of STATE AUDITS AND MEDI-CAL CONTRACT AMENDMENTS

1. Department of Health Care Services (DHCS):

a. February 2020 DHCS Annual Audit – DHCS conducted its annual on-site Medical Survey, including State Supported Services and issued the Final Reports on June 30, 2020. The Medical Survey Report indicated that the Plan successfully passed most audit areas and requested a CAP related to the Plan's deficiencies in two areas. The Plan filed the response to the Medical Survey CAP on July 31, 2020 and is in the process of implementing corrective actions with periodic updates to DHCS until corrected. The State Supported Services Final Report found no deficiencies.

b. DHCS 2018-2019 Performance Evaluation – The final report issued in July 2020 identified two external quality review (EQR) improvement recommendations related to HEDIS® measures. The Plan successfully implemented interventions addressing these areas.

c. DHCS 2019 - 2020 Encounter Data Validation (EDV) Study –The annual EDV study was postponed in 2020 due to the COVID-19 Public Health Emergency.

d. 2020 DHCS Annual Network Certification (ANC) – The Plan submitted the ANC in April of 2020. The DHCS issued a CAP on November 25, 2020 related to non-compliant time and distance standards. Accordingly, the Plan submitted its responses on December 28, 2020.

e. DHCS Contract Amendments - Several Medi-Cal contract amendments were executed between DHCS and CalViva Health.

Contract 10-87050 A12 - This amendment revises the Final Rule Amendment previously executed as some contract language was inadvertently missing from the amendment. The amendment was executed in 2020 and is retroactive to effective date 7/1/2017.

Contract 10-87050 A13 - The amendment is retroactive to effective date 7/1/2017 and incorporates new language requirements for Mental Health Parity, American Indian Health Service Programs, and Adult Expansion Risk Corridor. It also adjusts the 2017-2018 capitation rates by changing Exhibit B, Budget Detail and Payment Provisions.

Contract 10-87050 A14 - This amendment is retroactive to effective date 7/1/2017 and covers the following:

- Revised 2017-2018 capitation rates
- New language for the Directed Payment Initiative (Prop 56 payments, PHDP - hospital directed payments, etc.),
- New deliverable provisions related to Mental Health Parity.

Contract 10-87050 A17 Extension Amendment (Primary) & **Contract 10-87054 A05** Extension Amendment (Hyde) – Renews the Plan's Medi-Cal contract for one year through 12/31/21.

Note: Contract 10-87050 A15 and A16 are either pending CMS approval or still in progress. A17 is a term extension and it needed to be in place by 12/31/20 for continuity of a valid contract and for payments.

f. Covid-19 – The Plan reported provider site closures, positive COVID-19 tests and hospitalizations on a daily basis.

2. Department of Managed Health Care (DMHC):

a. Measurement Year (MY) 2019 Timely Access Report (TAR): The Plan submitted its annual MY2019 TAR filing in May of 2020. As of the end of 2020, DMHC has not issued its preliminary findings.

b. February 2019 (Triennial) DMHC Audit – DMHC issued its Final Report on February 5, 2020 citing deficiencies in four areas, two of which had been previously corrected by February 5, 2020. The Plan submitted an April 5, 2020 supplemental response to the remaining two findings followed by two CAP updates. On October 30, 2020, the DMHC notified the Plan that it would conduct an 18-month follow-up audit of the outstanding deficiencies. The follow-up audit would consist of a desk-level audit and telephonic interviews beginning March 1, 2021.

C. DHCS Fraud, Waste and Abuse Required Reporting:

In 2020, the Plan identified and investigated fourteen (14) cases which were determined to

reflect suspected fraud and/or abuse cases. Accordingly, fourteen (14) MC609 reports were filed with the DHCS. Twelve (12) were provider-related and 2 were member related cases. The DHCS closed six of these cases. There were no cases referred to other law enforcement agencies by the Plan.

D. Privacy and Security Oversight

1. Regulatory and Contractual Obligations

CalViva Health continued to review and refine their practices and processes to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) contractual obligations and any other privacy and security related laws and regulations. The following key activities were completed for 2020:

- Breach Notifications and Assessments – Risk assessments were conducted on cases to determine the probability of compromise of protected health information in the event of a breach of unsecured protected health information.
- Risk Analysis – CalViva Health completed the Plan's new HIPAA risk analysis utilizing HIPAA One. The privacy and security risk assessments identified a total of 9 privacy risks and 10 security risks to be addressed. All 9 privacy risks have been resolved. 9 out of the 10 security risks have been resolved.
- Periodic and Ongoing Training – The Plan conducted ad-hoc and annual privacy and security training to all employees. Educational newsletters were distributed quarterly.

CalViva Health continued efforts in the oversight and monitoring of Business Associates (BA) who create, maintain and/or transmit protected health information (PHI). In addition, CalViva Health maintained a contract with a company to conduct security and vulnerability scans, and another company for use of their software to assess CalViva Health's compliance with the HIPAA privacy and security regulations.

In 2021, CalViva Health will continue assessing their practices and processes to ensure compliance with HIPAA and any applicable state regulations. These assessments could include, but are not limited to, reviewing operational business practices, completing the annual risk analysis with HIPAA One, engaging in ongoing risk management activities, and reviewing program documents related to HIPAA.

2. Reports of Possible Privacy and Security Incidents/Breaches

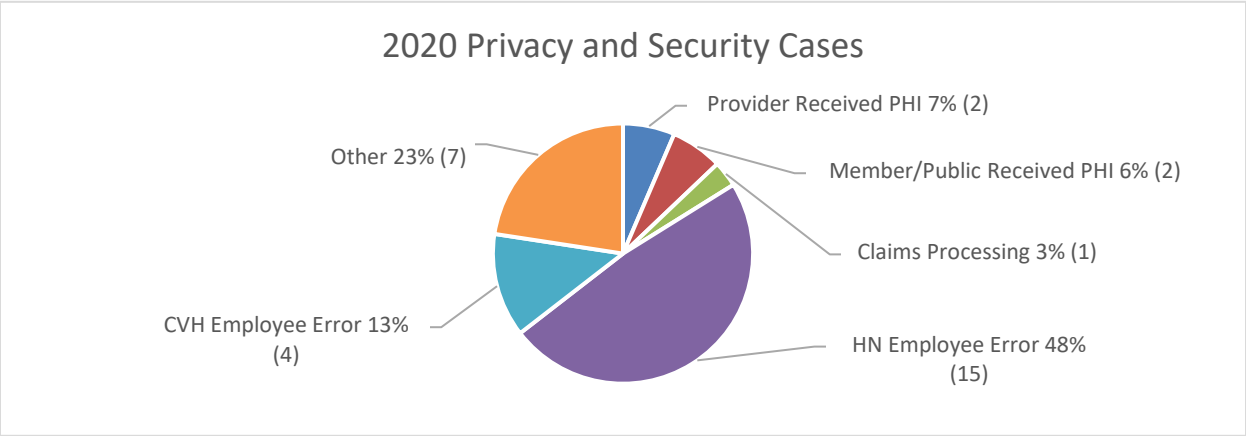
As described in the Plan's privacy and security policies and procedures, upon discovery of an incident/breach, CalViva Health must notify state and federal agencies of the incident/breach in accordance with regulatory requirements. In addition, the Plan must take prompt corrective action to mitigate any risks or damages involved.

In 2020, thirty-one (31) privacy and security incidents were reported to the DHCS. Four

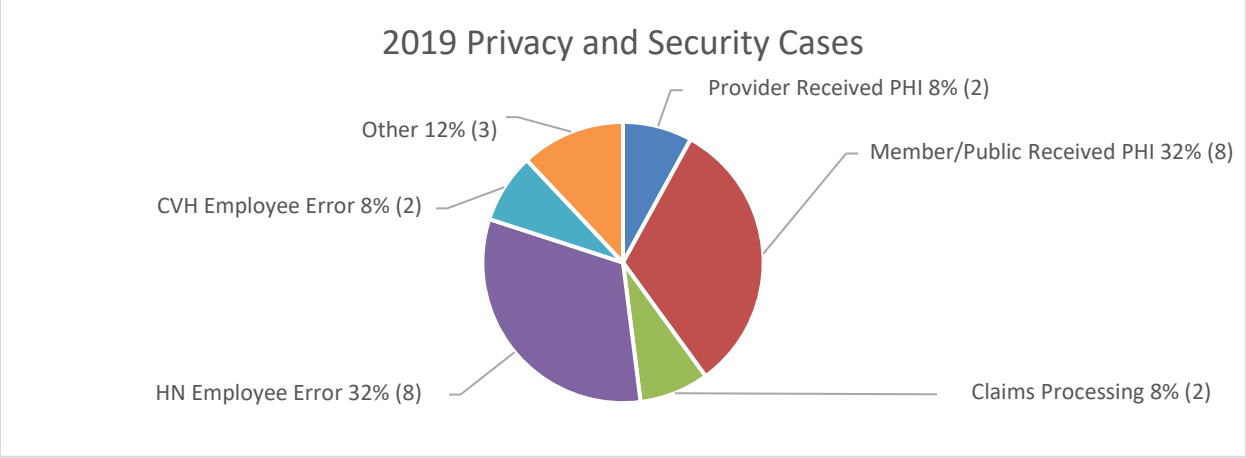
(4) incidents occurred within CalViva Health. The remaining twenty-seven (27) incidents involved the Plan's Administrator Health Net. Twenty-five (25) cases were deemed low risk or no risk after the completion of a risk assessment. Two (2) cases did not require completion of a risk assessment as there were zero (0) individuals affected by the privacy incidents. One (1) case was deemed moderate-risk, which required notification to the affected individual. There are three (3) cases which are still under investigation and waiting to be determined as a high-risk, moderate-risk, or low-risk case.

The first pie chart provides a high-level overview of the types of incidents which occurred in 2020. The second pie chart provides high-level overview of the types of incidents which occurred in 2019 for comparison purposes:

2020 Privacy and Security Cases



2019 Privacy and Security Cases



The pie charts reveal that the total number of privacy and security incidents increased by 24% in 2020 (31 incidents) from 2019 (25 incidents). The number of incidents involving providers receiving PHI had no change between 2020 and 2019. On the other

hand, the number of incidents involving Health Net employee errors increased by 88%. A retrospective review of the Health Net employee error cases failed to identify any trends or concerns with the large increase.

3. CalViva Health Internal Audits

CalViva Health conducts monthly workstation audits to enforce standards for protecting the privacy of Personal Health Information (PHI). Compliance staff conduct an after-business hours audit of internal workstations/offices and communal workspaces (e.g., document storage, fax machines, printers, and copy machines) to see if PHI is exposed and to determine if computers have been logged off. Spot check audits are also conducted during work hours to see if PHI is being exposed inappropriately or left unattended.

In 2020, there were three (3) incidents where an employee was subject to disciplinary action due to a privacy and security non-compliance issue.

E. DHCS Notice of New Benefits, Waivers or Programs:

1. Due to the 2020 Public Health Emergency (PHE), the DHCS received CMS approval to extend Section 1115(a) Waiver Program ("Medi-Cal 2020 Demonstration") by 12 months (the original end date was 12/31/2020 to be superseded by CalAIM).

2. DHCS implemented a Preventive Care Outreach project. The California State Auditor conducted an audit of DHCS' oversight of the delivery of preventive services to children in the Medi-Cal Program in 2018. The audit concludes that millions of children do not receive preventive services to which they are entitled. As a result, DHCS implemented an Outreach Project in which plans were to conduct call campaigns in two phases: Phase 1 (0-2 years old) and Phase 2 (2-6 years old). The campaign informed members about preventative care services available, such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including Lead Screening, and how to access them. The Plan successfully completed the call campaigns by October 2020.

3. The Trailer Bill implementing the 2019 Budget Act authorized DHCS to develop the Behavioral Health Integration (BHI) Incentive Program as part of its Proposition 56 Value-Based Payment initiatives in Medi-Cal managed care. Interested, eligible Medi-Cal providers had to submit applications to managed care plans in order to promote behavioral health integration. The goal of this program is to improve physical and behavioral health outcomes for Medi-Cal beneficiaries with co-morbid disorders by increasing rates of prevention, conducting early detection and interventions, and providing treatment that is clinically efficient, while being culturally and linguistically informed. Originally applicants selected one or more BHI projects to implement over a 33-month period (April 2020 through December 31, 2022). Due to the COVID-19 PHE, the time period was delayed and changed to January 1, 2021 through December 31, 2022. CalViva Health and DHCS approved two provider applicants covering three BHI programs for implementation.

4. DHCS started an initiative to address the risk of COVID for older adults and people with disabilities in Central Valley counties, and to reduce, avoid, and transition nursing facility stays. CalViva Health, Health Net and Anthem Blue Cross were required to convene county-level collaboration meetings (virtual meetings), including hospitals, nursing facilities, HCBS waivers/providers (including MSSP sites, CBAS centers, PACE organizations, HCBA and ALW waiver agencies, and CCT Lead Organizations), county social service agencies (for In-Home Supportive Services (IHSS)), and county health departments. On 10/1/20, a virtual, county-level, collaborative meeting, was convened. DHCS also participated in the convening which covered service organizations serving Fresno, Kings, Madera and Tulare counties.

5. On January 7, 2019, Governor Newsom signed Executive Order N-01-19 that required DHCS to transition pharmacy services for Medi-Cal managed care to fee-for-service (FFS) by January 2021. DHCS contracted with an administrative services vendor, Magellan, to manage and operate the Medi-Cal FFS pharmacy services program which is called Medi-Cal Rx. DHCS and its vendor, Magellan, created a Medi-Cal Rx website at: https://medi-calrx.dhcs.ca.gov/home/. In preparation for the transition, CalViva Health executed a Data Sharing Agreement with Magellan to facilitate the transfer of Rx related data (claims history, UM, etc.) established a member outreach campaign, created new or revised policies, revised the member ID card and developed provider communications. In late November, 2020, DHCS announced the pharmacy benefit transition was being deferred until April 1, 2021. The Plan is revising and updating materials to comply with the new transition date.

6. Pursuant to SB 104 (2019), aged, blind and disabled (ABD) persons could be transitioned into Medi-Cal Managed Care with no share of cost effective 12/1/20 and 2/1/21 as applicable based on the beneficiary's selection of a plan. The transition would be voluntary in Non-COHS counties such as CalViva. There was only one individual that transitioned to CalViva with the 12/1/20 effective date but additional enrollment is expected for the 2/1/21 date.

III. Compliance Program Activities

Due to the COVID-19 PHE and state and local emergency orders, CalViva Health has closed both its downtown and northeast Fresno offices to public visitors. There are signs at both locations referring members, providers and the public to call the CalViva Health toll free Customer Service number. The Customer Service Call Center is open 24/7. CalViva employees are working at the northeast Fresno office and remotely as appropriate to their circumstances and the status of state and local emergency orders.

A. Program Document Reviews/Updates:

CalViva Health continued to operate a comprehensive Compliance Program in 2020. The Plan's Compliance Program includes the following written descriptions which were reviewed and updated as necessary in 2020.

- Compliance Program Description
- Code of Conduct
- Compliance Committee Charter
- Anti-Fraud Plan
- Privacy and Security Plan
- Compliance Policies and Procedures

B. Oversight and Monitoring of Delegated Activities:

As a result of the COVID-19 PHE, the Plan's administrator, Health Net, transitioned its staff to a remote based working environment in March 2020. The Plan continues to provide oversight and work closely with Health Net on an ongoing daily basis to ensure CalViva members have information and access to services during this time. Health Net is continuing its remote based working environment until at least September 2021 and may extend it if the PHE continues.

1. Delegation Oversight Audits and CAPS

The table below lists the Plan's 2020 oversight audits of functions delegated to Health Net. Audits completed within the calendar year included desk reviews of any applicable functions subdelegated by Health Net, policies and procedures, reports, and evidence submitted to meet the required audit elements.

Appeals & Grievances*	Claims*	Marketing*
Privacy and Security	Provider Disputes*	Provider Network

* CAPs were required for the above functions and CAPs have been completed and approved.

2. Periodic Monitoring of Health Net

During 2020, CalViva Health staff continued a wide variety of activities to provide oversight and monitoring of the functions performed by Health Net and Health Net's delegated provider groups and subcontracted health plans on CalViva Health's behalf. These activities included:

- Monthly management oversight meetings with Health Net key management staff to review reports, discuss issues and any improvement actions needed.
- Monthly/Quarterly monitoring and analysis of key performance measures and reports from delegated entities for timeliness, accuracy and issues.
- Ongoing workgroup collaborations with Health Net to ensure process integrity and contract deliverables in the following areas:
  - Grievance System
  - Quality Improvement, Utilization Management and Credentialing
  - Encounter Data Integrity
  - Access and Availability
- On-going oversight of subdelegated functions through report dashboards of

comprehensive performance metrics accompanied by narrative reports explaining outlier data or issues.

C. 2020 CalViva Internal Audit

During 2020, the Compliance Department conducted an internal audit of employee, Commission and Committee member files to ensure completion of a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable. Records were also reviewed to ensure that no individual was listed on the Office of Inspector General ("OIG") exclusion list, the Medi-Cal suspended and ineligible provider lists, and licensing board sites. All files were found compliant and no CAP was issued.

D. CalViva Health Staff Trainings

A primary requirement of a successful Compliance Program is conducting ongoing education and training programs. Ongoing training helps CalViva Health staff to carry out daily Plan operations in an efficient and compliant manner. During 2020, the Plan conducted training for two new hires as well as the following mandatory annual staff trainings:

Compliance Program (including the Code of Conduct)	Anti-Fraud and Abuse Program
Privacy and Security Program	Cultural Competency

Staff members also attested to having read and signed the following documents on an annual basis:

Drug Free Workplace Statement	Confidentiality Agreement
Conflict of Interest Statement	

All employees successfully completed all required trainings.

E. Member Communications

CalViva Health maintains a process for the review and approval of communications with members. In 2020, 73 communications were reviewed by the Plan. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2020 Annual Mailing was distributed to members for calendar year 2020. A 2021 Member Handbook/Evidence of Coverage (EOC) is in production now and will be mailed to members in late Q1, 2021.

F. Provider Communications

CalViva Health maintains a process for the review and approval of communications to contracted providers within the CalViva Health service area. In 2020, contracted providers were sent approximately 234 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 34 informational letter templates and 17 forms intended for provider use.

H. Provider Relations

CalViva Health continued productive relationships with participating providers. The following information reflects activities from January to November 2020. There were 3,113 provider "touches" and 257 training visits throughout Fresno, Kings, and Madera Counties. Plan staff conducted outreach, trainings and assisted providers with Medi-Cal guidelines and CalViva Health requirements in their day-to-day operations. Outreach had to be modified in 2020 due to the COVID-19 pandemic to incorporate outreach by phone, email, Skype or Zoom. As a result, the Plan did not perform any in-person training visits in 2020 beyond March. The Plan and its administrator, Health Net, also offered support to providers during the COVID-19 PHE by providing supplies (PPE, and other equipment/supplies), monetary or other considerations, and removing or easing certain administrative rules.

I. Appeal and Grievance (A&G) Resolution Summary

CalViva monitors all appeal and grievance activity on an ongoing basis. Cases are reviewed for compliance with regulatory resolution timeframes, accuracy of language used in resolution letters, correct use of approved letter templates and completeness of case records. Expedited grievances and appeals must be resolved within 72 hours and standard appeals and grievances must be resolved within 30 calendar days. Exempt grievances are grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental/investigational treatment and that are resolved by the next business day following receipt.

The following table summarizes the number and type of A&G cases received in 2020, and the percent resolved within the compliance turnaround times (TAT) standards. For instances of non-compliance, corrective action was implemented to ensure there would not be future similar occurrences.

	No. of Cases Received	No. of Cases Resolved †	% of Cases Resolved within TAT (No.)
Expedited Grievances	110	111	100 % (111)
Standard Grievances	997	1033	100 % (1033)
Expedited Appeals	115	115	99.13% (114)
Standard Appeals	918	916	100 % (916)
Total:	**2140**	**2175**	**99.95% (2173)**
SPD Appeals & Grievances *	693	670	100 % (670)
Exempt Grievances #	2877	2877	100%

† Total will not match as some cases received in December 2020 may remain open at the start of 2021, and the resolved case number may include some cases received in December 2019 and resolved in 2020.

* The total number of A&G cases attributed to seniors and persons with disabilities (SPD).

Exempt Grievance are grievances that can be resolved within one business day.

J. Independent Medical Reviews (IMRs) and State Hearings

The following table summarizes the number of DMHC IMR and DHCS State Hearing requests processed by the Plan in 2020. All cases were submitted within the required turnaround times.

Cases Received	2020 Total	% Cases Submitted w/in the TAT
DMHC Cases	**112**	**100%**
DHCS State Hearings	**30**	**100%**
Total:	**142**	**100%**

IV. 2021 ACTIVITIES

In 2021, the Plan expects the California and Federal declarations of the COVID-19 PHE will continue to be renewed and have ongoing impacts on Plan activities. The DMHC and DHCS are requiring new as well as continuing COVID-19 reporting related to provider network stability and closures, support (monetary and supplies such as PPE) provided by plans to providers, information on relaxing of administrative rules and processes to ease the burden on hospitals and providers, etc.

Another significant focus in 2021 will be refocusing efforts to implement CalAIM. CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022. Programs proposed for January 2022 implementation include: the carve-in of major organ transplants as the responsibility of managed care plans, In Liu of Services (ILOS), and a Behavioral Health Medical Necessity Proposal. During 2021, DHCS workgroups will also focus on initiatives scheduled for implementation in 2023 and beyond such as Enhanced Case Management, Long Term Care carve-in to managed care plans, Population Health Management, Foster Care Model of Care, NCQA accreditation, etc.

A third major initiative the Plan will be handling in 2021 is the carve-out and transition of outpatient pharmacy benefits back to the Medi-Cal FFS program (Medi-Cal Rx). This transition was originally scheduled to be effective January 1, 2021 but was delayed by DHCS. This new transition date is April 1, 2021. Plan activities are focused on provider and member communications, transfer of historical pharmacy claims and authorization data to the DHCS Medi-Cal Rx administrator and establishing system access and liaison relationships with the Medi-Cal Rx administrator.

The Plan anticipates developing new policies and implementing/revising existing processes as a result of the initiatives described above, as well as new regulatory guidance and laws effective in 2020 and 2021.

The Plan also expects non COVID-19 related reporting requirements to intensify. Increased regulatory oversight and monitoring of health plan activities, is expected in the following areas:

- Provider network adequacy and certification requirements for direct and delegated networks
- Timely Access
- Encounter data quality and timeliness
- Clinical Quality Improvement (MCAS measures)
- Member Grievances/Appeals

The Compliance Department's efforts will focus on preparing for and monitoring the successful implementation of all new and current requirements.

APPROVAL:

		Date:	
Name:	Mary Beth Corrado		
Title:	Chief Compliance Officer		
		Date:	
Name:	Gregory Hund		
Title:	Chief Executive Officer		
		Date:	
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Item #11

Attachment 11.A

2021 Compliance Program Description

COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

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CALVIVA HEALTH COMPLIANCE PROGRAM

I. CALVIVA HEALTH OVERVIEW

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

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

In serving its membership, CalViva Health ("CalViva" or the "Plan") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, especially those pertaining to the Medi-Cal program. To that end, CalViva established a Compliance Program as described below.

II. COMPLIANCE PROGRAM PURPOSE AND OBJECTIVES

The Compliance Program exists to ensure that all CalViva members have access to quality health care services that are in compliance with all applicable state and federal statutes and regulations, and CalViva's contractual requirements to DHCS.

Table 1 presents the primary objectives implicit in this purpose.

Table 1. Program Objectives

Ensure the integrity of CalViva's Health Plan by upholding the ethical standards stated in the Code of Conduct, and complying with the policies and procedures that reflect our commitment to compliance.
Develop and maintain effective communication and collaboration with CalViva employees, subcontractors and regulators in order to maintain operational and regulatory integrity.
Provide oversight of subcontractors, including auditing of delegated functions.
Detect noncompliance as soon as possible, and in cooperation with CalViva subcontractors and stakeholders, make all reasonable efforts to correct or remedy the operational factors/circumstances under which the noncompliance occurred.
Report promptly to the appropriate state and federal agencies all required or contracted operational data, and also any suspected criminal and civil violations of statutes governing the provision of health care and health care plans.
Comply with the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) in their audits of CalViva and its providers.

Additionally, CalViva's Compliance Program is based on seven key elements stated in the Federal Sentencing Guidelines Manual as necessary for an effective compliance program:

1. Written standards of compliance
2. Designation of a Chief Compliance Officer
3. Effective education and training
4. Audits and evaluation techniques to monitor compliance
5. Reporting processes and procedures for complaints
6. Appropriate disciplinary mechanisms
7. Investigation and remediation of systemic problems

III. SCOPE

CalViva's Compliance Program oversight extends to the members of the Commission and the Commission's subcommittees, CalViva's employees and CalViva's delegated subcontractors, including contracted Knox-Keene licensed health plans, participating providers, and suppliers.

IV. AUTHORITY AND OVERSIGHT

A. GOVERNMENT AGENCIES

The following are some of the state and federal agencies that have legal authority to regulate various aspects of health care and health care plans.

- Centers for Medicare and Medicaid (CMS)
- Office of Civil Rights (OCR)
- Department of Managed Health Care (DMHC)
- Department of Health Care Services (DHCS)

By extension, CalViva assumes contractual responsibility from DHCS for assuring compliance with the regulations promulgated by these agencies and has developed various operational policies and procedures for that purpose. Section VIII of this Program Description lists the statutes and regulations that specifically relate to CalViva's Compliance Program. Moreover, these agencies have the right to access premises to determine/investigate compliance with the applicable regulations, executed contracts, and for any other reasonable purpose with or without notice to CalViva or its subcontractors and delegates.

Corporate oversight of CalViva's Compliance Program is shared by the RHA Commission, CalViva's Compliance Committee, and CalViva's Chief Compliance Officer ("CCO"). Their respective roles are briefly outlined below:

B. RHA COMMISSION

1. Bears ultimate responsibility for overseeing and supporting CalViva's operations, including the Compliance Program.
2. Reviews and approves the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct.
3. Reviews periodic reports of Compliance Program activities

C. THE COMPLIANCE COMMITTEE

1. Oversees CalViva's Compliance Program and advises the CCO on Program adequacy.
2. Reviews the Compliance Program annually, including the Privacy and Security Plan, the Anti-Fraud Plan, and the Code of Conduct and recommends revisions as needed.
3. Analyzes CalViva's contractual, legal, and regulatory requirements and risk areas and consults with advisors and legal counsel as necessary.
4. Monitors reports of fraud, waste and abuse, and unauthorized use and/or disclosures of personal information ("PI"), including protected health information ("PHI").
5. Reviews and approves recommendations to modify or establish internal systems and controls necessary to carry out the Compliance Program.
6. Supports investigational activities performed by the CCO, and or state and federal officials, as they relate to violations of the federal False Claims Act, Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act (HIPAA).
7. Reviews and approves disciplinary and corrective actions related to non-compliance with the Compliance Program.

D. CHIEF COMPLIANCE OFFICER (CCO)

1. Has operational accountability for the entire Compliance Program as detailed in this document.
2. Oversees the development, operation, evaluation and improvement of the Compliance Program, including corrective actions.
3. ~~Develops~~ Prepares the annual Compliance Program Evaluation~~Work Plan~~.
4. Reports to CalViva's Chief Executive Officer and the Commission.
5. Chairs the CalViva Compliance Committee.
6. Serves as CalViva's "Anti-Fraud Officer".
7. Is the primary CalViva liaison with DHCS and DMHC.

V. COMPLIANCE RISK AREAS

The following presents just some of the potential risks associated with the delivery of health care and health plan administration. These, and many others, are the focus of the Compliance Program's due diligence in monitoring, reporting, taking corrective action and improving**.**

A. Access & Availability, and Quality of Care:

- Unavailable or inaccessible covered services to members;
- Inappropriate withholding or delay of covered services;
- Improper interference with health care professionals' advice to members regarding member's health status, medical care and treatment;
- Non-credentialed physicians or unlicensed/certified practitioners and providers;
- Discrimination on the basis of race, color, national origin, sex, age, religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identify or sexual orientation.

B**.** Data Collection and Submission**:**

- Noncompliance with contractual and regulatory requirements related to the accurate, complete, timely and truthful submission of data (e.g., encounters data, claims data, financial reports and other required operational reports).

C. Member Grievance and Appeal Procedures:

- Failure to ensure that members are properly notified of their grievance and appeal rights;
- Failure to respond and resolve member grievances and appeals within the required timeframes.

D. Emergency Services:

- Improper use of prior authorization for emergency services;
- Denial of payment for emergency services based on contractual standards, including the "prudent layperson" standard;
- Unavailable or inaccessible emergency services within the Plan's service area.

E. Kickbacks and Other Inducements:

- Willful offer, payment, solicitation or receipt of remuneration to induce the referral of business reimbursable under the Medi-Cal program;
- Inappropriate incentives or remuneration to enrollees to induce them to use a particular practitioner, provider, or supplier.

F. False Claims:

- False or fraudulent claims knowingly presented for payment or approval;
- False records or statements material to a false or fraudulent claim knowingly made, used, or caused to be made or used.

G. Confidentiality:

- Unauthorized use and or disclosure of a member's or an employee's personal information (PI) or protected health information (PHI);
- Improper disclosure of protected peer review information.

H. Excluded Providers:

- Contractual or employment relationships with persons or entities which are suspended, excluded or otherwise not eligible to participate in federal or state health care programs;
- Improper reimbursement for items or services furnished, ordered, prescribed, or supplied by an excluded person or entity;
- Failure to take appropriate corrective action upon subsequently learning of a person's or entity's excluded status.

I. Member Dis-Enrollment:

- Improper action to request or encourage an individual to dis-enroll from any health plan.

J. Marketing

- Improper or misleading marketing materials

VI. COMPLIANCE PROGRAM ELEMENTS

A. POLICIES AND PROCEDURES

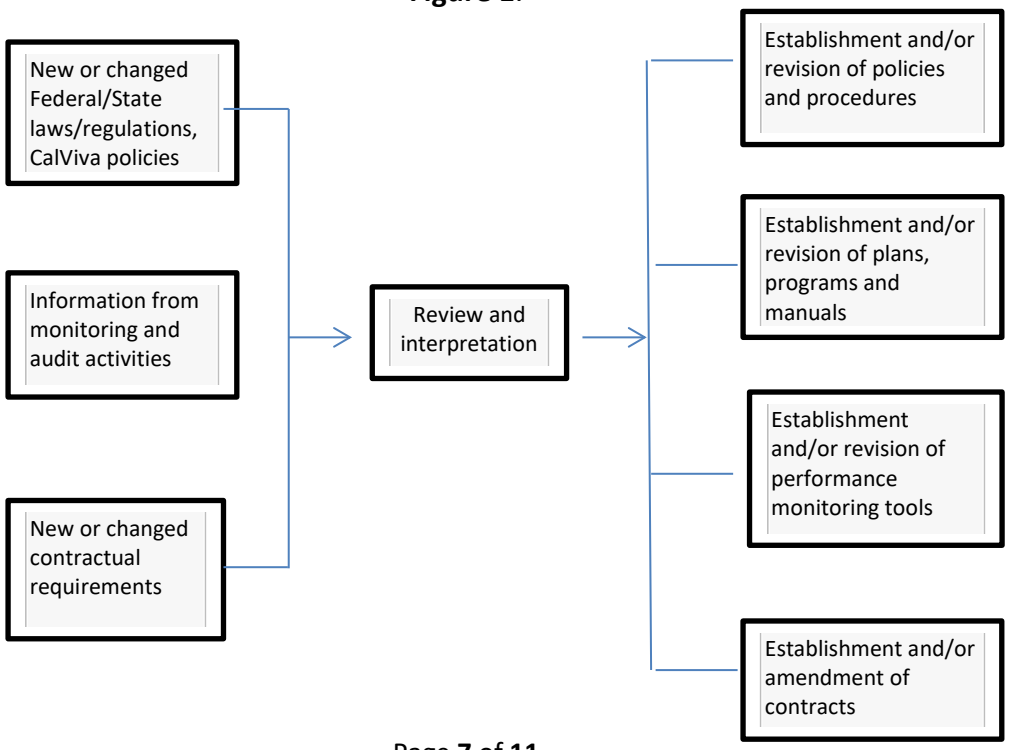
Prevention is the cornerstone to CalViva's Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from the Operations, Medical Management, and Finance Departments. CalViva's Compliance Committee or other Plan Committees, as applicable, meet regularly to review and approve proposed changes to CalViva's Policies and Procedures. CalViva maintains an on-line library of policies and procedures. Although it contains many policies, Table 2 lists those key policy topics that underpin the majority of CalViva's risk management approach and compliance methodologies. Two fundamental Compliance Program plans, the "Privacy and Security Plan" and the "Anti-Fraud Plan", are reviewed annually by the Commission and provide detailed plan requirements and activities.

Table 2. Key Compliance-Related Policy Topics

Code of Conduct	**Quality Improvement**
Conflict of Interest	**Utilization Management**
Privacy and Security	**Credentialing**
Anti-Fraud	**Peer Review**
Appeals and Grievances	**Delegation Oversight**
Claims	**Provider Disputes**

Figure 1 shows the factors that may precipitate changes in various policies, procedures, and ancillary documents.

Figure 1.



B. MONITORING

The Compliance Program incorporates periodic monitoring and auditing of its subcontractors. Mechanisms such as delegation oversight audits, case file audits, and periodic review of operational metrics are employed. Additionally, CalViva conducts joint operational and management meetings with subcontractors. Table 3 presents some of the key activities that are monitored and reported on a periodic basis (e.g., monthly, quarterly, annually).

Table 3. Activities Monitored by CalViva

Provider Network Contracting and Updating	Member Appeals and Grievances	Practitioner and Provider Credentialing
Provider Access	Facility Site Reviews & Medical Record Reviews	Encounter Data
Member Rights and Services	Cultural and Linguistic services	Claims Payment
Marketing	Provider Grievances and Disputes	Utilization Management & Case Management
Health Education	Mental Health & Behavioral Health Services	Quality Improvement
Pharmaceutical Services	Provider Training	Continuity of Care

When monitoring indicates problems, an appropriate Corrective Action Plan (CAP) is implemented to ensure issues are communicated and resolved.

C. EDUCATION AND TRAINING

The Compliance Department provides continuous training and education of its employees on their legal and ethical obligations under applicable laws, regulations and organizational policies. For example, upon completion of new hire training and annually thereafter, all employees must sign a certification statement acknowledging that they have read and understood the documents listed in Table 4.

Table 4. Program Documents

Compliance Program Description	Code of Conduct	Conflict of Interest	Anti-Fraud Plan
Privacy and Security Plan	Confidentiality Agreement	Drug and Alcohol Policy	

Contracted consultants also receive copies of the Compliance Program, Anti-Fraud Plan, Privacy and Security Plan, and Code of Conduct. They must sign a certification statement acknowledging that they have read and understand the documents.

Employees also receive training on the proper execution of key work processes. CalViva regularly reviews and updates its training programs as well as identifies additional areas of training as needed based on new developments. Information regarding these developments and their implications are also communicated to and from CalViva's contractors as applicable.

Additionally, CalViva's CCO, Management, and individual staff members receive additional education and training as needed through professional associations, webinars and regulatory agency meetings related to federal and state requirements and compliance.

D. Reporting Noncompliance

Fundamental to the effectiveness of CalViva's Compliance Program is the concept of nonretaliation. All persons associated with CalViva, including its Commission members, Committees, employees, subcontractors, consultants, and vendors are free to come forward and report suspected noncompliance with the Code of Conduct, Program Documents, CalViva policy and procedures, and state and federal regulations without fear of retaliation or retribution. The following types of noncompliance are of particular concern for expeditious reporting and corrective action:

1. **Criminal and Civil Violations of Law**: CalViva conducts fact-finding activities, and reports to the proper authorities for further investigation and action, all credible, suspected occurrences of fraud, waste, abuse, kickbacks, and unauthorized uses and disclosures of protected information, including PHI.

2. **Contractual Violations**: As outlined in the "Scope of Work" section of CalViva's contract with DHCS (and occasionally as issued in DHCS "All Plan Letters"), CalViva must submit a broad range of Plan data and information to DHCS and DMHC (e.g., encounter data, grievances /appeals, provider network, timely access, etc.). Many of these reports are submitted in agency-specified formats by each Department's stated due date. Additionally, CalViva must also respond to DMHC and DHCS as it relates to members' requests for Independent Medical Reviews (IMRs) and State Hearings (SHs) by each Department's due date. Failure to comply in a timely manner to these agency's requests may result in CalViva receiving an Enforcement Action.

3. **Other Misconduct**: Those behaviors that do not comport with the general principles outlined in the Code of Conduct of treating other employees, subcontractors, providers, and Plan members with honesty, dignity, respect and courtesy.

E. Response and Corrective Action

Noncompliance with, and violation of, state and federal regulations can threaten

CalViva's status as a reliable and trustworthy provider capable of participating in federal health care programs. Accordingly, CalViva in cooperation with subcontractors and regulators, will make all reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violations occurs. Depending on the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If any consultant or subcontractor is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination of CalViva's contract with the consultant or subcontractor.

VII. SUMMARY

CalViva's Compliance Program employs a comprehensive approach to ensuring its business operations are in compliance with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, including those specifically related to the Medi-Cal program. Moreover, CalViva maintains an on-going commitment to ensure that the Compliance Program remains relevant and vigilant to the requirements of a constantly evolving and regulated managed health care system.

VIII. AUTHORITY

1. Knox-Keene Health Care Service Plan Act of 1975 and its amendments (California Health and Safety Code)
2. Title 28 of the California Code of Regulations
3. Title 22 of the California Code of Regulations
4. California Welfare and Institutions Codes
5. 42 CFR 438 (Managed Care)
6. 45 CFR 160, 162, and 164 (HIPAA Privacy & Security Rules)
7. 45 CFR 92 (Anti-Discrimination)
8. California Information Practices Act of 1977 (IPA)
9. The California Confidentiality of Medical Information Act (CMIA)
10. CalViva-DHCS Medi-Cal Contract (Including all amendments)
11. Federal Sentencing Guidelines Manual: Chapter 8, §8B2.1. Effective Compliance and Ethics Program

IX. Program Documents

1. Code of Conduct
2. Anti-Fraud Plan
3. Privacy and Security Plan
4. CalViva Policies & Procedures

X. APPROVAL

	_____	_____
Name:	Mary Beth Corrado	Date
Title:	Chief Compliance Officer	
	_____	_____
Name:	Gregory Hund	Date
Title:	Chief Executive Officer	
	_____	_____
Name:	David S. Hodge, M.D.	Date
Title:	Chair, RHA Commission	

DOCUMENT HISTORY	
Date	**Comments**
03/01/2011	New Program Description
02/09/2012	Annual Update of Program Description
01/17/2013	Annual Update of Program Description
02/06/2014	Annual Review: Changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
01/26/2015	Annual Review: Changes to clarify monitoring and auditing activities
02/08/2016	Annual Review, added reference document
02/02/2017	Annual Review: Program Description is replaced in its entirety. Overall content is the same; reduced duplication with other program plans, formatting, editorial and organizational enhancements to all sections.
2/1/2018	Annual Review: Deleted "Privacy & Security Officer" from the CCO's responsibilities. CalViva's COO will now serve as the "Privacy & Security Officer", and this is reflected in the Privacy and Security Plan.
01/07/19	Annual Review: No changes.
01/21/20	Added additional Discrimination language to V. Compliance Risk areas, Section A.
2/18/21	Annual Review: Edited IV, D.(3.) to reflect current practice of preparing the annual Compliance Program Evaluation.

Item #12

Attachment 12.A

2021 Code of Conduct

Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

Mary Beth Corrado
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

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I. CalViva Health Overview:

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

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

II. Purpose:

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

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

III. Elements:

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

1. Member Services and Rights:

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Provider/Vendor Relations and Contracts:

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

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

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

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

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

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

4. For services that are not reasonable and necessary.

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

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

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

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

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

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

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

3. Business Operations and Accounting:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

O. CalViva Health prohibits the solicitation or acceptance of gifts, gratuities, favors or other benefits from persons or entities that do business with CalViva Health. Notwithstanding the foregoing, acceptance of common business hospitality, such as occasional meals, entertainment or nominal gifts with a value of $50.00 or less, are not considered a violation of this paragraph.

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

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

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

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

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

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

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

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

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

4. Medical Records:

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

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

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

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

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

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

C. CalViva Health retains records in accordance with a written policy which

incorporates Medicaid and all federal, state and local regulatory guidelines.

5. Medical Management and Claims:

A. CalViva Health monitors the claims submitted by providers to ensure honest, fair and accurate claim practices. All entities providing claims functions on behalf of CalViva Health are required to demonstrate experience and knowledge in performing such functions in accordance with federal, state and local law.

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

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

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

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

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

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

6. Employee Relations:

A. CalViva Health encourages all employees and contractors to respect the rights and

cultural differences of other individuals.

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

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

7. Avoiding Potential Conflict of Interest or Retribution

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

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

APPROVAL:

_____ Date: _____
Name: Mary Beth Corrado
Title: Chief Compliance Officer

_____ Date: _____
Name: Greg Hund
Title: Chief Executive Officer

_____ Date: _____
Name: David S. Hodge
Title: RHA Commission Chairperson

Item #13

Attachment 13.A

2021 Anti-Fraud Plan

ANTI-FRAUD PLAN

For inquiries regarding this Anti-Fraud Plan, please contact:

Mary Beth Corrado
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mbcorrado@calvivahealth.org
Phone: 559-540-7847

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RHA has an Administrative Services Agreement ("ASA") with Health Net Community Solutions ("Health Net") to provide certain administrative services on the Plan's behalf. RHA also has a Capitated Provider Services Agreement ("CPSA") with Health Net for the provision of health care services to CalViva Health members through Health Net's network of contracted providers. Health Net is contracted to provide a broad range of administrative and operational services on CalViva Health's behalf, including but not limited to: enrollment processing, provider contracting and credentialing, utilization management, claims processing, member and provider services and maintaining the systems for most CalViva Health operations.

Under the term of the ASA and CPSA, Health Net is responsible for fraud and abuse investigations related to potential fraud cases involving CalViva Health members, providers, Health Net employees and subcontractors performing functions on behalf of CalViva Health. CalViva Health maintains overall responsibility for anti-fraud and abuse activities, and performs oversight and monitoring of Health Net and their Special Investigations Unit ("SIU"). The Plan also retains responsibility for investigating and addressing any potential incidents of fraud and abuse involving CalViva Health employees and consultants.

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

1. Statement of Purpose:

The purpose of the RHA/CalViva Health ("CalViva" or the "Plan") Anti-Fraud Plan is to organize and implement an anti-fraud strategy to identify and reduce costs to the Plan, providers, members, and others caused by fraudulent and abusive activities, and to protect members and the public in the delivery of health care services through the timely

detection, investigation, and prosecution of suspected fraud. Through the Anti-Fraud Plan, CalViva also seeks to prevent violations of the Federal False Claims Act, as codified in Section 3729 of Title 31 of the United States Code. The Plan's Anti-Fraud Program will also comply with the federal Medicaid managed care requirements in 42 CFR 438.608, Health & Safety Code Section 1348 and the Department of Health Care Services Medi-Cal Contract requirements in Exhibit E, Attachment 2, Provision 26.

2. Definitions:

A. **Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2; W&I Code Section14043.1(i).)

Health care fraud is a crime. Any person convicted of health care fraud faces imprisonment and substantial fines. Health care fraud could be committed by dishonest health care providers such as doctors, laboratories, medical equipment suppliers, by health plan members, Plan staff, and Plan subcontractors.

Some examples of fraud include:

1. Billing for services or supplies not provided
2. Altering or falsifying claims
3. Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary
4. Using another person's Medi-Cal card to obtain medical care

See Appendix A for a more extensive set of examples.

B. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Some examples of abuse include:

1. Excessive charges for services or supplies
2. Overutilization/underutilization of medical or health care services

C. **Waste** means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit (42 CFR 455.2).

II. Scope of Anti-Fraud Plan:

In an effort to assure public accountability, conduct proper business practices, and operate within the limited resources of the Medi-Cal program, CalViva/delegated organizations will investigate and pursue prosecution of fraudulent activity by providers, enrollees, employees, and other individuals or entities. CalViva/delegated organizations also cooperate with local, state and federal authorities whenever appropriate.

The Anti-Fraud Plan is part of CalViva's comprehensive Compliance program and includes the following:

A. the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations;
B. training of plan personnel and contractors concerning the detection of health care fraud;
C. the plan's procedure for managing incidents of suspected fraud; and
D. the internal procedure for referring suspected fraud to the appropriate government agency.

1. Responsibilities for Anti-Fraud Plan:

The RHA Commission has ultimate responsibility for this Anti-Fraud Plan. The Anti-Fraud Plan will be submitted to the Commission for annual approval. An annual report will be made to the Commission regarding the Plan's Anti-Fraud activities, subject to any confidentiality protections which may be required.

The implementation of the Anti-Fraud Plan will be the responsibility of the Chief Compliance Officer ("CCO"), under the supervision of the Chief Executive Officer ("CEO"). The CEO will make certain that sufficient resources are in place to properly implement the Anti-Fraud Plan. The CCO will be responsible for overseeing any investigation or necessary corrective action, except as otherwise provided in this Plan.

The CCO will serve as the Anti-Fraud Officer and have the following duties:

1. Receive information (formal and informal) on cases of suspected fraud
2. Provide oversight of activities and investigations carried out on CalViva's behalf by Health Net and other delegated entities.
3. Receive information from Health Net and other delegated entities on cases of suspected fraud and abuse related to CalViva and investigated by the delegated entities' SIU.
4. Provide oversight and receive information from delegated organizations on cases of suspected fraud and abuse related to CalViva

5. Report to the CEO on suspected cases of fraud, plan of investigation, timelines, and resources required
6. Maintain logs to assure timely investigations and reporting
7. Review and approve training and other anti-fraud materials sent to participating providers on CalViva's behalf.
8. When directed by the CEO or legal counsel, make referrals to appropriate law enforcement agencies

2. General Anti-Fraud Oversight Mechanisms:

The general oversight mechanisms of the Plan's Anti-Fraud program include the following:

1. CalViva Health will conduct background checks on all employees, which includes staff designated to handle funds and prepare financial statements.
2. Policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program.
3. Development and implementation of corrective actions addressing fraud and abuse issues as appropriate.
4. Ongoing monitoring and oversight by the CalViva Compliance Committee.
5. Provide contracted providers with anti-fraud information including how to report suspected fraud incidents.
6. Provide members with information on how to report suspected fraud incidents such as in the CalViva Health EOC/Member Handbook.
7. Investigate cases of suspected fraud with the most appropriate internal or external resources, appropriate to the problem.
8. Assure that conflicts of interest are not present in the investigation of suspected fraud cases.
9. Ensure that findings from independent audits and regulatory audits and surveys are followed up promptly by both the Plan as well as the subcontractors who may be cited; and identify any recurring trends.
10. Monitor member and provider issues, tracking and trending types of grievances and settings; and implementing corrective action when necessary.
11. Perform an annual file audit of a sample of contracted providers credentialed by Health Net and their delegated entities which have delegated credentialing responsibilities.
12. Monitor and review fraud cases/issues reported by delegated organizations.

13. Conduct formal and informal ongoing monitoring of the administrative services contracted to Health Net and delegated entities~~,~~ through the review of performance reports, ~~and~~ annual audits, and quarterly member service verification reports; and developing corrective action plans, when appropriate.
14. Review the Anti-Fraud Plan annually and, if revised, maintain documentation that approval has been received from the Department of Managed Health Care (DMHC).
15. Review Health Net's annual anti-fraud report to the DMHC.
16. Assure that Medicaid/Medi-Cal or Medicare terminated or suspended providers do not receive program funds.

3. Procedures for Investigating Suspected Fraud:

Processes used to investigate suspected cases of fraud are described in CalViva's policies and procedures.

1. The procedure for undertaking an investigation includes:
    A. A review of all identified related documents;
    B. Consultation, if necessary, with internal or external resources with knowledge of applicable law, regulations or policies, procedures or standards; and
    C. Interviews with persons with knowledge of the alleged activity.
2. A description of the investigation process is included in Plan policies and procedures. The policies and procedures are reviewed annually and revised as needed.
3. The Compliance Committee reviews reports of fraud, waste and abuse cases investigated and any corrective actions implemented.
4. All cases of suspected fraud, waste and/or abuse where there is reason to believe that an incident of fraud, waste and/or abuse has occurred by subcontractors, members, providers, or employees will be reported to the DHCS.
5. In addition, in situations where fraud is confirmed, disciplinary action may be taken and reports to appropriate third parties may be made, including the following:
    A. For employees, incidents may be grounds for immediate dismissal, and, if appropriate, referral to law enforcement agencies.
    B. For contracted providers, disciplinary action may include terminating any contracted relationship between the Plan and the provider or, in the case of a group or institutional provider, removal of the provider's subcontractor or employee from providing services with respect to CalViva members.
    C. For Medi-Cal members, disciplinary action will include referral to the Department of Health Care Services and, if appropriate, the

initiation of procedures to disenroll the member from CalViva, according to provisions of the Medi-Cal managed care contract.

6. Appropriate local, State or Federal authorities will be notified as necessary.
7. A summary report of cases and outcomes is provided quarterly to the Compliance Committee and summary reports are included in the regular compliance reports to the RHA Commission.
8. To prevent repeat offenses, the CCO, and if applicable, in consultation with Health Net, may create new policies, procedures and employee training programs to address new issues regarding the Anti-Fraud Plan's implementation as they arise.

4. Use of External Resources for Special Investigations:

The following external resources are utilized by the Plan:

1. CalViva Employee, Consultant and Contractor Investigations - CalViva has retained Epperson Law Group, PC to provide its General Counsel services. The law firm has municipal and litigation attorneys experienced in matters involving public agency ethics rules, restrictions on self-dealing, and prohibited financial transactions. Cases involving alleged fraud and improprieties by CalViva employees, officers, directors, consultants or contractors will be referred to Epperson Law Group, PC for investigation as needed.
2. CalViva Member and Provider Investigations - As described in Section I, *CalViva Health Overview*, in accordance with the ASA and CPSA between CalViva and Health Net, the Special Investigations Unit (SIU) for Health Net performs fraud and abuse investigations (i.e. prepay reviews; retrospective reviews, etc.) related to potential fraud cases involving CalViva members or providers. Health Net also conducts routine reviews of provider's billing/coding practices to ensure compliance with state and federal regulations. In addition, Health Net will review claim reports to ensure that codes and practices used in billing are correct and that the Plan has paid health care providers appropriately. The SIU team has a diverse range of qualifications that stem from the legal, healthcare, loss prevention, law enforcement, medical and other experience/educational backgrounds. Several members of the team are also credentialed as Accredited Health Care Fraud Investigators ("AHFI"), Certified Professional Coders ("CPC"), and Certified Fraud Examiners ("CFE").

5. Additional Internal and External Resources:

Other internal and external investigative resources available to the Plan include the following:

1. The Plan's Chief Medical Officer, Chief Financial Officer, Chief Operating officer ("COO") other Plan staff.

2. The Plan's independent financial audit firm
3. DHCS audits and surveys
4. DMHC audits and surveys

6. Freedom from Retaliation and Avoiding Conflicts of Interest:

CalViva will promote an environment free from retaliation or threats of retaliation against individuals who report suspected fraud. The Plan will comply with Section 3730(h) of Title 31 of the United States Code, which prohibits employer discrimination against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the False Claims Act. In training sessions with employees regarding the Plan's anti-fraud efforts, employees will be informed that there is no retaliation against employees for reporting fraudulent activities. Employees are also notified in writing of the procedures for reporting potentially fraudulent activities, ~~including~~ and that there is no retaliation against individuals for reporting ~~potential fraudulent~~ those activities. If the reporting party still has concerns about retribution, the reporting party may choose to remain anonymous.

If the CEO, CCO, or member of the RHA Commission has a conflict of interest regarding an incident of suspected fraud, the individual must report the conflict of interest to the Chairperson of the RHA Commission, and disassociate him/herself from the relevant investigation. If appropriate, the investigation will be referred to outside counsel for investigation.

7. Referrals to or from Appropriate Outside Agencies:

Depending on the nature of fraud cases, CalViva may receive notices directly from the DHCS or will refer cases to the appropriate regulatory authority.

1. Fraud, Waste and Abuse Reporting to DHCS - CalViva will comply with the DHCS contractual requirements for prompt referral of any potential Fraud, Waste, or Abuse that the Plan identifies to the DHCS Audits and Investigations Intake Unit. The Plan shall conduct, complete, and promptly report to DHCS, the results of a substantiated preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.

   On CalViva's behalf, the Health Net SIU will conduct an investigation and provide the Plan with a report of the results. CalViva retains the discretion to determine if potential fraud and abuse claims are reportable to DHCS. The Plan's CCO will review the report with other Plan executives as appropriate to determine if the results involve a matter of suspected Fraud, Waste or Abuse. The CCO or designated Compliance staff will submit reports of suspected

Fraud, Waste or Abuse to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. The report will be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;
b. E-fax at (916) 440-5287; or
c. U.S. Mail at:
Department of Health Care Services
Audits & Investigations Division
Attention: Chief, Intake Unit
1500 Capitol Avenue
MS 2500
Sacramento, CA 95814

2. Receipts of a Credible Allegation from DHCS - CalViva may be notified by DHCS when there has been a credible allegation of fraud against a provider that is part of the Plan's provider network. In these cases, CalViva must take one or more of the following four actions and submit all supporting documentation to the PIUCases@DHCS.ca.gov inbox:

a. Terminate the provider from its network
b. Temporarily suspend the provider from its network pending resolution of the fraud allegation
c. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
d. Conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

3. Removed, Suspended, Excluded, or Terminated Provider Report - CalViva/delegated organizations are prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. CalViva/delegated organizations will check the list of suspended and ineligible providers maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). CalViva/delegated organizations are deemed to have knowledge of any providers on these lists. CalViva will notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A

removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a. Email at PIUCases@DHCS.ca.gov;
b. E-fax at (916) 440-5287; or
c. U.S. Mail at:
Department of Health Care Services
~~Medi-Cal~~ Managed Care Operations Division
Attention: Chief, Program Integrity Unit
MS 4417
P.O. Box 997413
Sacramento, CA 95899-7413

4. Referrals to Other Regulatory Authorities - If the occurrence of fraudulent activity is highly suspected or confirmed, CalViva may refer cases to the appropriate local, state or federal authority for prosecution of health care fraud committed by enrollees, providers, agents, company employees and other individuals. Such referrals include but are not limited to:
    a. Local police departments,
    b. U.S. Postal Inspector,
    c. Federal Bureau of Investigation,
    d. Office of the Inspector General of the U.S. Department of Health and Human Services,
    e. Internal Revenue Service
    f. Local departments of Public Health in Fresno, Kings, or Madera counties,
    g. DMHC,
    h. Centers for Medicare and Medicaid Services,
    i. State medical licensing and disciplinary boards or
    j. Any other appropriate authorities or agencies.

5. Prosecution - In the event of fraud, the CEO or the RHA Commission will evaluate the appropriateness of pursuing civil prosecution. The Plan will consult with legal counsel, as described in section II.4.1.

8. Staff Training and Education:

CalViva recognizes that the most effective way to combat fraud is to increase staff awareness through education. The Plan is therefore committed to assuring the education and training of its staff, the staff of its administrative contractor, and providers on fraud and fraud prevention.

The CEO and CCO, in consultation with the RHA Commission, and other executive

staff as applicable, will develop a strategic approach to educating CalViva and its community about fraudulent activities that occur in health care environments. CalViva will work closely with Health Net to assure that appropriate fraud prevention strategies are in place and that staff are trained and educated to detect, deter, and refer instances of suspected fraud to the appropriate levels of the organization.

1. CalViva will provide information regarding the detection, prevention and investigation of fraudulent activity to all new staff during initial employment orientation. Employees will also be notified in writing of the procedures for reporting fraud and that there is no retribution taken against individuals reporting fraud.

2. An annual training session will be required for all CalViva staff. External experts for training will be consulted, as necessary, to augment and implement the training program.

9. Public Awareness:

CalViva members and their families are the ultimate victims of any fraud activity occurring within the Plan. It is therefore essential for them to be aware of activities that may constitute fraud and to have avenues to report suspected fraudulent activities in order to assist with the prevention and cessation of such activities. Information is included in the Member Handbook/Evidence of Coverage and articles regarding health care fraud and CalViva's efforts to prevent fraud will be sent out in periodic newsletters to members.

The Plan will publicize a fraud reporting telephone number. Potential fraud, waste and abuse incidents may be reported directly to CalViva via one of the following methods:

Toll-free Phone: 1-866-863-2465
Fax: 559-446-1998
Mail: Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
Email: fraudtips@calvivahealth.org

CalViva is sensitive to providing a quick response to any member service concerns that may arise for health plan members. Plan employees will convey any complaints, grievances and/or customer service concerns to the CCO, its administrative subcontractor, Health Net, or, if necessary, to the appropriate regulatory or law enforcement agency.

Concerns expressed are documented and investigation is initiated immediately. If appropriate, within 30 days, a letter is sent out to the originator to acknowledge receipt of the concern and to provide a brief status update.

Medi-Cal anti-fraud information resources are also available on the Department of Health Care Services website: dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

The Medi-Cal Program has a hotline maintained by the Department of Health Care Services: Medi-Cal Fraud Hotline: 1-800-822-6222

10. Participating Health Care Providers:

The Plan contracts with health care provider organizations, Health Net and may contract with other delegated organizations to provide services to CalViva members through their network of health care providers. These provider networks include but are not limited to: primary care providers, medical specialists, mental health specialists, acute care hospitals, skilled nursing facilities, clinical laboratories, pharmacies and other ancillary providers. Providers are given information about fraud prevention, how to report suspected fraud or abuse incidents, and how the Plan and/or contracted organizations respond to fraudulent activity.

11. Location:

The address for the CEO, the CCO, and the Chairperson of the RHA Commission is:

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

12. Annual Report to the Department of Managed Health Care:

In compliance with California Health & Safety Code Section 1348, CalViva will file with the Department of Managed Health Care a written annual report regarding the Plan's anti-fraud activities, including, but not limited to:

1. CalViva's efforts to deter, detect and investigate fraud, and report cases of fraud to law enforcement agencies.
2. Of the cases reported to law enforcement agencies, a listing of the number of cases prosecuted and the status of prosecution if known.
3. Recommendations to further improve and refine the Plan's Anti-Fraud Plan.

Authority

- DHCS Contract, Exhibit E, Attachment 2, Provision 26
- Health & Safety Code Section 1348
- Code of Federal Regulations, 42 CFR 438.608, 42 CFR 438.610 and 42 CFR 455.2
- United States Code, 31 U.S.C. Section 3729 and 42 USC Section 1396a(a)(68)
- Welfare & Institutions Code Section 14043.1(a) and (i), and Section 14115.75
- DHCS All Plan Letters 08-007, 15-026, 16-001

References

- CalViva Health Compliance Plan
- CalViva Health Policies and Procedures

APPENDIX A

Types of Fraudulent Acts and Examples/Indicators of Potential Fraud (Adapted from National Health Care Anti-Fraud Association publications)

I. Types of Fraudulent Acts

It is virtually impossible to itemize every conceivable health care fraud; any opportunity to bill for services is an opportunity to commit health care fraud and every fraud scheme has its own unique characteristics. Most health care frauds, however, fall into one or more broad categories of activity, including the outright fabrication of claims and the falsification of claims.

A. Fabrication of Claims

In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or adds to otherwise legitimate claims fictitious charges for treatments or services that were never provided. Some examples of such fabrication are:

1. An individual provider who, using existing information on his/her patients creates claims for office visits or treatments that never took place.
2. A provider who, in the case of billing for patient treatments, adds charges for x-rays or lab tests that were never performed.
3. A contracted service provider/institution bills for services that were ordered but did not occur due to unforeseen circumstances (patient refused or was unable to make the appointment).

B. Falsification of Claims

In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more element(s) of information in a claim for the purpose of obtaining, a payment (or a higher payment) to which he/she is not entitled. Examples of outright falsifications include:

1. Falsifying patients' symptoms or diagnosis and/or the procedures performed as a pretext for obtaining payment for otherwise non-covered services (i.e.: alternative therapies; elective cosmetic surgeries etc.) and/or performing medically unnecessary services solely in order to submit claims and be paid.
2. Falsifying the dates on which service was provided so as to fall within a given coverage period.

3. Falsifying the identity of the provider of the service in an attempt to obtain payment for services rendered by a non-covered and/or non-licensed provider (i.e.: billing for massages as licensed physical therapy or counseling by a Social Worker as psychiatric treatment).
4. "Upcoding" or falsifying the nature of services provided to obtain a higher rate on payment (i.e.: filling a prescription with the generic equivalent but billing for the higher-priced brand-name drug).
5. "Unbundling" or deliberately billing separately for the various elements of a given medical procedure to which one all-encompassing billing code applies, so as to obtain a higher aggregate payment.

II. Examples of Indicators of Potential Fraud

Indicators of potential claims fraud are as varied as they are numerous, ranging from the obvious to more subtle signs. Visibly discernible alterations or handwriting anomalies on a given claim are examples of an obvious indicator. A subtler indicator would be an inconsistency of diagnosis and treatment or an unusually high incidence of a given condition among a provider's patients.

Deciding what factors represent indicators of potential fraud is a subjective matter that varies widely. There is no formulaic or universal set of such indicators. The presence of one or more indicators in and of itself does not necessarily signify fraud, it merely serves to call attention to a claim or situation that is out of the ordinary and therefore requires further review.

The following examples illustrate some of the signs that might represent indicators of potential fraud on the part of a dishonest provider, a provider employee and/or a dishonest claimant:

1. Misspelled medical terminology on claim.
2. Similarity of patient/provider handwriting.
3. Apparent alteration of dates, amounts and/or other claim information.
4. Claims for non-emergency services dated Sundays or holidays.
5. Inconsistency between treatment billed and patient's diagnosis, age, gender etc.
6. Inconsistency between provider type and treatment billed.
7. Inconsistency between patient diagnosis and prescription billed.
8. Inconsistency between patient's medical history and treatment billed.
9. Consistent submission of photocopied claims.
10. Provider's lack of support documentation for claim selected for audit.
11. High-dollar claim for service dated either soon after effective date of coverage or just before the termination of coverage.
12. Unusual time lapse between date of service and date claim submitted.
13. Anonymous and/or persistent telephone inquiries re: status of claims.
14. Undue pressure to pay claims quickly.
15. Payments to P.O. Box not under provider or claimant name.

~~15.~~16. Any confirmed cases based on Service Verification (SV) member reporting.

APPENDIX B

CalViva Health Referral Form for Incident of Suspected Fraud

Please Note: CalViva Health will not discriminate against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the Federal or California False Claims Act, including an investigation for, initiation of, testimony for, or assistance in such an action.

Name: _____ Contact Phone: _____

Department: _____

Please indicate here if you wish to remain anonymous: _ Yes, I wish to remain anonymous

Case Type: __ Provider __ Member __ Employee ___ Subcontractor ____Other ____

INFORMATION ABOUT THE SUSPECTED INDIVIDUAL/ENTITY

Name of Individual or Provider or Other: _____

Address: _____

Phone: _____

Other Identifying Information (Member ID Number, Date of Service, etc.) _____

Please describe how you were informed of the incident: _____

_____

_____

Please provide a description of the suspect incident: _____

_____

_____

_____

_____

Signed: _____ Date: _____

The completed form should be put in an envelope marked "Confidential, for CalViva Health Chief Compliance Officer and submitted to CalViva Health, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711

APPROVAL:

_____ **Date:** _____

Name: Mary Beth Corrado
Title: Chief Compliance Officer

_____ **Date:** _____

Name: Gregory Hund
Title: Chief Executive Officer

_____ **Date:** _____

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Program Description History		
Date	**Section #**	**Comment(s)**
3/1/2011		New Program Description
4/30/2012	Replaces former version	Annual review; changes to clarify and reflect current activity
1/7/2013	various	Annual review, clarified descriptions of activities
6/7/13	Cover page, sections 8 & 9	Changes to address DMHC requirements
2/6/14	Various	Annual review, changes to clarify current contractual relationships and activities
1-26-15	Sections 5, 6, 7, 8, 11, 13 and 15	Annual review, changes to update General Counsel information, clarify several sections to better reflect current activities and correct typographical errors
2-18-16	Section 11 and office address throughout	Updated office address and phone numbers and added information from APL15-026

2-17-17	Various	Clarified the overview and operational structure of CalViva Health. Removed reference to Optum as Health Net no longer uses Optum in their SIU activity.
2-15-18	Various	Annual Review, minor grammatical changes and added a reference to the COO and Operations Department staff.
01/07/19	Section II 7.	Inserted PIU e-mail address.
2-20-20	Overview; Sections II.4.1; II.7, 1 & 4	Clarified contractual relationships related to anti-fraud activity; updated external resources information; added revisions to reflect new requirements specified in DHCS–CalViva Contract (10-87050 A12) and made other minor editorial changes (grammar, regulatory citations, clarification to reflect current activities, etc.).
7/8/20	Section II # 9	Updated the DHCS website URL. Deleted an obsolete DHCS URL.
2/18/21	Sections II, 2 (6. and 13.); Section II, 6; Section II, 7 (1. and 3) and Appendix A. II (#16.)	Section II, 2 (6. and 13.) added reference to EOC, and new Service Verification (SV) language; Section II, 7(1.) deleted typo and added "Promptly" reported and "Substantiated" preliminary to paragraph. Section II, 7(3.) added correct department name for mailing, "Managed Care Operations Division." Appendix A, #16 added reference to Service Verification (SV) reporting.

Item #14

Attachment 14.A

2021 Privacy and Security Plan

PRIVACY AND SECURITY PLAN

For inquiries regarding this Privacy and Security Plan, please contact:

Jeffrey Nkansah
Chief Operating Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
jnkansah@calvivahealth.org
Phone: 559-540-7850

Table of Contents

I. **CalViva Health Overview**

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

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

All of the processes and activities performed by contracted or delegated entities on CalViva Health's behalf are performed in compliance with CalViva Health's Privacy and Security Plan described in the following pages. These entities agree to the same restrictions and conditions that apply to CalViva Health with respect to Protected Health Information (PHI) and applicable provisions governing the use of PHI are incorporated into CalViva Health's service and/or business associate agreements with contracted or delegated entities.

1. **Statement of Purpose**:

The purpose of CalViva Health's Privacy and Security Plan is to safeguard the Confidentiality of personal information (PI) and Protected Health Information (PHI) while not impeding the exchange of information needed to provide quality health care treatment, payment and operations. To that end, CalViva Health develops and implements policies and procedures designed to enable compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the American Recovery and Reinvestment Act (ARRA) California's Information Practices Act of 1977 (IPA) and Confidentiality of Medical Information Act (CMIA). CalViva Health is committed to creating a culture that effectively encourages its employees and associates to comply with applicable laws, regulations and policies related to privacy of health information and to perform work duties with a conscious regard for the privacy rights of its members.

CalViva Health ensures that member health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

Everyone has a responsibility for monitoring and reporting any activity that appears toviolate this program or the supporting policies and procedures. Failure to follow the Privacy and Security Plan and related policies and procedures are grounds for appropriate discipline, which may include immediate termination.

2. **Confidentiality Guideline:**

CalViva Health and its business associates have adopted a strict guideline regarding the Confidentiality of certain information provided to CalViva Health employees and business associates. This guideline applies to all CalViva Health employees/business associates:

All employees/associates are prohibited from any unauthorized access to, use or Disclosure of patient ("Member") Protected Health Information (PHI), health care provider confidential information, or CalViva Health proprietary information. This includes, but is not limited to: medical records, claims, benefits or other administrative data that is personally identifiable, CalViva Health compliance program cases, peer review cases, quality improvement and utilization management programs, reports and disease management information containing PHI (hereinafter, collectively referred to as "Confidential Information").

Employees/associates must hold in strict confidence, and not copy, disclose or permit the Disclosure to any person of any PHI or Confidential Information disclosed or delivered to him/her by CalViva Health or any provider except that which is allowable based on employee job role, by regulation, or by contractual and business associate agreements.
Employees/associates must comply with all CalViva Health policies and procedures concerning the maintenance of all Confidential Information made known to him/her as a CalViva Health employee/associate.

Employees must comply with all applicable state and federal laws and regulations regarding the Confidential Information. CalViva Health limits access to CalViva Health employee data to a subset of employees who are permitted the use and Disclosure of other employee confidential information as required in the scope of their duties.

Any violation of statutes, regulations, policies and/or procedures designed to safeguard the Confidentiality of the Confidential Information may include a range of disciplinary and corrective actions up to and including immediate discharge from CalViva Health. Failure to comply with this guideline and all applicable policies, laws, and regulations may result in legal action brought against the violating employee/associate.

II. <u>OVERSIGHT AND EVALUATION OF PLAN</u>

1. Designation of Privacy and Security Officer:

CalViva Health has appointed a Chief Operating Officer ("COO") to serve as the focal point for privacy and security activities and report directly to the Chief Executive Officer and to the RHA Commission. The COO is charged with the responsibility for developing, operating and monitoring the Privacy and Security Plan. This includes establishing and overseeing an auditing and monitoring plan, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities; assisting management with formulation of corrective action plans and overseeing and/or verifying implementation of corrective action. The COO works with a Compliance Committee to assist in implementation of the Privacy and Security Plan.

The COO responsibilities include:

A. Serving as the Privacy and Security Officer

B. Ensuring a Privacy and Security Plan is developed along with any applicable policies and procedures;

C. Ensuring Risk Analyses and Risk Mitigation plans are implemented;

D. Ongoing oversight and monitoring of Privacy and Security activities;

E. Preparing and overseeing distribution of the Notice of Privacy Practices;

F. Reporting on a regular basis to the RHA Commission on implementation and compliance;

G. Developing, coordinating and participating in an educational and training program on the elements of the Plan and ensuring that employees and managers are informed;

H. Developing an atmosphere to encourage employees to report possible noncompliance to CalViva Health, DHCS, or the Secretary of HHS without fear of retaliation;

I. Acting on matters related to privacy compliance, with the authority to design and coordinate internal reviews and any resulting need for corrective action;

J. Coordinating with the CEO regarding disciplinary sanctions for violations of the Privacy and Security Plan, policies and procedures;

K. Coordinating mitigation efforts in the event of a Disclosure that violates the privacy

laws; and

L. Periodically evaluating and revising the Privacy and Security Plan and policies and procedures in light of changes at CalViva Health or in response to changes in federal or state requirements.

2. CalViva Health's Compliance Committee:

CalViva Health has a Compliance Committee to advise the Privacy and Security Officer and to assist in the implementation of the Privacy and Security Plan. The Committee is composed of the Plan's Chief Officers and meets at least quarterly and more frequently, as necessary. The Chief Compliance Officer ("CCO") serves as chairperson of the meeting. The Committee shall maintain minutes of all its meetings to document its activities and recommendations.

The Committee's responsibilities include:

A. Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy and security policies and procedures as part of daily operations;

B. Determining the appropriate strategy/approach to promote compliance with the Privacy and Security Plan and detection of any potential violations, such as through hotlines and other reporting mechanisms;

C. Developing a system to solicit, evaluate and respond to complaints and problems;

D. Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;

E. Reviewing and tracking of possible Confidentiality Breaches that may be identified through incident reports, reports from CalViva Health's COO, reports from contractors, appeals and grievances, etc.;

F. Overseeing the analysis and data collection of business processes, systems and relationships to understand the cause of a Breach;

G. Creating or revising policies to better prevent or address privacy and security Breaches; and

H. Overseeing development of resolutions to Breach issues.

When a potential problem is identified, the COO may also select various individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a

recurrence in the future.

3. CalViva Health Management:

Chief Officers and Directors must be available to discuss with each employee under their direct supervision and every contractor/business associate with which they are the primary liaison:

A. The content and procedures in the Privacy and Security Plan and any applicable Policies and Procedures

B. The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable

C. That adherence to the Plan and Policies and Procedures is a condition of employment

D. That CalViva Health shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with CalViva Health, for violation of the principles and requirements set forth in the Privacy and Security Plan and applicable law and regulations

The Chief Operating Officer will include any significant privacy and Security issues as part of the operations reports to the RHA Commission (CalViva Health's governing board).

4. Auditing and Monitoring of Delegated Activities and Internal Operations:

CalViva Health is committed to aggressive monitoring of its Privacy and Security Plan and applicable policies and procedures. Routine and random audits will be conducted to identify problems, reduce identified problems and maintain a high level of privacy.

The COO along with Department staff are responsible for ensuring the implementation of the Privacy and Security Plan and all associated policies and procedures, performance standards and activities. This includes oversight and monitoring activities of CalViva Health internal business units and subcontractors (i.e. administrative services contractors, delegated providers).

Oversight monitoring of delegated entities is done to ensure that delegated responsibilities and services comply with requirements and the appropriate state and federal regulatory requirements. Any deficiencies identified during the monitoring process will result in corrective action plans. The corrective action plan developed will identify the deficiency, outline how the deficiency will be corrected and set a time frame for implementing the corrective actions.

III. DEFINITIONS, MISSION, AND GOALS AND OBJECTIVES

1. Definitions:

A. **Abuse** - Incidents or practices of a provider, which although are not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary cost to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.

B. **Access and Uses** - Allows employee access to PHI subject to qualifying job requirements. Each employee is provided appropriate levels of Security to perform their job duties.

C. **Authorization** - Written authorization for any use or Disclosure of PHI that is not for treatment, payment, health care operations or otherwise permitted or required by regulations and/or statutes.

D. **Breach** - The acquisition, access, use, or Disclosure of Protected Health Information, where the Security or privacy of an individual's information is compromised; the compromise shall be presumed to be a breach unless CalViva Health or one of its Business Associates as applicable demonstrates that there is a low probability that the Protected Health Information has been compromised based on a Risk Assessment. See 45 C.F.R. § 164.402.

a. "Breach" excludes three scenarios:

- Any unintentional acquisition, access, or use of Protected Health Information by a CalViva Health employee or person acting under the authority of CalViva Health or one of its business associates, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or Disclosure.

- Any inadvertent Disclosure between employees of CalViva Health or of a CalViva Health business associate, where both employees are authorized to access such Protected Health Information, and where the information received as a result of such Disclosure is not further used or disclosed.

- A Disclosure of Protected Health Information where CalViva Health or one of its business associates has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

E. **Confidentiality** - The obligation of the holder of personal information to protect an individual's privacy. This obligation is determined by common practice, federal and state laws and regulations.

F. **Data Aggregation** – The combining of PHI created or received by the Plan on behalf of DHCS with PHI received by CalViva Health in its capacity as the contractor of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

G. **Disclosure** - The release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

H. **Protected Health Information (PHI)** - Individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic data, that relates to: 1) the individual's past, present or future physical or mental health or condition, 2) the provision of health care to the individual, or 3) the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

I. **Risk Assessment/Analysis** – The process of identifying, prioritizing, and estimating risks of organizational operations (including mission, functions, image, and reputation), organizational assets, individuals, other organizations, and the Nation, resulting from the operation of an information system.

J. **Risk Management** – The program and supporting processes to manage information Security risk to organizational operations (including mission, functions, image, reputation), organizational assets, individuals, other organizations, and the Nation, and includes: (i) establishing the context for risk-related activities; (ii) assessing risk; (iii) responding to risk once determined; and (iv) monitoring the risk over time.

K. **Risk Mitigation** – Prioritizing, evaluating, and implementing the appropriate risk-reducing controls/countermeasures recommended from the Risk Management process.

L. **Security** - Security or security measures encompassing all of the administrative, physical and technical safeguards in an information system. It relates to the extent to which information can be stored and provided with access limited to those who are authorized and have a legitimate "need to know".

M. **Threat** – Any circumstance or event with the potential to adversely impact organizational operations (including mission, functions, image or reputation), organizational assets, individuals, other organizations, or the Nation through an information system via unauthorized access, destruction, Disclosure, or modification of information, and/or denial of service.

N. **Vulnerability** – Weakness in an information system, system Security procedures, internal controls, or implementation that could be exploited by a threat source and lead to a compromise in the integrity of that system.

2. **Mission:**

CalViva Health has incorporated the HIPAA General Administrative Privacy Rule Requirements, the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the HITECH Act and the National Institute of Standards and Technology (NIST) Risk Management Guide for Information Technology systems into its Privacy and Security Plan. CalViva Health has administrative and management arrangements or procedures, including a Privacy and Security Plan, which is designed to guard against the unauthorized access and/or use of PHI. This document provides a description of these requirements, which are as follows:

A. Written standards of conduct, policies, and procedures, which promote CalViva Health's commitment to comply with all applicable Federal and State standards.
B. The designation of a Privacy and Security Officer and compliance committee responsible for implementing and monitoring privacy and security activities.
C. Effective lines of communication with the organization's employees
D. Conducting ongoing education and training programs
E. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.
F. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.
G. Monitoring and auditing processes to assess the effectiveness of the Privacy and Security Plan.
H. An internal reporting system for receiving complaints and for prompt response to detected offenses.
I. Mechanisms for enforcing compliance standards through well-publicized disciplinary guidelines.
J. The implementation of appropriate measures to prevent future offenses.

The elements of the mission allow CalViva Health to:

A. Ensure that Member's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.
B. Comply with the requirements of ARRA including, but not limited to, Member

requests for restrictions and accounting of disclosures.

C. Protect the public's health and well-being.
D. Adhere to the HIPAA General Administrative Privacy Rule Requirements as published in the final rule on December 28, 2000 and amended on March 27, 2002 and August 14, 2002. These requirements are found in 45 C.F.R. Part 160 and Part 164, sections 101 through 106 (otherwise known as Subparts A, B and C).
E. Adhere to the HIPAA General Administrative Security Rule as published in the final rule on February 20, 2003. These requirements are found in 45 C.F.R. Part 160, 162 and 164.
F. Adhere to the HIPAA Omnibus Rule as published on January 25, 2013.
G. Comply with the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
H. Comply with the California Civil Code sections 1798.29(a) and 1798.82(a), California Confidentiality of Medical Information Act, Civil Code 56 et seq. and California Health and Safety Code sections 1364.5 and 1386 (b) (15) requirements and the California information Practices Act of 1977.
I. Comply with the California Department of Health Care Services (DHCS) contract requirements Exhibit G; Department of Managed Health Care (DMHC), California Civil Code section 1798.82, Center for Medicare and Medicaid Services (CMS); and, the HITECH Act Breach reporting requirements.
J. Ensure privacy and Security training is provided to CalViva Health employees, management and business associates.
K. Ensure Risk Analyses and Risk Mitigation Implementation Plans are conducted and implemented.

3. **Goals and Objectives:**

The goal is to assure that a CalViva Health member's personal health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

CalViva Health's Privacy and Security Plan incorporates the following objectives:

A. Provides oversight and monitoring of responsibilities delegated to contracted and sub- contracted entities.
B. Implement corrective action plans to address deficiencies in the safeguard or use of Protected Health Information.
C. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.
D. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.
E. Conduct internal monitoring and auditing of CalViva Health operations and functions to assess compliance with state and federal requirements.
F. Identify and investigate potential privacy and Security Breaches. Take appropriate

action(s) to resolve and report Breaches.

G. Provide education and other available resources to assist contracted providers and sub- contractors in becoming compliant with privacy and information Security requirements.

H. Educate staff and enforce adherence to CalViva Health's Code of Conduct standards, privacy and Security policies and procedures and mission.

I. Provide new legislation updates to providers and contractors that specify required actions to ensure contractual compliance and makes available additional information about privacy and Security activities and requirements on an ongoing basis as needed.

Anyone with questions or concerns about the Privacy and Security Plan or a particular policy or procedure should seek the guidance of the Privacy and Security Officer. The Privacy and Security Officer provides support in CalViva Health's ongoing commitment to provide quality services in compliance with the health information privacy and Security laws.

IV. SCOPE OF PLAN

1. Policy and Procedures:

CalViva Health has adopted a set of policies and procedures. The policies and procedures are available to employees and business associates. Employees and business associates are able to access the policies in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Privacy and Security Plan and outline areas such as:

A. How PHI is used and disclosed
B. The individual's rights to PHI
C. CalViva Health's relationship with contractors and sub-contractors
D. CalViva Health's response plan for complaints and privacy Breaches
E. CalViva Health's training programs
F. CalViva Health's Risk Analyses and Risk Mitigation measures
G. CalViva Health's contingency plans
H. CalViva Health's utilization of technology to communicate with members, providers, consumers, and employees.

2. Permitted Uses and Disclosures:

CalViva Health's Privacy and Security Plan covers the permitted uses and disclosures pertaining to Protected Health Information. This includes sending a Notice of Privacy Practice to members upon enrollment and annually thereafter explaining how CalViva Health uses and discloses Protected Health Information. CalViva Health is permitted to use and disclose Protected Health Information for activities that are directly connected with the administration of the Plan's healthcare program, which includes but is not limited to establishing eligibility and methods of reimbursement, and providing services for members. CalViva Health extends this commitment to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners. CalViva Health provides DHCS with a list of external entities, including persons, organizations, and agencies to which it discloses PHI annually. The guiding principles of CalViva Health's Permitted Uses and Disclosures of PHI include:

A. Use/Disclosure of PHI for CalViva Health management and administration
B. Use/Disclosure of PHI by CalViva Health for Data Aggregation services to DHCS
C. Use/Disclosure of PHI by CalViva Health for conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan's healthcare program
D. Use/Disclosure of PHI by CalViva Health for legislative investigations/audits related to the administration of the Plan's healthcare program

3. CalViva Health Responsibilities:

CalViva Health has made several commitments in its Privacy and Security Plan, policies and procedures and business operations. CalViva Health takes steps to ensure a member's Medi-Cal status is not divulged without prior approval except for treatment, payment and operations, or as required by law. CalViva Health's commitment to privacy and security of PHI also includes:

A. Implementing Safeguards – CalViva Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in both electronic and hard-copy form. CalViva Health employees are trained in methods to assure that they use all reasonable measures to safeguard Protected Health Information from any use or Disclosure that would violate the HIPAA or state regulations or CalViva Health's privacy and security policies. CalViva Health's employees have limited access to Protected Health Information through role-based access and password protections. CalViva Health also has firewalls to protect information from those who do not need to access the Protected Health Information to perform their job functions.

B. Implementing Security Measures – CalViva Health employees working with PHI sign a confidentiality agreement; undergo a background check and use workstations and laptops with encryption mechanisms. CalViva Health enforces the "minimum necessary" principle in regards to PHI and ensures employees send secure emails or utilize another appropriate secure method (i.e. secure file transfer protocol ("FTP") when PHI is involved. CalViva Health uses the latest antivirus software and security patches on their workstation and/or laptops. Any uses of removable media devices or remote access used by CalViva Health associates for PHI are encrypted. CalViva Health incorporates a data destruction method consistent with the Department of Defense standard methods and assigns unique usernames and passwords to users accessing PHI. CalViva Health enforces security measures in several ways:

1. **Use of System Security Controls –** CalViva Health will ensure computer systems automatically timeout after no more than 20 minutes of inactivity. CalViva Health will make sure all systems containing PHI display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. CalViva Health's systems will include system-logging functions, access controls, transmission encryption and host-based intrusion detection. Logs and user activities are maintained by CalViva Health in accordance with the Plan's document and data retention policy and procedures.

2. **Use of Audit Controls –** CalViva Health will conduct system security reviews of all systems processing and/or storing PHI. The audit controls in place include reviewing systems logs for unauthorized access and ensuring there is a documented change control procedure in place.

3. **Use of Paper Document Controls –** CalViva Health's paper document controls includes protection of data by making sure PHI in paper form is locked in a file cabinet rather than left unattended. CalViva Health also escorts visitors to areas in which PHI is housed. CalViva Health confidentially shreds and destroys PHI in paper form and never removes PHI from the premises except for routine business purposes or with the express written permission of a state and/or federal agency. Faxes containing PHI are never left unattended and outgoing faxes include a confidentiality statement notifying the recipient receiving to destroy faxes received in error. PHI is mailed using secure means and for large volume mailings of PHI, CalViva Health uses a bonded courier with signature required on receipt.

4. **Use of a Contingency Plan –** CalViva Health's contingency plan includes an ability to enable continuation of critical business processes and protection of the Security of electronic PHI in the event of an emergency. CalViva Health makes sure all sensitive data including PHI is backed up regularly. Data backups are stored offsite, which allows for restoration of data in the event of an outage.

C. Notification and Investigation of Incidents and/or Breaches - CalViva Health is committed to compliance with HIPAA and state health information compliance laws and to correcting violations. Upon discovery of a suspected Security incident and/or Breach, CalViva Health notifies the applicable state and federal agencies without unreasonable delay. CalViva Health takes prompt corrective action to mitigate any risks or damages involved with the Breach. Refer to the Plan's Privacy and Security policies and procedures for detailed descriptions of the Breach investigation and notification processes.

1. **Investigation and Corrective Action -** If there is a report of noncompliance, the Privacy and Security Officer, a member of the Compliance Committee or a Plan employee/associate discovers credible evidence of a violation, an investigation will immediately ensue. When CalViva Health substantiates a reported violation, it is the policy to institute corrective action.

2. **Initiating Systemic Changes to Correct Problems** - After a problem has been identified and corrected, the Privacy and Security Officer and Compliance Committee will review the circumstances to determine 1) whether similar problems have been uncovered elsewhere and 2) whether modifications of the policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy and Security Officer will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

4. Education and Training Programs:

CalViva Health will ensure that training is provided to all employees and business associates. All

employees with access to Protected Health Information are required to attend and participate in privacy and security training sessions. Adherence to the provisions of this plan, such as attending training sessions, will be a factor in the annual evaluation of each employee. All new employees will be provided training within a reasonable period after orientation.

5. Risk Analysis and Risk Management:

CalViva Health understands a Risk Analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security rule. CalViva Health works to ensure an accurate and thorough assessment of the potential risks and vulnerabilities to the Confidentiality, integrity and availability of PHI held by the Plan.

CalViva Health implements these steps when conducting a Risk Analysis:

a. Step 1: System Characterization
b. Step 2: Threat Identification
c. Step 3: Vulnerability Identification
d. Step 4: Control Analysis
e. Step 5: Likelihood Determination
f. Step 6: Impact Analysis
g. Step 7: Risk Determination
h. Step 8: Control Recommendations
i. Step 9: Results Documentation

The steps referenced above are consistent with the methodologies described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30 Risk Management Guide for Information Technology Systems and NIST SP 800-66 An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security rule.

Along with risk analyses, CalViva Health maintains a Risk Management protocol which provides a structure for the evaluation, prioritization, and implementation of risk-reducing Security measures. CalViva Health has a team of individuals in place who are knowledgeable about the organization's Privacy and Security policies, procedures, training program, computer system set up, and technical Security controls.

APPROVAL:

_____ **Date:** _____

Name: Jeffrey Nkansah
Title: Chief Operating Officer

_____ **Date:** _____

Name: Gregory Hund
Title: Chief Executive Officer

_____ **Date:** _____

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Program Description History		
Date	**Section #**	**Comment(s)**
1/1/2012		New Program Description
3/1/2013		Updated entire document to properly reflect Privacy and Security Measures
2/6/2014		Changes to the Breach and Protected Health Information definition to align with the HIPAA FINAL Rule published on January 17, 2013; added language pertaining to the Risk Management Team; clarification to identify the Chief Compliance Officer is also the Privacy and Security Officer and other minor changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
1/5/2015		Annual Review; No Changes Needed
2/18/2016		Annual Review; Updated the contact information for the Compliance Officer. Minor edits to clarify current practices.

2/16/2017		Annual Review; Updated overview clarify current contractual relationships and activities. Updated the name of document from Privacy and Security Program to Privacy and Security Plan.
2/15/2018		Annual Review; Updated the officer responsible for the Privacy and Security Plan, added a reference to comply with California's Data Breach Security Reporting Requirements, Updated the Department Responsible for the Plan and the reference to the name of the report which would be provided to the RHA Commission. Re-arranged sections for readability.
2/21/2019		Annual Review; No Changes Needed
2/20/2020		Annual Review; Added language referencing new policy HI-031 Member Communications under Telephone Consumer Protections Act (TCPA). Clarified a definition and a publishing date for a previously released regulatory law.
2/18/2021		Annual Review; No Changes Needed

Item #15

Attachment 15.A

Financials as of December 31, 2020

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of December 31, 2020

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	132,861,026.10
5	Total Bank Accounts	$ 132,861,026.10
6	Accounts Receivable	
7	Accounts Receivable	219,507,142.56
8	Total Accounts Receivable	$ 219,507,142.56
9	Other Current Assets	
10	Interest Receivable	0.00
11	Investments - CDs	0.00
12	Prepaid Expenses	630,982.89
13	Security Deposit	0.00
14	Total Other Current Assets	$ 630,982.89
15	Total Current Assets	$ 352,999,151.55
16	Fixed Assets	
17	Buildings	6,571,706.27
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	109,343.80
21	Total Fixed Assets	$ 9,842,469.17
22	Other Assets	
23	Investment -Restricted	300,332.09
24	Total Other Assets	$ 300,332.09
25	TOTAL ASSETS	$ 363,141,952.81
26	LIABILITIES AND EQUITY	
27	Liabilities	
28	Current Liabilities	
29	Accounts Payable	
30	Accounts Payable	142,330.21
31	Accrued Admin Service Fee	4,128,674.00
32	Capitation Payable	205,314,719.58
33	Claims Payable	2,793.45
34	Directed Payment Payable	1,691,311.36
35	Total Accounts Payable	$ 211,279,828.60
36	Other Current Liabilities	
37	Accrued Expenses	662,500.00
38	Accrued Payroll	45,609.22
39	Accrued Vacation Pay	365,213.20
40	Amt Due to DHCS	0.00
41	IBNR	4,017.39
42	Loan Payable-Current	0.00
43	Premium Tax Payable	0.00
44	Premium Tax Payable to BOE	5,958,557.70
45	Premium Tax Payable to DHCS	37,406,250.00
46	Total Other Current Liabilities	$ 44,442,147.51
47	Total Current Liabilities	$ 255,721,976.11
48	Long-Term Liabilities	
49	Renters' Security Deposit	0.00
50	Subordinated Loan Payable	0.00
51	Total Long-Term Liabilities	$ 0.00
52	Total Liabilities	$ 255,721,976.11
53	Equity	
54	Retained Earnings	108,757,395.00
55	Net Income/ (Loss)	(1,337,418.30)
56	Total Equity	$ 107,419,976.70
57	TOTAL LIABILITIES AND EQUITY	$ 363,141,952.81

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2020 - December 2020 (FY 2021)

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Investment Income	83,250.09	198,000.00	(114,749.91)
3	Premium/Capitation Income	647,654,615.42	649,473,102.00	(1,818,486.58)
4	**Total Income**	**647,737,865.51**	**649,671,102.00**	**(1,933,236.49)**
5	Cost of Medical Care			
6	Capitation - Medical Costs	543,925,249.96	541,329,390.00	2,595,859.96
7	Medical Claim Costs	369,256.69	510,000.00	(140,743.31)
8	**Total Cost of Medical Care**	**544,294,506.65**	**541,839,390.00**	**2,455,116.65**
9	**Gross Margin**	**103,443,358.86**	**107,831,712.00**	**(4,388,353.14)**
10	Expenses			
11	Admin Service Agreement Fees	24,434,597.00	24,023,994.00	410,603.00
12	Bank Charges	993.77	3,300.00	(2,306.23)
13	Computer/IT Services	91,485.80	84,048.00	7,437.80
14	Consulting Fees	0.00	52,500.00	(52,500.00)
15	Depreciation Expense	143,178.36	153,000.00	(9,821.64)
16	Dues & Subscriptions	80,121.00	90,096.00	(9,975.00)
17	Grants	2,475,000.00	2,481,815.00	(6,815.00)
18	Insurance	87,699.04	89,310.00	(1,610.96)
19	Labor	1,798,923.94	1,773,720.00	25,203.94
20	Legal & Professional Fees	62,717.00	95,400.00	(32,683.00)
21	License Expense	379,663.67	427,710.00	(48,046.33)
22	Marketing	658,359.95	800,000.00	(141,640.05)
23	Meals and Entertainment	11,360.08	12,200.00	(839.92)
24	Office Expenses	31,376.24	42,000.00	(10,623.76)
25	Parking	0.00	750.00	(750.00)
26	Postage & Delivery	1,074.91	1,680.00	(605.09)
27	Printing & Reproduction	835.65	2,400.00	(1,564.35)
28	Recruitment Expense	1,573.98	18,000.00	(16,426.02)
29	Rent	0.00	6,000.00	(6,000.00)
30	Seminars and Training	946.04	12,000.00	(11,053.96)
31	Supplies	4,018.00	5,400.00	(1,382.00)
32	Taxes	74,811,403.50	74,812,500.00	(1,096.50)
33	Telephone	16,938.26	17,400.00	(461.74)
34	Travel	144.34	16,700.00	(16,555.66)
35	**Total Expenses**	**105,092,410.53**	**105,021,923.00**	**70,487.53**
36	**Net Operating Income/(Loss)**	**(1,649,051.67)**	**2,809,789.00**	**(4,458,840.67)**
37	Other Income			
38	Other Income	311,633.37	240,000.00	71,633.37
39	**Total Other Income**	**311,633.37**	**240,000.00**	**71,633.37**
40	**Net Other Income**	**311,633.37**	**240,000.00**	**71,633.37**
41	**Net Income/(Loss)**	**(1,337,418.30)**	**3,049,789.00**	**(4,387,207.30)**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2021 vs FY 2020

		Total	
		July 2020 - Dec 2020 (FY 2021)	July 2019 - Dec 2019 (FY 2020)
1	Income		
2	Investment Income	83,250.09	558,211.26
3	Premium/Capitation Income	647,654,615.42	516,507,779.62
4	**Total Income**	**647,737,865.51**	**517,065,990.88**
5	Cost of Medical Care		
6	Capitation - Medical Costs	543,925,249.96	483,431,878.87
7	Medical Claim Costs	369,256.69	1,618,703.47
8	**Total Cost of Medical Care**	**544,294,506.65**	**485,050,582.34**
9	**Gross Margin**	**103,443,358.86**	**32,015,408.54**
10	Expenses		
11	Admin Service Agreement Fees	24,434,597.00	23,479,632.00
12	Bank Charges	993.77	5.00
13	Computer/IT Services	91,485.80	67,911.89
14	Consulting Fees	0.00	1,575.00
15	Depreciation Expense	143,178.36	145,143.78
16	Dues & Subscriptions	80,121.00	82,074.00
17	Grants	2,475,000.00	724,562.43
18	Insurance	87,699.04	92,771.28
19	Labor	1,798,923.94	1,581,431.66
20	Legal & Professional Fees	62,717.00	55,230.52
21	License Expense	379,663.67	381,553.44
22	Marketing	658,359.95	556,175.75
23	Meals and Entertainment	11,360.08	11,783.56
24	Office Expenses	31,376.24	29,573.88
25	Parking	0.00	743.31
26	Postage & Delivery	1,074.91	1,629.89
27	Printing & Reproduction	835.65	1,248.25
28	Recruitment Expense	1,573.98	946.15
29	Rent	0.00	1,800.00
30	Seminars and Training	946.04	6,060.11
31	Supplies	4,018.00	4,881.88
32	Taxes	74,811,403.50	(984.79)
33	Telephone	16,938.26	17,068.79
34	Travel	144.34	12,752.96
35	**Total Expenses**	**105,092,410.53**	**27,255,570.74**
36	**Net Operating Income/(Loss)**	**(1,649,051.67)**	**4,759,837.80**
37	Other Income		
38	Other Income	311,633.37	393,838.61
39	**Total Other Income**	**311,633.37**	**393,838.61**
40	**Net Other Income**	**311,633.37**	**393,838.61**
41	**Net Income/(Loss)**	**(1,337,418.30)**	**5,153,676.41**

Item #15

Attachment 15.B

Appeals and Grievances Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2020

Current as of End of the Month: December
Revised Date: 01/21/2021

CalViva - 2020																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2020 YTD**	**2019**
Expedited Grievances Received	10	4	12	26	7	8	8	23	12	10	3	25	17	9	10	36	110	189
Standard Grievances Received	101	97	98	296	61	75	76	212	82	74	65	221	113	75	80	268	997	1118
Total Grievances Received	**111**	**101**	**110**	**322**	**68**	**83**	**84**	**235**	**94**	**84**	**68**	**246**	**130**	**84**	**90**	**304**	**1107**	**1307**
Grievance Ack Letters Sent Noncompliant	0	2	0	2	0	0	0	0	0	1	0	1	0	0	0	0	3	12
Grievance Ack Letter Compliance Rate	**100.0%**	**97.9%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.6%**	**100.0%**	**99.5%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.70%**	**98.9%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	10	4	12	26	6	9	7	22	13	10	3	26	17	9	11	37	111	189
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	109	88	121	318	100	49	71	220	88	68	74	230	69	106	90	265	1033	1100
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**99.9%**
Total Grievances Resolved	**119**	**92**	**133**	**344**	**106**	**58**	**78**	**242**	**101**	**78**	**77**	**256**	**86**	**115**	**101**	**302**	**1144**	**1290**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**96**	**60**	**107**	**263**	**80**	**43**	**56**	**179**	**83**	**62**	**55**	**200**	**66**	**92**	**78**	**236**	**878**	**983**
Access - Other - DMHC	7	7	7	21	4	3	5	12	6	3	1	10	1	9	10	20	63	58
Access - PCP - DHCS	10	9	12	31	5	3	4	12	14	11	11	36	17	3	8	28	107	166
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	10	4	1	15	1	2	1	4	6	1	4	11	3	9	6	18	48	59
Administrative	13	9	23	45	12	21	16	49	22	18	10	50	15	15	17	47	191	211
Continuity of Care	2	0	0	2	0	0	0	0	1	0	0	1	0	0	0	0	3	10
Interpersonal	8	5	9	22	11	5	7	23	9	3	2	14	4	11	8	23	82	106
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	5	6	22	8	7	5	20	9	5	6	20	8	5	5	18	80	87
Pharmacy	7	2	11	20	5	1	4	10	5	1	1	7	4	7	3	14	51	50
Transportation - Access	17	11	22	50	15	0	9	24	6	5	7	18	4	14	6	24	116	160
Transportation - Behaviour	7	4	14	25	17	1	5	23	3	10	6	19	5	17	11	33	100	56
Transportation - Other	4	4	2	10	2	0	0	2	2	5	7	14	5	2	4	11	37	20
Quality Of Care Grievances	**23**	**32**	**26**	**81**	**26**	**15**	**22**	**63**	**18**	**16**	**22**	**56**	**20**	**23**	**23**	**66**	**266**	**307**
Access - Other - DMHC	1	0	2	3	1	0	0	1	0	0	0	0	0	0	0	0	4	11
Access - PCP - DHCS	0	0	1	1	1	0	1	2	1	0	1	2	0	1	0	1	6	4
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	1	2	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	6	6	15	8	3	5	16	6	5	6	17	2	4	2	8	56	51
PCP Care	10	19	3	32	10	5	11	26	6	6	10	22	3	8	4	15	95	108
PCP Delay	1	2	6	9	2	3	3	8	3	2	1	6	9	3	7	19	42	50
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Specialist Care	8	3	6	17	4	3	2	9	2	3	3	8	4	3	5	12	46	65
Specialist Delay	0	1	2	3	0	1	0	1	0	0	1	1	2	3	5	10	15	15
Exempt Grievances Received	324	243	239	**806**	144	218	281	**643**	252	198	233	**683**	260	284	201	**745**	**2877**	NA
Access - Avail of Appt w/ PCP	17	12	8	**37**	2	6	6	**14**	5	4	8	**17**	12	9	4	**25**	**93**	NA
Access - Avail of Appt w/ Specialist	1	0	0	**1**	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	**2**	NA
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Wait Time - wait too long on telephone	1	3	2	**6**	2	1	0	**3**	5	2	5	**12**	9	3	2	**14**	**35**	NA
Access - Wait Time - in office for appt	0	3	1	**4**	1	1	2	**4**	0	3	4	**7**	0	2	0	**2**	**17**	NA
Access - Panel Disruption	3	3	3	**9**	1	8	6	**15**	9	5	4	**18**	8	7	0	**15**	**57**	NA
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	NA
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Geographic/Distance Access PCP	1	1	0	**2**	2	0	1	**3**	0	0	2	**2**	1	1	1	**3**	**10**	NA
Access - Geographic/Distance Access Specialist	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	NA
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Attitude/Service - Health Plan Staff	4	1	1	**6**	1	1	4	**6**	0	0	0	**0**	4	0	1	**5**	**17**	NA
Attitude/Service - Provider	24	30	29	**83**	12	19	26	**57**	28	10	25	**63**	32	26	24	**82**	**285**	NA
Attitude/Service - Office Staff	0	0	0	**0**	1	1	1	**3**	3	4	2	**9**	0	0	0	**0**	**12**	NA

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Attitude/Service - Vendor	2	1	4	**7**	0	0	0	**0**	1	2	0	**3**	0	0	1	**1**	**11**	NA
Attitude/Service - Health Plan	0	1	3	**4**	0	2	1	**3**	0	0	2	**2**	0	1	1	**2**	**11**	NA
Authorization - Authorization Related	4	2	1	**7**	2	2	6	**10**	2	2	2	**6**	0	0	2	**2**	**25**	NA
Eligibility Issue - Member not eligible per Health Plan	1	3	0	**4**	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**	**6**	NA
Eligibility Issue - Member not eligible per Provider	2	2	3	**7**	1	5	3	**9**	2	4	2	**8**	4	8	1	**13**	**37**	NA
Health Plan Materials - ID Cards-Not Received	14	20	16	**50**	6	14	17	**37**	16	16	26	**58**	37	28	25	**90**	**235**	NA
Health Plan Materials - ID Cards-Incorrect Information on Card	1	0	0	**1**	1	1	0	**2**	1	2	0	**3**	0	1	0	**1**	**7**	NA
Health Plan Materials - Other	0	0	0	**0**	0	2	1	**3**	0	0	0	**0**	0	0	0	**0**	**3**	NA
PCP Assignment/Transfer - Health Plan Assignment - Change Request	109	59	74	**242**	59	84	127	**270**	120	96	109	**325**	103	134	88	**325**	**1162**	NA
PCP Assignment/Transfer - HCO Assignment - Change Request	29	14	10	**53**	3	12	18	**33**	11	12	9	**32**	7	24	7	**38**	**156**	NA
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	2	**2**	0	2	2	**4**	1	1	1	**3**	4	2	4	**10**	**19**	NA
PCP Assignment/Transfer - Rollout of PPG	3	0	2	**5**	4	7	6	**17**	8	3	3	**14**	5	4	0	**9**	**45**	NA
PCP Assignment/Transfer - Mileage Inconvenience	6	17	3	**26**	2	3	3	**8**	4	0	1	**5**	6	9	4	**19**	**58**	NA
Pharmacy - Authorization Issue	0	0	1	**1**	1	1	1	**3**	0	1	0	**1**	0	0	0	**0**	**5**	NA
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	NA
Pharmacy - Eligibility Issue	26	15	20	**61**	14	11	6	**31**	10	9	9	**28**	12	8	4	**24**	**144**	NA
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	**2**	NA
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Pharmacy - Pharmacy-Retail	5	4	4	**13**	2	6	3	**11**	4	3	3	**10**	2	5	4	**11**	**45**	NA
Transportation - Access - Provider No Show	9	1	1	**11**	0	2	0	**2**	1	2	1	**4**	0	2	5	**7**	**24**	NA
Transportation - Access - Provider Late	15	9	7	**31**	1	4	2	**7**	2	2	4	**8**	3	2	1	**6**	**52**	NA
Transportation - Behaviour	27	31	26	**84**	7	5	8	**20**	4	1	1	**6**	2	3	4	**9**	**119**	NA
Transportation - Other	2	1	0	**3**	0	0	0	**0**	2	0	1	**3**	2	0	4	**6**	**12**	NA
OTHER - Other	0	0	0	**0**	4	1	0	**5**	0	0	0	**0**	0	0	2	**2**	**7**	NA
OTHER - Balance Billing from Provider	18	9	18	**45**	15	16	29	**60**	13	14	8	**35**	6	5	10	**21**	**161**	NA

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Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	11	9	12	32	12	6	14	32	8	8	10	26	12	8	5	25	115	158
Standard Appeals Received	78	91	96	265	67	53	57	177	108	79	54	241	96	74	65	235	918	744
Total Appeals Received	**89**	**100**	**108**	**297**	**79**	**59**	**71**	**209**	**116**	**87**	**64**	**267**	**108**	**82**	**70**	**260**	1033	**902**
Appeals Ack Letters Sent Noncompliant	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	2	0	0	**2**	3	3
Appeals Ack Letter Compliance Rate	**100.0%**	**98.9%**	**100.0%**	**99.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.9%**	**100.0%**	**100.0%**	**99.1%**	**99.67%**	**99.6%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0
Expedited Appeals Resolved Compliant	11	10	11	**32**	13	6	12	**31**	9	9	8	**26**	13	8	4	25	114	158
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**87.5%**	**100.0%**	**96.0%**	**99.13%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Standard Appeals Resolved Compliant	65	69	95	229	100	78	51	229	53	98	78	229	59	86	84	229	916	726
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**99.6%**
Total Appeals Resolved	**76**	**79**	**106**	**261**	**113**	**84**	**63**	**260**	**62**	**107**	**86**	**255**	**72**	**95**	**88**	**255**	**1031**	**887**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**76**	**78**	**106**	**260**	**113**	**84**	**63**	**260**	**62**	**107**	**86**	**255**	**71**	**95**	**88**	**254**	**1029**	883
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Consultation	0	0	0	0	0	3	3	6	3	3	0	6	1	2	2	5	17	12
DME	5	5	3	13	4	0	2	6	2	5	3	10	5	4	9	18	47	51
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	1	1	0	0	0	0	0	1	0	1	2	11
Advanced Imaging	34	37	49	120	55	37	29	121	33	66	51	150	22	38	37	97	488	412
Other	5	6	3	14	9	1	2	12	5	2	3	10	7	13	11	31	67	71
Pharmacy	31	26	48	105	43	42	25	110	18	31	26	75	29	23	20	72	362	274
Surgery	1	4	3	8	2	1	1	4	1	0	3	4	7	14	9	30	46	50
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**2**	4
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	2
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	33	41	63	**137**	65	50	32	147	38	58	47	143	44	58	48	150	577	463
Uphold Rate	**43.4%**	**51.9%**	**59.4%**	**52.5%**	**57.5%**	**59.5%**	**50.8%**	**56.5%**	**61.3%**	**54.2%**	**54.7%**	**56.1%**	**61.1%**	**61.1%**	**54.5%**	**58.8%**	**56.0%**	**52.2%**
Overturns - Full	40	35	39	**114**	47	33	30	**110**	21	48	39	**108**	27	34	39	**100**	432	399
Overturn Rate - Full	**52.6%**	**44.3%**	**36.8%**	**43.7%**	**41.6%**	**39.3%**	**47.6%**	**42.3%**	**33.9%**	**44.9%**	**45.3%**	**42.4%**	**37.5%**	**35.8%**	**44.3%**	**39.2%**	**41.9%**	**45.0%**
Overturns - Partials	3	2	2	**7**	1	0	0	**1**	1	1	0	**2**	0	2	0	**2**	12	19
Overturn Rate - Partial	**3.9%**	**2.5%**	**1.9%**	**2.7%**	**0.9%**	**0.0%**	**0.0%**	**0.4%**	**1.6%**	**0.9%**	**0.0%**	**0.8%**	**0.0%**	**2.1%**	**0.0%**	**0.78%**	**1.2%**	**2.1%**
Withdrawal	0	1	2	**3**	0	1	1	**2**	2	0	0	**2**	1	1	1	3	**10**	6
Withdrawal Rate	**0.0%**	**1.3%**	**1.9%**	**1.1%**	**0.0%**	**1.2%**	**1.6%**	**0.8%**	**3.2%**	**0.0%**	**0.0%**	**0.8%**	**1.4%**	**1.1%**	**1.1%**	**1.2%**	**1.0%**	**0.7%**
Membership	348,034	347,538	347,090		348,814	354,281	358,004		361,207	364,479	368,417		370,845	373,301	374,862			
Appeals - PTMPM	0.22	0.23	0.31	0.25	0.32	0.24	0.18	0.25	0.17	0.29	0.23	0.23	0.19	0.25	0.23	0.23	0.24	0.21
Grievances - PTMPM	0.34	0.26	0.38	0.33	0.30	0.16	0.22	0.23	0.28	0.21	0.21	0.23	0.23	0.31	0.27	0.27	0.27	0.30

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Fresno County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2020 YTD	2019
Expedited Grievances Received	8	4	9	21	4	6	7	17	11	7	3	21	15	8	10	33	92	152
Standard Grievances Received	79	85	78	242	54	67	69	190	77	69	57	203	98	63	68	229	864	928
Total Grievances Received	**87**	**89**	**87**	**263**	**58**	**73**	**76**	**207**	**88**	**76**	**60**	**224**	**113**	**71**	**78**	**262**	**956**	**1080**
Grievance Ack Letters Sent Noncompliant	0	2	0	2	0	0	0	0	0	1	0	1	0	0	0	0	3	11
Grievance Ack Letter Compliance Rate	**100.0%**	**97.6%**	**100.0%**	**99.2%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.6%**	**100.0%**	**99.5%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**	**98.81%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	8	4	9	21	3	7	6	16	12	7	3	22	15	8	11	34	93	152
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	91	68	104	263	83	42	64	189	81	65	68	214	61	89	78	228	894	917
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**99**	**72**	**113**	**284**	**86**	**49**	**70**	**205**	**93**	**72**	**71**	**236**	**76**	**97**	**89**	**262**	**987**	**1069**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**79**	**47**	**92**	**218**	**64**	**35**	**51**	**150**	**77**	**57**	**52**	**186**	**58**	**77**	**69**	**204**	**758**	**816**
Access - Other - DMHC	7	5	7	19	3	2	5	10	6	3	1	10	1	7	9	17	56	52
Access - PCP - DHCS	9	7	11	27	4	3	3	10	14	9	11	34	16	3	8	27	98	146
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	1	1	7	1	2	1	4	6	1	4	11	3	7	6	16	38	44
Administrative	11	7	18	36	9	18	13	40	20	17	8	45	14	12	15	41	162	175
Continuity of Care	2	0	0	2	0	0	0	0	1	0	0	1	0	0	0	0	3	9
Interpersonal	5	5	9	19	10	4	7	21	8	2	2	12	4	11	6	21	73	90
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	8	2	6	16	7	4	5	16	6	5	5	16	6	4	3	13	61	68
Pharmacy	6	2	4	12	3	1	4	8	5	1	1	7	4	6	3	13	40	37
Transportation - Access	16	10	20	46	13	0	8	21	3	4	7	14	4	13	6	23	104	137
Transportation - Behaviour	7	4	14	25	13	1	5	19	6	10	6	22	3	12	9	24	90	41
Transportation - Other	3	4	2	9	1	0	0	1	2	5	7	14	3	2	4	9	33	17
Quality Of Care Grievances	**20**	**25**	**21**	**66**	**22**	**14**	**19**	**55**	**16**	**15**	**19**	**50**	**18**	**20**	**20**	**58**	**229**	**253**
Access - Other - DMHC	1	0	1	2	1	0	0	1	0	0	0	0	0	0	0	0	3	9
Access - PCP - DHCS	0	0	1	1	1	0	1	2	1	0	1	2	0	1	0	1	6	4
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	1	2	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	4	6	13	7	3	5	15	5	4	5	14	1	3	2	6	48	43
PCP Care	8	14	3	25	8	4	10	22	6	6	9	21	3	8	4	15	83	90
PCP Delay	1	2	4	7	2	3	2	7	2	2	1	5	9	2	7	18	37	41
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Specialist Care	7	3	5	15	3	3	1	7	2	3	2	7	4	2	3	9	38	49
Specialist Delay	0	1	1	2	0	1	0	1	0	0	1	1	1	3	4	8	12	14

CalViva Health Appeals and Grievances Dashboard 2020 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	10	6	9	25	12	6	11	29	7	7	9	23	9	7	3	19	96	134
Standard Appeals Received	65	82	75	222	57	47	50	154	86	72	46	204	88	64	57	209	789	626
Total Appeals Received	**75**	**88**	**84**	**247**	**69**	**53**	**61**	**183**	**93**	**79**	**55**	**227**	**97**	**71**	**60**	**228**	885	**760**
Appeals Ack Letters Sent Noncompliant	0	1	0	0	0	0	0	0	0	0	0	0	2	0	0	2	2	3
Appeals Ack Letter Compliance Rate	**100.0%**	**98.8%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.7%**	**100.0%**	**100.0%**	**99.0%**	**99.7%**	**99.5%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0
Expedited Appeals Resolved Compliant	10	7	8	25	13	6	9	28	8	8	7	23	11	6	2	19	95	134
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**83.3%**	**100.0%**	**94.7%**	**98.9%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Standard Appeals Resolved Compliant	56	56	86	198	79	67	44	**190**	43	82	70	**195**	50	80	72	**202**	785	610
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**
Total Appeals Resolved	**66**	**63**	**94**	**223**	**92**	**73**	**53**	**218**	**51**	**90**	**77**	**218**	**61**	**87**	**74**	**222**	**881**	**746**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**66**	**63**	**94**	**223**	**92**	**73**	**53**	**218**	**51**	**90**	**77**	**218**	**60**	**87**	**74**	**221**	**880**	**742**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Consultation	0	0	0	0	0	1	3	4	3	3	0	6	1	2	2	5	15	10
DME	4	4	3	11	2	0	2	4	1	4	2	7	4	4	8	16	38	46
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	1	1	0	0	0	0	0	1	0	1	2	10
Advanced Imaging	32	33	44	109	46	37	25	108	27	59	46	132	20	35	32	87	436	358
Other	4	3	3	10	8	0	2	10	5	2	2	9	7	11	11	29	58	56
Pharmacy	26	20	41	87	35	34	19	88	14	22	24	60	23	20	13	56	291	219
Surgery	0	3	3	6	1	1	1	3	1	0	3	4	5	14	8	27	40	41
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**1**	**4**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1
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	29	33	58	**120**	53	42	28	**123**	31	48	42	**121**	37	54	42	**133**	497	391
Uphold Rate	**43.9%**	**52.4%**	**61.7%**	**53.8%**	**57.6%**	**57.5%**	**52.8%**	**56.4%**	**60.8%**	**53.3%**	**54.5%**	**55.5%**	**60.7%**	**62.1%**	**56.8%**	**59.9%**	**56.4%**	**52.4%**
Overturns - Full	34	28	32	**94**	38	30	24	**92**	17	41	35	**93**	23	30	32	**85**	364	335
Overturn Rate - Full	**51.5%**	**44.4%**	**34.0%**	**42.2%**	**41.3%**	**41.1%**	**45.3%**	**42.2%**	**33.3%**	**45.6%**	**45.5%**	**42.7%**	**37.7%**	**0.0%**	**0.0%**	**38.3%**	**41.3%**	**44.9%**
Overturns - Partials	3	2	2	**7**	1	0	0	**1**	1	1	0	**2**	0	2	0	**2**	12	14
Overturn Rate - Partial	**4.5%**	**3.2%**	**2.1%**	**3.1%**	**1.1%**	**0.0%**	**0.0%**	**0.5%**	**2.0%**	**1.1%**	**0.0%**	**0.9%**	**0.0%**	**2.3%**	**0.0%**	**0.9%**	**1.4%**	**1.9%**
Withdrawal	0	0	2	**2**	0	1	1	**2**	2	0	0	**2**	1	1	0	**2**	8	6
Withdrawal Rate	**0.0%**	**0.0%**	**2.1%**	**0.9%**	**0.0%**	**1.4%**	**1.9%**	**0.9%**	**3.9%**	**0.0%**	**0.0%**	**0.9%**	**1.6%**	**1.1%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**
Membership	281,473	280,719	280,297		282,402	286,059	289,126		291,870	294,617	298,003		300,085	302,118	303,493			
Appeals - PTMPM	0.23	0.22	0.34	0.26	0.33	0.26	0.18	0.25	0.17	0.31	0.26	0.25	0.20	0.29	0.24	0.00	0.19	0.15
Grievances - PTMPM	0.35	0.26	0.40	0.34	0.30	0.17	0.24	0.24	0.32	0.24	0.24	0.27	0.25	0.32	0.29	0.00	0.21	0.23

CalViva Health Appeals and Grievances Dashboard 2020 (Fresno County)

Kings County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2020 YTD	2019
Expedited Grievances Received	1	0	3	4	2	0	0	2	1	1	0	2	1	1	0	2	10	14
Standard Grievances Received	13	3	13	29	3	1	2	6	0	3	3	6	9	4	4	17	58	58
Total Grievances Received	**14**	**3**	**16**	**33**	**5**	**1**	**2**	**8**	**0**	**4**	**3**	**8**	**10**	**5**	**4**	**19**	**68**	**72**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	0	3	4	2	0	0	2	1	1	0	2	1	1	0	2	10	14
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Grievances Resolved Compliant	4	12	7	23	8	4	1	13	1	0	3	4	3	11	3	17	57	59
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.3%**
Total Grievances Resolved	**5**	**12**	**10**	**27**	**10**	**4**	**1**	**15**	**2**	**1**	**3**	**6**	**4**	**12**	**3**	**19**	67	**74**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**5**	**7**	**10**	**22**	**9**	**4**	**1**	**14**	**2**	**1**	**1**	**4**	**4**	**9**	**3**	**16**	**56**	**54**
Access - Other - DMHC	0	1	0	1	1	0	0	1	0	0	0	0	0	1	0	1	3	1
Access - PCP - DHCS	1	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	2	7
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	2	1	0	3	0	0	0	0	0	0	0	0	0	1	0	1	4	6
Administrative	1	1	3	5	1	1	1	3	1	1	0	2	1	1	1	3	13	18
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	3
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	3	0	4	0	3	0	3	1	0	1	2	1	1	1	3	12	7
Pharmacy	0	0	6	6	1	0	0	1	0	0	0	0	0	1	0	1	8	5
Transportation - Access	0	1	1	2	2	0	0	2	0	0	0	0	0	1	0	1	5	6
Transportation - Behaviour	0	0	0	0	2	0	0	2	0	0	0	0	1	3	0	4	6	1
Transportation - Other	0	0	0	0	1	0	0	1	0	0	0	0	1	0	0	1	2	0
Quality Of Care Grievances	**0**	**5**	**0**	**5**	**1**	**0**	**0**	**1**	**0**	**0**	**2**	**2**	**0**	**3**	**0**	**3**	**11**	**20**
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	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	0	1	0	0	0	0	0	0	1	1	0	1	0	1	3	3
PCP Care	0	4	0	4	1	0	0	1	0	0	0	0	0	0	0	0	5	7
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	4
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	1	2	4
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

CalViva Health Appeals and Grievances Dashboard 2020 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	0	2	0	2	0	0	1	1	0	0	0	0	2	1	0	3	6	5
Standard Appeals Received	2	4	8	14	5	4	1	10	6	1	2	9	3	3	2	8	41	33
Total Appeals Received	**2**	**6**	**8**	**16**	**5**	**4**	**2**	**11**	**6**	**1**	**2**	**9**	**5**	**4**	**2**	**11**	47	**38**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	2	0	2	0	0	1	1	0	0	0	0	1	2	0	3	6	5
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	5	2	4	11	9	6	2	**17**	3	4	2	**9**	2	2	4	**8**	45	28
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**5**	**4**	**4**	**13**	**9**	**6**	**3**	**18**	**3**	**4**	**2**	**9**	**3**	**4**	**4**	**11**	**51**	**33**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**5**	**4**	**4**	**13**	**9**	**6**	**3**	**18**	**3**	**4**	**2**	**9**	**3**	**4**	**4**	**11**	**51**	**33**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0
DME	0	0	0	0	0	0	0	0	0	0	1	1	1	0	1	2	3	2
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	2	0	4	7	0	1	**8**	1	3	0	**4**	1	2	2	5	21	8
Other	1	0	0	1	0	1	0	**1**	0	0	0	**0**	0	2	0	2	4	6
Pharmacy	2	1	4	7	1	4	2	7	2	1	1	4	1	0	1	2	20	15
Surgery	0	1	0	1	1	0	0	1	0	0	0	0	0	0	0	0	2	2
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	2	2	3	**7**	5	3	2	**10**	2	2	2	**6**	1	1	1	**3**	26	13
Uphold Rate	**40.0%**	**50.0%**	**75.0%**	**53.8%**	**55.6%**	**50.0%**	**66.7%**	**55.6%**	**66.7%**	**50.0%**	**100.0%**	**66.7%**	**33.3%**	**25.0%**	**25.0%**	**27.3%**	**51.0%**	**39.4%**
Overturns - Full	3	2	1	**6**	4	3	1	**8**	1	2	0	**3**	2	3	2	**7**	24	18
Overturn Rate - Full	**60.0%**	**50.0%**	**25.0%**	**46.2%**	**44.4%**	**50.0%**	**33.3%**	**44.4%**	**33.3%**	**50.0%**	**0.0%**	**33.3%**	**66.7%**	**75.0%**	**50.0%**	**63.6%**	**47.1%**	**54.5%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.1%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	1	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**25.0%**	**9.1%**	**2.0%**	**0.0%**
Membership	29,392	29,575	29,534		29,788	30,168	30,421		30,624	30,827	31,085		31,230	31,450	31,450			
Appeals - PTMPM	0.17	0.14	0.14	0.15	0.30	0.20	0.10	0.20	0.10	0.13	0.06	0.10	0.10	0.13	0.13	0.12	0.14	0.09
Grievances - PTMPM	0.17	0.41	0.34	0.31	0.34	0.13	0.03	0.17	0.07	0.03	0.10	0.06	0.13	0.38	0.10	0.20	0.18	0.21

Madera County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2020 YTD	2019
Expedited Grievances Received	1	0	0	1	1	2	1	4	0	2	0	2	1	0	0	1	8	23
Standard Grievances Received	9	9	7	25	4	7	5	16	5	2	5	12	6	8	8	22	75	132
Total Grievances Received	**10**	**9**	**7**	**26**	**5**	**9**	**6**	**20**	**5**	**4**	**5**	**14**	**7**	**8**	**8**	**23**	**83**	**155**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**83.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.3%**	**98.5%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	0	0	1	1	2	1	4	0	2	0	2	1	0	0	1	8	23
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	14	8	10	32	9	3	6	18	6	3	3	12	5	6	9	20	82	124
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**15**	**8**	**10**	**33**	**10**	**5**	**7**	**22**	**6**	**5**	**3**	**14**	**6**	**6**	**9**	**21**	**90**	**147**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**12**	**6**	**5**	**23**	**7**	**4**	**4**	**15**	**4**	**4**	**2**	**10**	**4**	**6**	**6**	**16**	**64**	**113**
Access - Other - DMHC	0	1	0	1	0	1	0	1	0	0	0	0	0	1	1	2	4	5
Access - PCP - DHCS	0	2	1	3	0	0	1	1	0	2	0	2	1	0	0	1	7	13
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	3	2	0	5	0	0	0	0	0	0	0	0	0	1	0	1	6	9
Administrative	1	1	2	4	2	2	2	6	1	0	2	3	0	2	1	3	16	18
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Interpersonal	3	0	0	3	1	1	0	2	1	1	0	2	0	0	1	1	8	13
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	0	0	2	1	0	0	1	2	0	0	2	1	0	1	2	7	12
Pharmacy	1	0	1	2	1	0	0	1	0	0	0	0	0	0	0	0	3	8
Transportation - Access	1	0	1	2	0	0	1	1	0	1	0	1	0	0	0	0	4	17
Transportation - Behaviour	0	0	0	0	2	0	0	2	0	0	0	0	1	2	2	5	7	14
Transportation - Other	1	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	2	3
Quality Of Care Grievances	**3**	**2**	**5**	**10**	**3**	**1**	**3**	**7**	**2**	**1**	**1**	**4**	**2**	**0**	**3**	**5**	**26**	**34**
Access - Other - DMHC	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	0	1	1	0	0	1	1	1	0	2	1	0	0	1	5	5
PCP Care	2	1	0	3	1	1	1	3	0	0	1	1	0	0	0	0	7	11
PCP Delay	0	0	2	2	0	0	1	1	1	0	0	1	0	0	0	0	4	5
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	1	0	1	2	1	0	1	2	0	0	0	0	0	0	2	2	6	12
Specialist Delay	0	0	1	1	0	0	0	0	0	0	0	0	1	0	1	2	3	1

CalViva Health Appeals and Grievances Dashboard 2020 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	1	1	3	5	0	0	2	2	1	1	1	3	1	0	2	3	13	19
Standard Appeals Received	11	5	13	29	5	2	6	13	16	6	6	28	5	7	6	18	88	85
Total Appeals Received	**12**	**6**	**16**	**34**	**5**	**2**	**8**	**15**	**17**	**7**	**7**	**31**	**6**	**7**	**8**	**21**	101	**104**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	1	1	3	5	0	0	2	2	1	1	1	3	1	0	2	3	13	19
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	4	11	5	20	12	5	5	**22**	7	12	6	**25**	7	4	8	**19**	86	88
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**5**	**12**	**8**	**25**	**12**	**5**	**7**	**24**	**8**	**13**	**7**	**28**	**8**	**4**	**10**	**22**	**99**	**107**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**5**	**11**	**8**	**24**	**12**	**5**	**7**	**24**	**8**	**13**	**7**	**28**	**8**	**4**	**10**	**22**	**98**	**107**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	2
DME	1	1	0	2	2	0	0	2	1	1	0	2	0	0	0	0	6	3
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	1
Advanced Imaging	0	2	5	7	2	0	3	5	5	4	5	14	1	1	3	5	31	45
Other	0	3	0	3	1	0	0	1	0	0	1	1	0	0	0	0	5	10
Pharmacy	3	5	3	11	7	4	4	15	2	8	1	11	5	3	6	14	51	39
Surgery	1	0	0	1	0	0	0	0	0	0	0	0	2	0	1	3	4	7
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	2	6	2	**10**	7	5	2	**14**	5	8	3	**16**	6	3	5	**14**	54	59
Uphold Rate	**40.0%**	**50.0%**	**25.0%**	**40.0%**	**58.3%**	**100.0%**	**28.6%**	**58.3%**	**62.5%**	**61.5%**	**42.9%**	**57.1%**	**75.0%**	**75.0%**	**50.0%**	**63.6%**	**54.5%**	**55.1%**
Overturns - Full	3	5	6	**14**	5	0	5	**10**	3	5	4	**12**	2	1	5	**8**	44	45
Overturn Rate - Full	**60.0%**	**41.7%**	**75.0%**	**56.0%**	**41.7%**	**0.0%**	**71.4%**	**41.7%**	**37.5%**	**38.5%**	**57.1%**	**42.9%**	**25.0%**	**25.0%**	**50.0%**	**36.36%**	**44.4%**	**42.1%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.8%**
Withdrawal	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Withdrawal Rate	**0.0%**	**8.3%**	**0.0%**	**4.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.0%**	**0.0%**
Membership	37,169	37,244	37,259		36,624	38,054	38,457		38,713	39,035	39,329		39,530	39,733	39,919			
Appeals - PTMPM	0.13	0.32	0.21	0.22	0.33	0.13	0.18	0.21	0.21	0.33	0.18	0.24	0.20	0.10	0.25	0.18	0.21	0.24
Grievances - PTMPM	0.40	0.21	0.27	0.30	0.27	0.13	0.18	0.19	0.15	0.13	0.08	0.12	0.15	0.15	0.23	0.18	0.20	0.33

CalViva SPD only

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2020 YTD	2019
Expedited Grievances Received	6	2	3	11	2	2	2	6	4	3	1	8	5	1	1	7	32	61
Standard Grievances Received	37	42	29	108	21	29	24	74	33	29	31	93	52	37	37	126	401	409
Total Grievances Received	**43**	**44**	**32**	119	**23**	**31**	**26**	**80**	**37**	**32**	**32**	**101**	**57**	**38**	**38**	**133**	**433**	**470**
Grievance Ack Letters Sent Noncompliant	0	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3
Grievance Ack Letter Compliance Rate	**100.0%**	**95.2%**	**100.0%**	**98.1%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.5%**	**99.27%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	6	2	3	11	2	2	1	5	5	3	1	9	0	1	2	3	28	61
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	36	33	50	119	31	14	30	75	28	28	30	86	25	49	40	114	394	400
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**42**	**35**	**53**	**130**	**33**	**16**	**31**	**80**	**33**	**31**	**31**	**95**	**25**	**50**	**42**	**117**	422	**461**
Grievance Descriptions - Resolved Cases	**42**	**35**	**53**	**130**	**33**	**16**	**31**	**80**	**33**	**31**	**31**	**95**	**25**	**50**	**42**	**117**	422	**461**
Access to primary care	5	2	5	12	0	1	1	2	4	5	3	12	6	1	2	9	35	39
Access to specialists	0	0	1	1	0	0	0	0	2	0	2	4	0	5	2	7	12	16
Continuity of Care	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	2	5	4	11	7	0	3	10	4	2	1	7	0	3	4	7	35	46
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	5	9	10	24	9	3	7	19	3	3	6	12	4	6	8	18	73	88
QOS Non Access	30	19	33	49	17	12	20	49	20	21	19	60	15	35	26	76	234	270
Exempt Grievances Received	8	0	17	**25**	6	14	7	**27**	9	9	7	**25**	12	8	16	**36**	**113**	NA
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	0	0	**2**	**2**	NA
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Wait Time - wait too long on telephone	0	0	0	**0**	1	1	0	**2**	0	0	1	**1**	0	0	0	**0**	**3**	NA
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	**1**	NA
Access - Panel Disruption	0	0	1	**1**	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	**3**	NA
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Attitude/Service - Health Plan Staff	1	0	0	**1**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	**2**	NA
Attitude/Service - Provider	1	0	3	**4**	0	0	1	**1**	1	0	1	**2**	1	0	5	**6**	**13**	NA
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	NA
Attitude/Service - Vendor	1	0	1	**2**	0	0	0	**0**	1	1	0	**2**	0	0	1	**1**	**5**	NA
Attitude/Service - Health Plan	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	NA
Authorization - Authorization Related	0	0	0	**0**	1	1	0	**2**	1	0	0	**1**	0	0	1	**1**	**4**	NA
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	NA
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0	1	**2**	**2**	NA
Health Plan Materials - ID Cards-Not Received	0	0	3	**3**	0	1	0	**1**	1	0	1	**2**	4	1	1	**6**	**12**	NA
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Health Plan Materials - Other	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	NA
PCP Assignment/Transfer - Health Plan Assignment - Change Request	3	0	2	**5**	1	5	1	**7**	1	3	0	**4**	2	3	3	**8**	**24**	NA
PCP Assignment/Transfer - HCO Assignment - Change Request	0	0	3	**3**	0	0	0	**0**	0	0	2	**2**	0	1	1	**2**	**7**	NA
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	2	**2**	**2**	NA
PCP Assignment/Transfer - Rollout of PPG	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	**2**	NA
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	NA
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	**1**	NA
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Pharmacy - Eligibility Issue	0	0	1	**1**	1	1	0	**2**	1	0	1	**2**	1	1	0	**2**	**7**	NA
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	**1**	NA

Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Pharmacy - Pharmacy-Retail	1	0	1	**2**	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	**4**	NA
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	NA
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	NA
OTHER - Balance Billing from Provider	1	0	0	**1**	1	3	1	**5**	3	1	1	**5**	1	0	0	**1**	**12**	NA

CalViva Health Appeals and Grievances Dashboard 2020 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	4	3	6	13	4	1	4	9	1	2	4	7	5	2	3	10	39	47
Standard Appeals Received	17	18	24	59	24	8	17	49	33	16	10	59	20	19	15	54	221	173
Total Appeals Received	**21**	**21**	**30**	**72**	**28**	**9**	**21**	**58**	**34**	**18**	**14**	**66**	**25**	**21**	**18**	**64**	260	**220**
Appeals Ack Letters Sent Noncompliant	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Appeals Ack Letter Compliance Rate	**100.0%**	**94.4%**	**100.0%**	**98.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.5%**	**98.8%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	5	3	5	13	4	1	3	8	2	2	3	7	1	2	3	6	34	47
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-600.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Standard Appeals Resolved Compliant	13	15	20	48	24	23	10	**57**	16	30	18	**64**	8	17	20	**45**	214	175
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**
Total Appeals Resolved	**18**	**18**	**25**	**61**	**28**	**24**	**13**	**65**	**18**	**32**	**21**	**71**	**9**	**19**	**23**	**51**	**248**	**223**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**18**	**18**	**25**	**61**	**28**	**24**	**13**	**65**	**18**	**32**	**21**	**71**	**9**	**19**	**23**	**51**	**248**	**222**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	1	0	1	2	1	0	3	0	0	0	0	4	0
DME	3	2	1	6	1	0	1	2	2	3	3	8	2	3	3	8	24	30
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Advanced Imaging	6	8	7	21	11	5	5	21	9	19	8	36	2	6	11	19	97	92
Other	0	2	1	3	5	0	0	5	0	2	0	2	0	2	2	4	14	17
Pharmacy	9	4	15	28	10	18	7	35	5	7	10	22	4	6	5	15	100	68
Surgery	0	2	1	3	1	0	0	1	0	0	0	0	1	2	2	5	9	9
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	5	7	12	**24**	16	13	4	**33**	8	13	15	**36**	5	14	11	**30**	123	108
Uphold Rate	**27.8%**	**38.9%**	**48.0%**	**39.3%**	**57.1%**	**54.2%**	**30.8%**	**50.8%**	**44.4%**	**40.6%**	**71.4%**	**50.7%**	**55.6%**	**73.7%**	**47.8%**	**58.8%**	**49.6%**	**48.4%**
Overturns - Full	11	10	11	**32**	12	10	8	**30**	9	18	6	**33**	4	5	12	**21**	116	108
Overturn Rate - Full	**61.1%**	**55.6%**	**44.0%**	**52.5%**	**42.9%**	**41.7%**	**61.5%**	**46.2%**	**50.0%**	**56.3%**	**28.6%**	**46.5%**	**44.4%**	**26.3%**	**52.2%**	**41.2%**	**46.8%**	**48.43%**
Overturns - Partials	2	1	1	**4**	0	0	1	**1**	1	1	0	**2**	0	0	0	**0**	7	6
Overturn Rate - Partial	**11.1%**	**5.6%**	**4.0%**	**6.6%**	**0.0%**	**0.0%**	**7.7%**	**1.5%**	**5.6%**	**3.1%**	**0.0%**	**2.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.8%**	**2.7%**
Withdrawal	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	2	1
Withdrawal Rate	**0.0%**	**0.0%**	**4.0%**	**1.6%**	**0.0%**	**4.2%**	**0.0%**	**1.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.8%**	**0.0%**
Membership	32,836	32,838	32,797		32,952	33,195	33,406		33,456	33,556	33,578		33,704	33,785	33,844			
Appeals - PTMPM	0.55	0.55	0.76	0.00	0.85	0.72	0.39	0.00	0.54	0.95	0.63	0.71	0.27	0.56	0.68	0.50	0.30	0.68
Grievances - PTMPM	1.28	1.07	1.62	0.00	1.00	0.48	0.93	0.00	0.99	0.92	0.92	0.94	0.74	1.48	1.24	1.15	0.52	1.43

Item #15

Attachment 15.C

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 12/01/2020 to 12/31/2020

Report created 1/28/2021

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

Exhibits:

Contact Information

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

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 12/01/2020 to 12/31/2020
Report created 1/28/2021

ER utilization based on Claims data	2019-12	2019-Trend	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Qtr Trend	CY- 2019	YTD-2020	YTD-Trend
																Quarterly Averages									Annual Averages		
Expansion Mbr Months	85,324		84,559	84,043	83,764	84,560	85,997	87,471	88,912	90,748	91,924	93,004	94,353	95,232		85,497	85,418	86,850	85,876	84,122	86,009	90,528	94,196		85,910	88,714	
Family/Adult/Other Mbr Mos	246,046		244,968	244,366	243,647	245,026	247,135	249,187	250,941	252,508	253,831	254,922	255,950	256,506		241,979	241,474	249,603	246,717	244,327	247,116	252,427	255,793		244,943	249,916	
SPD Mbr Months	34,221		34,161	34,155	34,045	34,088	34,082	34,126	34,143	34,154	34,121	34,120	34,082	34,060		32,767	32,988	33,950	34,143	34,120	34,099	34,139	34,087		33,462	34,111	
Admits - Count	2,247		2,345	2,195	2,087	1,618	1,795	1,943	2,059	2,254	2,010	2,033	1,621	606		2,227	2,222	2,307	2,253	2,209	1,785	2,108	1,420		2,252	1,881	
Expansion	664		675	672	614	507	555	606	670	686	674	706	550	186		619	660	705	656	654	556	677	481		660	592	
Family/Adult/Other	1,043		1,086	1,016	974	790	866	921	983	1,094	958	944	734	295		1,061	1,018	1,060	1,061	1,025	859	1,012	658		1,050	888	
SPD	527		570	502	495	314	369	408	399	466	375	376	331	122		537	532	525	524	522	364	413	276		529	394	
Admits Acute - Count	1,509		1,615	1,527	1,397	948	1,172	1,289	1,346	1,492	1,296	1,313	1,174	404		1,550	1,519	1,514	1,501	1,513	1,136	1,378	964		1,521	1,248	
Expansion	487		511	487	441	350	426	458	511	517	503	516	444	138		456	502	521	484	480	411	510	366		491	442	
Family/Adult/Other	533		570	573	504	307	394	434	455	531	449	453	408	151		594	522	505	533	549	378	478	337		538	436	
SPD	480		526	462	449	286	347	389	374	439	343	341	320	114		491	488	478	476	479	341	385	258		483	366	
Readmit 30 Day - Count	309		312	274	287	199	236	236	258	309	259	258	213	50		297	294	299	310	291	224	275	174		300	241	
Expansion	81		92	94	73	56	83	75	81	95	95	90	86	17		78	85	100	87	86	71	90	64		87	78	
Family/Adult/Other	79		72	73	76	54	68	69	73	99	80	78	55	14		85	78	90	87	74	64	84	49		85	68	
SPD	147		146	105	138	88	85	91	102	114	84	89	71	18		133	130	106	133	130	88	100	59		126	94	
Readmit 14 Day - Count	21		31	26	36	18	23	21	22	26	21	28	23	4		26	32	26	23	31	21	23	18		27	23	
Expansion	5		9	9	12	5	7	4	8	6	6	12	10	2		7	8	9	7	10	5	7	8		8	8	
Family/Adult/Other	7		7	9	7	2	11	5	7	5	8	8	6	0		8	8	7	4	8	6	7	5		7	6	
SPD	9		15	8	17	11	5	12	7	15	7	8	6	2		10	16	11	12	13	9	10	5		12	9	
**ER Visits - Count	16,135		18,474	17,875	13,488	7,565	9,356	10,732	12,205	11,207	10,481	10,617	9,917	5,651		16,724	15,635	15,755	15,698	16,612	9,218	11,298	8,728		15,953	11,464	
Expansion	3,755		4,058	3,836	3,405	2,429	2,922	3,378	3,823	3,590	3,325	3,349	3,094	1,835		3,693	3,881	4,096	3,667	3,766	2,910	3,579	2,759		3,834	3,254	
Family/Adult/Other	10,540		12,380	12,109	8,493	4,000	5,107	6,019	6,712	6,246	5,839	6,028	5,687	3,223		11,316	9,987	9,790	10,236	10,994	5,042	6,266	4,979		10,332	6,820	
SPD	1,798		1,982	1,878	1,553	1,113	1,302	1,299	1,365	1,333	1,254	1,202	1,075	580		1,693	1,723	1,821	1,753	1,804	1,238	1,317	952		1,747	1,328	
Admits Acute - PTMPY	49.5		53.2	50.4	46.3	31.2	38.2	41.6	43.1	47.3	40.9	41.2	36.6	12.5		51.6	50.6	49.0	49.0	50.0	37.1	43.8	30.1		50.0	40.1	
Expansion	68.5		72.5	69.5	63.2	49.7	59.4	62.8	69.0	68.4	65.7	66.6	56.5	17.4		64.0	70.5	72.0	67.6	68.4	57.4	67.6	46.6		68.5	59.8	
Family/Adult/Other	26.0		27.9	28.1	24.8	15.0	19.1	20.9	21.8	25.2	21.2	21.3	19.1	7.1		29.5	25.9	24.3	25.9	27.0	18.4	22.7	15.8		26.4	20.9	
SPD	168.3		184.8	162.3	158.3	100.7	122.2	136.8	131.4	154.2	120.6	119.9	112.7	40.2		179.8	177.4	168.8	167.4	168.5	119.9	135.4	90.9		173.3	128.7	
Bed Days Acute - PTMPY	251.6		251.8	244.1	242.1	166.2	207.3	233.3	269.9	264.8	226.0	218.4	209.3	83.3		261.6	247.7	236.6	246.2	246.0	202.5	253.5	170.2		247.9	217.6	
Expansion	347.4		378.3	369.2	349.3	244.2	327.6	347.1	455.2	390.5	373.7	382.7	329.1	120.2		332.4	335.2	379.6	340.0	365.7	306.9	406.0	276.4		346.9	338.0	
Family/Adult/Other	108.7		96.9	107.5	87.4	71.9	85.2	103.9	119.7	127.9	88.2	91.4	94.0	46.1		111.6	99.0	86.9	101.6	97.3	87.1	111.9	77.1		99.7	93.3	
SPD	1,014.8		1,044.7	903.3	1,080.7	648.4	786.9	870.7	885.0	936.7	857.1	717.8	733.8	255.8		1,168.7	1,102.4	959.3	1,035.2	1,009.5	768.7	892.9	569.2		1,065.2	810.2	
ALOS Acute	5.1		4.7	4.8	5.2	5.3	5.4	5.6	6.3	5.6	5.5	5.3	5.7	6.6		5.1	4.9	4.8	5.0	4.9	5.5	5.8	5.7		5.0	5.4	
Expansion	5.1		5.2	5.3	5.5	4.9	5.5	5.5	6.6	5.7	5.7	5.7	5.8	6.9		5.2	4.8	5.3	5.0	5.3	5.3	6.0	5.9		5.1	5.7	
Family/Adult/Other	4.2		3.5	3.8	3.5	4.8	4.5	5.0	5.5	5.1	4.2	4.3	4.9	6.5		3.8	3.8	3.6	3.9	3.6	4.7	4.9	4.9		3.8	4.5	
SPD	6.0		5.7	5.6	6.8	6.4	6.4	6.4	6.7	6.1	7.1	6.0	6.5	6.4		6.5	6.2	5.7	6.2	6.0	6.4	6.6	6.3		6.1	6.3	
Readmit % 30 Day	13.8%		13.3%	12.5%	13.8%	12.3%	13.1%	12.1%	12.5%	13.7%	12.9%	12.7%	13.1%	8.3%		13.3%	13.2%	12.9%	13.8%	13.2%	12.5%	13.1%	12.2%		13.3%	12.8%	
Expansion	12.2%		13.6%	14.0%	11.9%	11.0%	15.0%	12.4%	12.1%	13.8%	14.1%	12.7%	15.6%	9.1%		12.6%	12.8%	14.1%	13.3%	13.2%	12.8%	13.3%	13.4%		13.2%	13.2%	
Family/Adult/Other	7.6%		6.6%	7.2%	7.8%	6.8%	7.9%	7.5%	7.4%	9.0%	8.4%	8.3%	7.5%	4.7%		8.0%	7.7%	8.5%	8.2%	7.2%	7.4%	8.3%	7.5%		8.1%	7.6%	
SPD	27.9%		25.6%	20.9%	27.9%	28.0%	23.0%	22.3%	25.6%	24.5%	22.4%	23.7%	21.5%	14.8%		24.7%	24.5%	20.3%	25.4%	24.8%	24.2%	24.2%	21.5%		23.7%	23.9%	
Readmit % 14 Day	1.4%		1.9%	1.7%	2.6%	1.9%	2.0%	1.6%	1.6%	1.7%	1.6%	2.1%	2.0%	1.0%		1.7%	2.1%	1.7%	1.6%	2.0%	1.8%	1.7%	1.9%		1.8%	1.9%	
Expansion	1.0%		1.8%	1.8%	2.7%	1.4%	1.6%	0.9%	1.6%	1.2%	1.2%	2.3%	2.3%	1.4%		1.6%	1.6%	1.7%	1.5%	2.1%	1.3%	1.3%	2.2%		1.6%	1.7%	
Family/Adult/Other	1.3%		1.2%	1.6%	1.4%	0.7%	2.8%	1.2%	1.5%	0.9%	1.8%	1.8%	1.5%	0.0%		1.3%	1.6%	1.4%	0.8%	1.4%	1.6%	1.4%	1.4%		1.3%	1.4%	
SPD	1.9%		2.9%	1.7%	3.8%	3.8%	1.4%	3.1%	1.9%	3.4%	2.0%	2.3%	1.9%	1.8%		2.0%	3.2%	2.2%	2.5%	2.8%	2.7%	2.5%	2.1%		2.5%	2.6%	
**ER Visits - PTMPY	528.7		608.5	590.6	447.0	249.2	305.2	346.7	390.9	355.7	330.5	332.8	309.0	175.4		556.9	520.8	509.6	512.8	548.8	300.6	358.8	272.2		524.9	368.4	
Expansion	528.1		575.9	547.7	487.8	344.7	407.7	463.4	516.0	474.7	434.1	432.1	393.5	231.2		518.3	545.2	565.9	512.4	537.3	406.0	474.5	351.5		535.5	440.1	
Family/Adult/Other	514.1		606.4	594.6	418.3	195.9	248.0	289.9	321.0	296.8	276.0	283.8	266.6	150.8		561.2	496.3	470.7	497.9	540.0	244.8	297.9	233.6		506.2	327.5	
SPD	630.5		696.2	659.8	547.4	391.8	458.4	456.8	479.7	468.3	441.0	422.7	378.5	204.3		619.9	626.8	643.5	616.2	634.6	435.7	463.0	335.3		626.7	467.2	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 12/01/2020 to 12/31/2020
Report created 1/28/2021

ER utilization based on Claims data	2019-12	2019-Trend	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Qtr Trend	CY- 2019	YTD-2020	YTD-Trend
Services	pliance Go		TAT Compliance Goal: 100%													TAT Compliance Goal: 100%									TAT Compliance Goal: 100%		
Preservice Routine	92.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.9%	65.6%	87.3%	88.7%	100.0%	100.0%	100.0%	100.0%				
Preservice Urgent	92.0%		100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%		98.9%	90.0%	91.8%	89.3%	98.7%	99.3%	100.0%	99.3%				
Postservice	94.0%		100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	98.9%	92.9%	94.0%	100.0%	98.7%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		92.2%	96.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	92.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Urgent	NA		N/A	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%				
Deferrals - Post Service	NA		null	null	null	null	null	null	null	null	null	null	null	null		null	null	null	null	null	null	null	null				
	CS ID RATE		CCS ID RATE													CCS ID RATE									CCS ID RATE		
CCS %	8.31%		8.36%	8.25%	8.42%	8.24%	8.15%	8.30%	8.18%	8.16%	8.31%	8.29%	8.27%	8.25%		8.07%	8.10%	8.19%	8.28%	8.34%	8.23%	8.22%	8.27%		8.16%	8.27%	
	rinatal Case Manageme		Perinatal Case Management													Perinatal Case Management									Perinatal Case Management		
Total Number Of Referrals	184		258	250	275	207	176	178	232	166	161	164	127	113		135	507	655	396	783	561	559	404		1,693	2,307	
Pending	6		0	1	0	0	0	0	0	0	0	1	2	2		0	1	5	8	1	0	0	5		14	6	
Ineligible	3		8	9	9	6	9	15	8	12	11	2	4	2		10	40	35	5	26	30	31	8		90	95	
Total Outreached	175		250	240	266	201	167	163	224	154	150	161	121	109		125	466	615	383	756	531	528	391		1,589	2,206	
Engaged	64		80	67	75	73	59	70	73	42	42	45	41	26		31	121	149	140	222	202	157	112		441	693	
Engagement Rate	37%		32%	28%	28%	36%	35%	43%	33%	27%	28%	28%	34%	24%		25%	26%	24%	37%	29%	38%	30%	29%		28%	31%	
New Cases Opened	64		80	67	75	73	59	70	73	42	42	45	41	26		31	121	149	140	222	202	157	112		444	693	
Total Cases Managed	283		324	344	367	383	369	406	416	391	390	365	299	271		99	177	273	316	465	472	485	413		503	943	
Total Cases Closed	40		44	52	55	73	35	61	74	57	62	84	54	51		44	37	80	99	151	169	193	189		260	702	
Cases Remained Open	228		266	275	291	292	324	319	267	311	267	205	205	205		52	125	197	228	291	319	267	205		228	205	
	egrated Case Managem		Integrated Case Management													Integrated Case Management									Integrated Case Management		
Total Number Of Referrals	112		97	125	151	139	156	144	214	188	159	178	160	150		152	258	290	301	373	439	561	488		1,001	1,861	
Pending	7		1	0	0	0	0	1	0	0	0	4	2	14		0	4	6	10	1	1	0	20		20	22	
Ineligible	10		10	9	4	10	6	12	12	26	13	32	33	32		10	31	34	30	23	28	51	97		105	199	
Total Outreached	95		86	116	147	129	150	131	202	162	146	142	125	104		142	223	250	261	349	410	510	371		876	1,640	
Engaged	49		45	61	66	57	66	70	108	94	88	78	77	69		58	73	98	119	172	193	290	224		348	879	
Engagement Rate	52%		52%	53%	45%	44%	44%	53%	53%	58%	60%	55%	62%	66%		41%	33%	39%	46%	49%	47%	57%	60%		40%	54%	
Total Screened and Refused/Decline	14		10	17	28	22	22	21	34	22	16	23	16	10		28	58	65	65	55	65	72	49		216	241	
Unable to Reach	42		31	38	53	50	62	40	60	46	42	41	32	25		67	131	127	122	122	152	148	98		447	520	
New Cases Opened	49		45	61	66	57	66	70	108	94	88	78	77	69		58	73	98	113	172	193	290	224		342	879	
Total Cases Closed	30		19	39	47	55	37	50	51	65	80	92	85	63		63	70	102	111	105	142	196	240		346	683	
Cases Remained Open	125		141	160	184	221	252	289	359	397	314	292	292	292		116	137	130	125	184	289	314	292		125	292	
Total Cases Managed	139		151	196	221	228	240	276	339	381	417	407	373	357		164	189	192	202	279	367	533	541		444	990	
Critical-Complex Acuity	31		36	31	30	35	47	55	59	64	64	57	55	55		26	32	31	39	42	65	77	73		65	130	
High/Moderate/Low Acuity	108		115	165	191	193	193	221	280	317	353	350	318	302		138	157	159	163	237	302	456	468		379	860	
	sitional Case Managen		Transitional Case Management													Transitional Case Management									Transitional Case Management		
Total Number Of Referrals	132		131	113	177	153	147	179	268	227	245	251	233	204		152	137	377	414	421	479	740	688		1,080	2,328	
Pending	29		0	0	0	0	0	0	0	0	0	0	0	25		0	3	18	34	0	0	0	25		55	25	
Ineligible	15		10	8	9	8	11	14	20	27	27	22	25	22		29	45	61	41	27	33	74	69		176	203	
Total Outreached	88		121	105	168	145	136	165	248	200	218	229	208	157		123	89	298	339	394	446	666	594		849	2,100	
Engaged	48		76	57	81	79	62	77	122	105	116	125	99	79		50	25	125	167	214	218	343	303		367	1,078	
Engagement Rate	55%		63%	54%	48%	54%	46%	47%	49%	53%	53%	55%	48%	50%		41%	28%	42%	49%	54%	49%	52%	51%		43%	51%	
Total Screened and Refused/Decline	14		13	14	38	19	29	27	38	32	25	26	28	19		44	25	66	85	65	75	95	73		220	308	
Unable to Reach	29		32	34	49	47	45	61	88	63	77	78	81	59		36	48	124	101	115	153	228	218		309	714	
New Cases Opened	48		76	57	81	79	62	77	122	105	116	125	99	79		51	24	125	167	214	218	343	303		367	1,078	
Total Cases Closed	55		55	58	86	80	81	65	82	103	118	105	124	113		29	43	79	167	199	226	303	342		318	1,070	
Cases Remained Open	55		74	62	63	74	54	56	81	93	106	42	42	42		18	13	45	55	63	56	106	42		55	42	
Total Cases Managed	117		138	140	164	157	141	135	193	217	228	236	230	185		52	55	128	167	280	296	398	394		378	1136	
High/Moderate/Low Acuity	117		138	140	164	157	141	135	193	217	228	236	230	185		52	55	128	167	280	296	398	394		378	1136	

Key Indicator Report
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Report created 1/28/2021

ER utilization based on Claims data	2019-12	2019-Trend	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Qtr Trend	CY- 2019	YTD-2020	YTD-Trend
	Palliative Care		Palliative Care																Palliative Care						Palliative Care		
Total Number Of Referrals	21		23	24	22	24	22	35	15	10	8	10	20	10					21	69	81	33	40		21	223	
Pending	3		0	0	0	1	0	0	0	0	0	2	5	0					3	0	1	0	7		3	4	
Ineligible	0		8	7	9	9	11	14	4	4	3	3	5	6					0	24	34	11	14		0	83	
Total Outreached	18		15	17	13	14	11	21	11	6	5	5	10	4					18	45	46	22	19		18	132	
Engaged	14		12	13	9	10	8	17	6	5	5	3	8	3					14	34	35	16	14		14	99	
Engagement Rate	78%		80%	76%	69%	71%	73%	81%	55%	83%	100%	60%	80%	75%					78%	76%	76%	73%	74%		78%	75%	
Total Screened and Refused/Decline	2		1	4	3	3	2	4	3	1	0	2	2	0					2	8	9	4	4		2	25	
Unable to Reach	2		2	0	1	1	1	0	2	0	0	0	0	1					2	3	2	2	1		2	8	
New Cases Opened	13		13	14	9	9	8	16	6	5	5	3	8	3					13	36	33	16	14		13	99	
Total Cases Closed	9		5	7	11	10	12	3	5	7	10	5	12	11					9	23	25	22	28		9	98	
Cases Remained Open	84		85	89	88	88	84	96	97	101	91	90	92	87					84	88	96	91	87		84	87	
Total Cases Managed	109		90	96	100	102	101	103	108	109	106	101	109	105					109	107	122	126	122		109	262	
	oral Health Case Mana		Behavioral Health Case Management																Behavioral Health Case Management						Behavioral Health Case Managemen		
Total Number Of Referrals	24		24	47	49	111	92	122	112	132	120	111	84	96		80	104	174	97	120	325	364	291		455	1,100	
Pending	2		0	0	0	0	0	0	0	0	0	0	0	6		0	1	8	3	0	0	0	6		12	6	
Ineligible	2		2	1	1	4	5	6	2	7	7	5	6	5		9	9	23	5	4	15	16	16		46	51	
Total Outreached	20		22	46	48	107	87	116	110	125	113	106	78	85		71	94	143	89	116	310	348	269		397	1,043	
Engaged	10		12	16	23	45	29	45	45	57	54	47	33	34		29	40	54	40	51	119	156	114		163	440	
Engagement Rate	50%		55.0%	35.0%	48.0%	42.0%	33.0%	39%	41%	46%	48%	44%	42%	40%		41%	43%	38%	45%	44%	38%	45%	42%		41%	42%	
Total Screened and Refused/Decline	2		0	0	0	1	2	3	3	2	11	1	4	3		2	2	7	5	0	6	16	8		16	30	
Unable to Reach	11		10	30	25	60	56	68	62	66	48	58	41	48		44	58	99	53	65	184	176	147		254	572	
New Cases Opened	10		12	16	23	45	29	45	45	57	54	47	33	34		29	40	53	40	51	119	156	114		163	440	
Total Cases Closed	11		21	15	16	17	24	24	25	42	58	53	36	51		21	26	60	45	52	65	125	140		152	382	
Cases Remained Open	25		18	19	28	56	60	73	81	66	94	78	78	78		21	34	25	25	28	73	94	78		25	78	
Total Cases Managed	39		39	37	46	84	96	119	141	177	203	192	151	149		47	63	76	63	81	164	295	279		181	496	
Critical-Complex Acuity	4		5	4	7	9	11	14	16	15	15	7	8	7		4	6	9	10	9	17	22	13		14	26	
High/Moderate/Low Acuity	35		34	33	39	75	85	105	125	162	188	185	143	142		43	57	67	53	72	147	273	266		167	470	
	Record Processing		Record Processing																Record Processing						Record Processing		
Total Records	7,418		8,341	7,703	7,536	5,414	7,551	7,558	7,566	7,570	6,699	6,785	4,586	4,594		22,529	24,476	23,285	23,559	23,580	20,523	21,835	22,827		93,849	81,903	
Total Admissions	2,155		2,244	2,201	2,092	1,595	2,072	2,069	2,066	2,060	2,001	2,055	1,617	1,610		6,490	6,440	6,604	6,459	6,537	5,736	6,127	6,342		25,993	23,682	

Item #15

Attachment 15.D

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: February 18th, 2021

SUBJECT: CalViva Health QI & UM Update of Activities Quarter 4 2020 (February 2021)

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 2020.

I. Meetings

Two meetings were held in Quarter 4, one in October and one in November. The October meeting was reported on at the November meeting. This report covers the November meeting only. The only general documents that were approved at the November meeting were:

1. Pharmacy Formulary & Provider Updates
2. Public Health & County Relations Policies & Procedures

II. QI Reports -

The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance Dashboard** for September 2020 tracks volumes, turn-around times, and case classifications. Results demonstrate that the volume of grievances (QOS & QOC) in the third quarter remained relatively consistent with Q2 2020, however it is important to note that current volumes are lower than Q1 and previous quarters. This is attributed to decreased provider-member interactions due to COVID 19.
   a. Majority of grievances reported were in the Quality of Service and Exempt categories. Two categories stated as "PCP Assignment/Transfer" that were labeled incorrectly have been modified to better reflect the issues.
   b. Appeal volumes as of the end of Q3 have demonstrated variation quarter to quarter with increased volumes compared to prior year. Opportunities to further evaluate these appeals and educate providers have been identified, and training was conducted.
2. **Potential Quality Issues (PQI) Report** provides a summary of the quarterly evaluation of cases/issues that may result in substantial harm to a member. PQI issues originate during the provision of care or services when the omission or commission of care interventions results in potential harm to the member.
   a. Non-member initiated PQI category cases were lower when compared to the last three Quarters. No cases were generated from Provider Preventable Conditions (PPCs).
   b. Member generated PQI's have also decreased compared to the previous three Quarters.
   c. There were eight (8) peer review cases processed.

   Follow up has been initiated when appropriate. PQI and PPC cases will continue to be tracked, monitored and reported.

3. **MHN Performance Indicator Report for Behavioral Health** was reviewed in the November meeting with Q3 data presented**. I**n Q3 2020, MHN reported on 15 of 15 metrics that met or exceeded their targets.
   a. Performance was below the target of 100% for Authorization Decision Timeliness for ABA authorization decisions, however it exceeded the threshold for action of 95%.
   b. The Q2 2020 utilization rate was 2.2%. Utilization of services is demonstrating quarter over quarter increases over the past 12 months. (one quarter lag)
   c. There were three non-life-threatening emergent cases and the appointment access standard was met. There were two life-threatening emergent cases and the appointment access standard was met.
   d. There were two PQI cases in Q3 2020 and they were resolved within timeliness standards.
4. **Facility Site and Medical Record Review & PARS** report was presented for first and second quarters of 2020. The following was noted:
   a. There were eight (8) Facility Site Reviews (FSR) and eight (8) Medical Record Reviews (MRR) completed in the 1st and 2nd Quarters of 2020.
   b. The overall mean FSR score for Fresno, Kings and Madera Counties was 99% for the 1st and 2nd Quarters of 2020 and the mean FSR score for the 3rd and 4th Quarters of 2019 was 97%.
   c. The overall mean MRR score for Fresno, Kings and Madera Counties was 91% for the 1st and 2nd Quarters of 2020. The mean MRR score for the 3rd and 4th Quarters of 2019 was 93%.
   d. The Pediatric Preventive Care section mean score was 83%.
   e. The Adult Preventive Care section mean score was 86%.
   f. Due to COVID-19, the onsite Facility Site Reviews were stopped after March 13, 2020. The data above reflects sites reviewed prior to the reviews halted.
5. **Initial Health Assessment Quarterly Audit Report** provides a summary of the various activities employed to facilitate completion of the Initial Health Assessment (IHA) for new Medi-Cal members within 120 days of enrollment. This includes the following:
   1. Medical Record Review (MRR) via onsite provider audits.
   2. Monitoring of claims and encounters data.
   3. Member outreach following a three-step methodology.

   However, due to the COVID-19 public health emergency, the DHCS distributed APL 20-004 to temporarily halt requirements to complete IHA's from December 1, 2019 to the end of the public health emergency currently in effect. Additionally, there were no on-site medical record reviews completed due to COVID-19.

   Based upon a DHCS Corrective Action Plan (CAP) CalViva is developing a quality improvement activity for IHA/IHEBA completion. This is being accomplished through collaboration with a low-performing IHEBA provider and a high-performing IHEBA provider to identify barriers and test interventions for improvement. Focus at this time is on obtaining the New Member List and addressing coding issues for IHEBA.
6. **Additional Quality Improvement Reports** including County Relations Quarterly Report, CCS Report, and the Provider Preventable Conditions Report. Additionally, there were two Access Related reports presented: Provider Office Wait Time and Specialty Referral Report.

III. UMCM Reports -

The following is a summary of some of the reports and topics reviewed:

1. **The Key Indicator Report (KIR)** provided data through September 30th, 2020. A quarterly comparison was reviewed with the following results:
   a. In-hospital utilization rates have dipped in all areas in Q3. The lower admission numbers may be related to the spikes in COVID-19 cases throughout the year.
   b. Turn-around time compliance in Q3 was 100%
   c. Case Management results in 2020 continue to demonstrate positive trends in all areas.

2. **Additional Utilization Management/Case Management Reports** presented were the UM Concurrent Review Report, the UM IRR Report and the Case Management & CCM Report.

IV. Pharmacy Reports – This quarter included the following Pharmacy reports: Pharmacy Call Report, Operation Metrics, Top 30 Medication Prior Authorizations, and the Inter-rater Reliability Report.

1. Authorization (PA) Requests, and quarterly Formulary changes were all reviewed. All third quarter 2020 pharmacy prior authorization metrics were within 5% of standard.
2. The Interrater Reliability Report was presented. This report describes an evaluation of a sample of 10 prior authorization denials per month which are reviewed quarterly to ensure they are completed timely, accurately, and consistently. The target goal of this review is 95% accuracy or better. Results met the 95% threshold. Follow up occurs with PA managers when opportunities for improvement are identified.

V. HEDIS® Activity

In Q4 HEDIS® related activities were focused on analyzing the results for RY2020 under the new Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile and initiating activities to address opportunities for improvement.

The areas that CalViva reported results below the 50th percentile MPL are:

a. Antidepressant Medication Management (AMM), for both the Acute Phase and the Continuation Phase, for all three counties.
b. Adolescent Well-Care (AWC) Visit for Fresno County.
c. Breast Cancer Screening (BCS) for Fresno County.
d. Chlamydia Screening (CHL)for Madera County.
e. Childhood Immunization – Combo 10 (CIS-10) for Fresno and Kings counties.
f. Well-Child Visits in the first 15 months of life (W-15) for Fresno and Kings counties.

The two (2) Performance Improvement Projects (PIPs) for RY 2020 were Childhood Immunization – Combo 10 *(Child & Adolescent)*, and Breast Cancer Screening *(BCS Disparity).* On November 2nd CalViva submitted notification to DHCS of our intent to re-establish Performance Improvement Projects (PIPs) for these two measures. The PIP Modules were updated by HSAG and CalViva Medical Management staff will participate in the training sessions provided on how to complete these Modules. Module 1 is due 3/1/2021 for CIS-10 PIP and 3/26/2021 for BCS PIP.

Each MCP is also required to develop one PDSA rapid cycle improvement project from the MCAS measures. For our PDSA project, Medical Management submitted our initial plan for improvement for Chlamydia Screening in Madera County on October 21st, 2020. This plan was accepted by DHCS and intervention implementation is underway.

Thirdly, each Plan is required to report on what is called the "COVID-19 Quality Improvement Plan (QIP)". This is a selection of 3 or more improvement strategies that demonstrate how the Plan has/will adapt to improve the health/wellness of its members during the COVID 19 Emergency. These interventions are to be associated with preventive services, chronic illness and/or behavioral health.

The initial CalViva COVID-19 QIP report was submitted to DHCS on October 21st, 2020 and accepted by DHCS. The 3 improvement strategies include:

1. Antidepressant Medication Management (AMM) Member Outreach effort by Behavioral Health Case Managers in Kings and Madera counties to encourage medication adherence.
2. Adolescent Well-Care Visits will be addressed through a MemberConnections Outreach intervention for families in Fresno County.
3. Pharmacy Outreach effort to encourage medication adherence for patients on blood pressure medications and/or anti-diabetic agents in Fresno County.

VI. Findings/Outcomes

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

Item #15

Attachment 15.E

Operations Report

IT Communications and Systems	**Active Presence of an External Vulnerability within Systems**	**NO**	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	**NO**	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	**NO**	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	**NO**	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	**NO**	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Age of Workstations	**3 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The COO	At present time, there are no issues, items of significance to report at this time as it relates to the Plan's IT Communications and Systems.		

Privacy and Security	**Risk Analysis (Last Completed mm/yy: 11/20)**	**Privacy Risk Rating: 9 Risks / Grade: A** **Security Risk Rating: 10 Risks / Grade: A**	Description: Conducting an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of PHI and ePHI held by the Health Plan. A Letter Grade is assigned: A (90%-100%), B (80-89%), C (74-79%), D (70%-73%), and D- (0-69%) based on risk assessment questions marked yes and remediated. The denominator is the total # of questions in the assessment.
	Eff. Date & Last Annual Mail Date of NPP (mm/yy)	**4/18 & 2/20**	Description: Notice of Privacy Practices (NPP) describes how PHI may be used and disclosed. The NPP is review and updated when appropriate. The NPP is distributed upon enrollment and annually thereafter
	Active Business Associate Agreements	**5**	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	**2020**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**
Month	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
No/Low Risk	**2**	**3**	**2**	**3**	**3**	**2**	**1**
High Risk	**0**	**1**	**0**	**0**	**0**	**0**	**0**
Total Cases By Month	**2**	**4**	**2**	**3**	**3**	**2**	**1**
Year	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
No/Low Risk	**54**	**36**	**28**	**38**	**23**	**28**	**3**
High Risk	**3**	**5**	**1**	**1**	**2**	**3**	**0**
Total Cases By Year	**57**	**41**	**29**	**39**	**25**	**31**	**3**

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

Member Call Center CalViva Health Website		**Year**	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**30,232**	**27,416**	**29,707**	**20,544**	**23,684**	**23,685**
		# of Calls Answered	**30,031**	**27,140**	**29,564**	**20,407**	**23,488**	**23,520**
		Abandonment Level (Goal < 5%)	**0.70%**	**1.00%**	**0.50%**	**0.70%**	**0.80%**	**0.70%**
		Service Level (Goal 80%)	**92%**	**86%**	**96%**	**98%**	**93%**	**95%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,204**	**1,132**	**1,228**	**1,028**	**1,798**	**936**
		# of Calls Answered	**1,188**	**1,124**	**1,218**	**1,022**	**1,752**	**927**
		Abandonment Level (Goal < 5%)	**1.30%**	**0.70%**	**0.80%**	**0.60%**	**2.60%**	**1.00%**
		Service Level (Goal 80%)	**88%**	**87%**	**93%**	**94%**	**78%**	**89%**
	Transportation Call Center	**# of Calls Received**	**16,285**	**16,264**	**17,872**	**11,717**	**10,011**	**9,867**
		# of Calls Answered	**15,943**	**16,085**	**17,765**	**11,506**	**9,801**	**9,808**
		Abandonment Level (Goal < 5%)	**2.10%**	**1.10%**	**0.60%**	**1.80%**	**2.10%**	**0.60%**
		Service Level (Goal 80%)	**67%**	**83%**	**83%**	**76%**	**44%**	**76%**
	CalViva Health Website	**# of Users**	**20,000**	**20,000**	**21,000**	**16,000**	**22,000**	**25,000**
		Top Page	**Find a Provider**	**Find a Provider**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (57%)**	**Mobile (57%)**	**Mobile (60%)**	**Mobile (56%)**	**Mobile (63%)**	**Mobile (61%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**
Message from the COO	CalViva Health unveiled a cosmetic refresh of the CalViva Health website approximately around December 28, 2020. Management has been working with the Transportation Call Center to meet the Service Level goal of 80%.							

Provider Network Activities & Provider Relations	**Year**	**2020**	**2020**	**2020**	**2020**	**2020**	**2020**	**2020**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**132**	**132**	**135**	**139**	**141**	**141**	**140**
	PCP	**385**	**382**	**381**	**382**	**377**	**380**	**386**
	PCP Extender	**215**	**216**	**216**	**210**	**217**	**219**	**220**
	Specialist	**1405**	**1410**	**1430**	**1435**	**1448**	**1452**	**1456**
	Ancillary	**195**	**197**	**196**	**197**	**197**	**194**	**195**
	Year	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Pharmacy	**151**	**151**	**152**	**151**	**153**	**152**	**154**
	Behavioral Health	**343**	**342**	**368**	**356**	**357**	**354**	**359**
	Vision	**39**	**42**	**41**	**42**	**45**	**47**	**46**
	Urgent Care	**14**	**13**	**12**	**12**	**11**	**12**	**11**
	Acupuncture	**6**	**6**	**5**	**4**	**5**	**7**	**7**
	Year	**2019**	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**94%**	**93%**	**90%**	**93%**	**93%**	**93%**	**94%**
	% Of Specialists Accepting New Patients - Goal (85%)	**95%**	**95%**	**95%**	**95%**	**94%**	**97%**	**96%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)			**72%**	**78%**	**82%**	**95%**	**96%**
	Year	**2020**	**2020**	**2020**	**2020**	**2020**	**2020**	**2020**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Providers Touched by Provider Relations	**401**	**118**	**84**	**146**	**200**	**205**	**241**
	Provider Trainings by Provider Relations	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
	Total Providers Touched	**1,790**	**2,003**	**2,604**	**2,786**	**2,552**	**1,932**	**3,354**
	Total Trainings Conducted	**148**	**550**	**530**	**762**	**808**	**1,353**	**257**
Message From the COO	DHCS placed CalViva Health under a Network Adequacy CAP for failing to meet Time and Distance Standards for 19 Provider Type(s) in 3 Counties. DHCS represented the Plan Passed With Conditions.							

	Year	**2019**	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
Claims Processing	**Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure**	90% / 99% YES	94% / 99% YES	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	98% / 99% N/A	97% / 99% N/A	97%/98% N/A	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	97% / 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	99% /100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 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	95% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure							
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	97% / 98% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	95% / 97% NO	100% / 100% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	92% / 100 % NO	99% / 100 % NO	93% / 99% NO	93% / 100% NO	96% / 100% NO	85% / 100% NO	95% / 100% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	95% / 100% NO	99% / 100% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	93% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	97% / 100% NO	90% / 99% NO	89% / 100% YES	88% / 98% YES	96% / 99% NO	82%/100% YES	100% / 100% YES
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	94% / 100% NO	92% / 99% NO	99% / 100% YES	100% / 100% YES	100% / 100% NO	87% / 100% YES	98% / 98% YES
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 100% NO	96% / 99% NO	99% / 100% YES	98% / 98% YES	98% / 100% NO	73% / 100% YES	99% / 100% YES
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	92% / 100% NO	100% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the COO	Quarter 3 numbers are available. All areas met the timeliness goals. Deficiency disclosure was noted for the quarter for PPG 5-7.							

Provider Disputes	**Year**	**2019**	**2019**	**2019**	**2019**	**2020**	**2020**	**2020**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	99%	96%	95%	97%	99%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	85%	89%	100%	90%	99%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	100%	100%	N/A	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	100%	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)							
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	98%	100%	89%	64%	92%	100%	91%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	97%	100%	100%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	87%	91%	97%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	99%	95%	99%	100%	100%	100%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	96%	100%	93%	100%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	N/A	67%	100%	100%	100%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	98%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	100%
Message from the COO	Quarter 3 numbers are available. PPG 2 did not meet goal. All other PPGs and areas met goal.							

Item #15

Attachment 15.F

Executive Dashboard

	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2020	2021
Month	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**
CVH Members													
Fresno	281,473	280,719	280,297	282,402	286,059	289,126	291,870	294,617	298,003	300,085	302,118	303,493	304,759
Kings	29,392	29,575	29,534	29,788	30,168	30,421	30,624	30,827	31,085	31,230	31,450	31,570	31,802
Madera	37,169	37,244	37,259	37,624	38,054	38,457	38,713	39,035	39,329	39,530	39,733	39,919	40,209
Total	348,034	347,538	347,090	349,814	354,281	358,004	361,207	364,479	368,417	370,845	373,301	374,982	376,770
SPD	32,797	32,834	32,797	32,952	33,195	33,406	33,456	33,556	33,578	33,704	33,785	33,844	33,854
CVH Mrkt Share	71.34%	71.27%	71.21%	71.15%	71.01%	70.82%	70.68%	70.52%	70.40%	70.32%	70.21%	70.10%	70.02%
ABC Members													
Fresno	101,664	101,800	102,085	103,359	105,487	107,750	109,576	111,590	113,570	114,867	116,308	117,408	118,389
Kings	18,926	18,996	18,890	18,955	19,218	19,423	19,591	19,758	20,020	20,139	20,380	20,546	20,697
Madera	19,246	19,268	19,345	19,554	19,934	20,344	20,673	21,036	21,340	21,494	21,735	21,992	22,253
Total	139,836	140,064	140,320	141,868	144,639	147,517	149,840	152,384	154,930	156,500	158,423	159,946	161,339
Default													
Fresno	945	1,080	1,256	992	1,073	1,313	1,052	1,067	655	747	824	518	616
Kings	181	204	227	173	166	183	178	153	123	143	164	105	150
Madera	98	92	148	105	107	114	123	126	79	89	117	173	97
County Share of Choice as %													
Fresno	62.50%	65.00%	64.80%	65.10%	62.00%	61.50%	61.80%	58.70%	61.60%	60.20%	59.40%	57.80%	59.10%
Kings	65.20%	60.00%	64.30%	59.40%	54.00%	59.50%	48.80%	53.40%	42.90%	47.20%	51.10%	45.40%	48.40%
Madera	60.80%	63.20%	69.70%	62.50%	62.70%	59.80%	55.70%	57.90%	58.90%	61.60%	60.40%	52.70%	57.90%
Voluntary Disenrollment's													
Fresno	336	334	361	402	293	340	352	370	388	359	342	363	421
Kings	48	33	36	39	21	30	31	63	39	42	31	27	36
Madera	73	64	85	80	30	51	54	57	77	70	51	54	59