FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, Interim 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

Vacant, 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: September 16, 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, September 16, 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 **10** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum is maintained

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
September 16, 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**	J. Neves, Co-Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B Attachment 3.C Attachment 3.D	**Consent Agenda:** • Commission Minutes dated 7/15/2021 • Finance Committee Minutes dated 5/20/2021 • QI/UM Committee Minutes dated 5/20/2021 • Public Policy Committee Minutes dated 6/9/2021 *Action: Approve Consent Agenda*	J. Neves, Co-Chair
	Handouts will be available at meeting	*PowerPoint Presentations will be used for item 4 – 6* ***One vote will be taken for combined items 5 – 6***	
4. Information	No attachment	**HEDIS Update – Reporting Year 2021**	P. Marabella, MD, CMO
5. Action	Attachment 5.A Attachment 5.B	**2021 Quality Improvement Work Plan Mid-Year Evaluation** • Executive Summary • Work Plan Evaluation *Action: See item 6 for Action*	P. Marabella, MD, CMO
6. Action	Attachment 6.A Attachment 6.B	**2021 Utilization Management Work Plan Mid-Year Evaluation** • Executive Summary • Work Plan Evaluation *Action: Approve 2021 Quality Improvement Work Plan Mid-Year Evaluation; and 2021 Utilization Management Work Plan Mid-Year Evaluation*	P. Marabella, MD, CMO

7 Action		**Standing Reports**	
	Attachment 7.A Attachment 7.B	**Finance Report** • Financial Report Fiscal Year End June 30, 2021 • Financials as of July 31, 2021	D. Maychen, CFO
	Attachment 7.C	**Compliance** • Compliance Report	M.L. Leone, CCO
	Attachment 7.D Attachment 7.E Attachment 7.F Attachment 7.G	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	Attachment 7.H	**Executive Report** • Executive Dashboard	J. Nkansah, CEO
		Action: Accept Standing Reports	
8		**Final Comments from Commission Members and Staff**	
9		**Announcements**	
10		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
11		**Adjourn**	J. Neves, Co-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 October 21, 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

Attachment 3.A

Commission Minutes
Dated 7/15/2021

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
July 15, 2021

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	✓	**David Luchini**, Interim Director, Fresno County Dept. of Public Health
✓	**David Cardona**, M.D., Fresno County At-large Appointee	✓	**Aftab Naz**, Madera County At-large Appointee
	Aldo De La Torre, Community Medical Center Representative	✓●	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
	Joyce Fields-Keene, Fresno County At-large Appointee	✓●	**Harold Nikoghosian**, Kings County At-large Appointee
✓●	**John Frye**, Commission At-large Appointee, Fresno		**Sal Quintero**, Fresno County Board of Supervisor
✓●	**Soyla Griffin**, Fresno County At-large Appointee		**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 1:32 pm. A quorum was present via conference call in lieu of gathering in public per executive order signed by the Governor of	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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 5/20/2021 b) Finance Committee Minutes 3/18/2021 c) QIUM Committee Minutes dated 3/18/2021 d) Public Policy Committee Minutes dated 3/3/21 e) Finance Committee Charter f) Credentialing Committee Charter g) Peer Review Committee Charter h) QIUM Committee Charter i) Public Policy Committee Charter	All consent items were presented and accepted as read.	***Motion**: Approve Consent Agenda* *11 – 0 – 0 – 6* *(Naz / Luchini)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action D. Hodge, MD, Chair		
#4 Official Appointment of Incoming CEO as Trustee of Retirement Plans Action Greg Hund, CEO	Incoming CEO Jeff Nkansah, was officially appointed as one of the trustees of the Plan's retirement plans effective 8/1/21.	***Motion**: Approve Appointment of incoming CEO as Trustee of Retirement Plans* *11 – 0 – 0 – 6* *(Frye / Nikoghosian)* *A roll call was taken*
#5 Review of Fiscal Year End 2021 Goals Information Greg Hund, CEO	Greg Hund reported the results for fiscal year end 2021 goals. All targeted goals were met with the exception of market share. This was due to the current default rate adopted and applied for FY 2021 favored ABC. The Plan has appealed to the State to analyze the formula and make changes to be more equitable.	
#6 Goals and Objectives for Fiscal Year 2022 Action Greg Hund, CEO	Greg Hund presented the goals and objectives for FY 2022.	***Motion**: Approve Goals & Objectives for FY 2022* *11 – 0 – 0 – 6* *(Nikoghosian / Griffin)* *A roll call was taken*
#7 Standing Reports	**<u>Finance</u>**	***Motion**: Standing Reports*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Finance Report** Daniel Maychen, CFO	**Financials as of May 31, 2021**: Total current assets were approximately $314.4M; total current liabilities were approximately $208.5M. Current ratio is 1.51. Total equity was approximately $116M which is approximately 722% above the minimum DMHC required TNE amount. For the first eleven months of current fiscal year 2021, investment income actual recorded was approximately $93.5K, which is $269K less than projected due to declining yields on money market accounts. Premium capitation income actual recorded was approximately $1.2B which is approximately $122.2M above budgeted amounts, primarily due to FY 2021 budget including Pharmacy Carve-out to be effective January 2021 which would have reduced revenues given the fact the Pharmacy component in rates would have been removed; however, the Pharmacy carve-out was delayed and will not be effective in FY 2021. In conjunction with enrollment being higher than projected, this is the cause of revenues being higher than projected. Total cost of medical care expense actual recorded is approximately $1B which is approximately $119M more than budgeted due to the delay in the Pharmacy Carve-out and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $45.3M, which is approximately $1.3M more than budgeted due to actual enrollment being higher than budgeted. Taxes are approximately $92.5K more than budgeted due to DHCS paying the Plan retroactive rate adjustments received during FY 2021. Net income actual recorded through May 2021 was approximately $7.2M which is approximately $2.3M more than budgeted primarily due to the Pharmacy Carve-out delay and enrollment being higher than budgeted. MCO tax loss of approximately $4.5M the Plan incurred during the first six months	*Approved* *11 – 0 – 0 – 6* *(Smullin / Hill)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Compliance** M.B. Corrado, CCO	of the fiscal year 2021 has turned positive due to an increase in MCO tax revenue rates from DHCS beginning January 2021. As of the end of May 2021 the Plan is positive by approximately $387K in relation to MCO taxes. **<u>Compliance</u>** There was one fraud and abuse case in June where a MC609 was filed due to suspected abuse. No additional audits completed since the May Commission meeting. The Plan submitted the 2021 Annual Network Certification materials in April, with additional information submitted in May and June at the request of DHCS. A letter has been received from DHCS with no findings. Next step is validation. The Plan submitted the Subcontracted Network Certification Readiness Plan in May; at the request of DHCS for additional information the Plan submitted a response in June. The Plan received an additional letter from DHCS in July requesting additional information specifically related to the Plan's oversight of Health Net and the corrective action process. The Plan is currently awaiting the DMHC final report findings on the 2021 DMHC 18-month Follow-Up Audit. The next routine DMHC medical survey for the Plan will be in September 2022 One CAP for the DHCS Final 2020 Audit Report was accepted and deficiency closed on 8/28/20. The second CAP related to the IHEBA is ongoing with periodic reports to DHCS on progress of CAP activities.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The next routine DHCS medical audit for the Plan will be in April 2022 The Plan received the final 2019-20 Performance Evaluation Report from HSAG. HSAG had three recommendations related to performance. They were related to the 2020 DHCS Medical Audit and CAP, dual eligibility calculations related to continuous enrollment criteria for performance measures and two QI PIPs. The Plan must submit a description of the actions taken from 7/1/20 through 6/30/21 to address the findings. The Plan continues to participate in DHCS calls, association calls and working with Health Net in reference to CalAIM to implement key initiatives such as major organ transplant, and enhanced care management (ECM) and in lieu of services (ILOS). DHCS requires plans to submit Model of Care (MOC) filings in phases describing how they plan to design, implement, and administer ECM & ILOS. The Plan's initial ECM-ILOS Model of Care was filed with DHCS 7/1/21. DHCS has a list of pre-approved ILOS that plans can implement. CalViva through its administrator, Health Net, is planning to offer these services on a phased in basis from 1/1/22 to 1/1/23 in the 3-county service area. A Medi-Cal contract amendment is being executed between DHCS and CalViva Health - Contract 10-87050 A15 Final Rule II Amendment. This amendment is effective retroactive to 7/1/2018. On 6/11/21 the Governor signed a "Mega Executive Order" (EO N-08-21) that repealed a significant number of previous EOs related to the COVID-19 Public Health Emergency and also extended some EOs previously issued. The Mega EO established a timeline and process to wind down provisions of the 58 COVID-related executive orders issued during the pandemic. The various EO provisions will sunset in phases,	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	beginning in June, in July and in September and by the end of September, nearly 90 percent of the executive actions taken since March 2020 will have been lifted. The Plan continues to submit required reports to DMHC and DHCS. Due to easing of state and federal restrictions related to the public health emergency, the Palm office opened to members and public walk-in visitors on June 15, 2021. The downtown office for walk-ins remains closed. Health Net has indicated they will still continue to carry out operations on a remote basis until at least September 2021. The Public Policy Committee met on June 9, 2021, via telephone conference due to the COVID-19 state of emergency. Reports presented included Q1 2021 Grievance and Appeals; the 2020 End-of-Year Health Education and Cultural & Linguistics (C&L) Work Plans; and 2021 Health Education and C&L Program Descriptions and Work Plans. A Population Needs Assessment Update was also provided to the Committee. The Public Policy Committee reviewed the Committee Charter. No changes were needed and the Committee approved the Charter with a recommendation to forward it to the Commission for final approval. There were no other recommendations for referral to the Commission. The next meeting will be held on September 1, 2021, at 11:30am. It is still to be determined if the meeting will be in person or if it will remain as a teleconference due to COVID-19.	
• **Medical Management** P. Marabella, MD, CMO	**<u>Medical Management</u>** **Appeals and Grievances Dashboard** Dr. Marabella presented the Appeals & Grievances Dashboard through May 2021. The total number of grievances through May 2021 is slightly elevated compared to	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	last year. Quality of Service (QOS) for Access, Administrative, and Transportation remain the majority of grievances. The volume of "Quality of Care" grievances remains consistent. Exempt Grievances have slightly decreased from previous months. The total number of Appeals Received through May 2021 has decreased compared to Q1 2021. **Key Indicator Report** Dr. Marabella presented the Key Indicator Report (KIR) through April 2021. Overall membership has had a very slight decrease. In-hospital utilization rates have leveled off since March. The readmission rate continues to decrease. Turn-around-time compliance dropped slightly to 98% in only one metric; all others met goal at 100%. Case Management results remain strong and demonstrate positive results in all areas consistent with previous months. **QIUM Quarterly Summary Report**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Marabella provided the QI/UM Qtr. 2, 2021 update. One QI/UM meeting was held in May 2021. The following guiding documents were approved at this meeting: • 2020 Culture & Linguistics (C & L) End of Year Evaluation • 2021 C & L Program Description • 2021 C & L Work Plan • 2020 C & L Language Assistance Program Report • 2020 Health Education End of Year Evaluation • 2021 Health Education Program Description • 2021 Health Education Work Plan In addition, the following general documents were approved: • Pharmacy Formulary & Provider Updates. • Medical Policies. The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard and Quarterly A & G reports, A & G Validation Audit Report, and Provider Office Wait Time Report. Additional QI reports reviewed included Potential Quality Issues (PQI) Report and others scheduled for presentation at the QI/UM Committee during Q2. The Utilization Management & Case Management reports reviewed were the Key Indicator Report and UM Concurrent Review Report, and PA Member Letter Monitoring Report. Additional UMCM Reports included Concurrent Review IRR Report, TurningPoint Quarterly Report, and others scheduled for presentation at the QI/UM Committee during Q2.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Pharmacy reports reviewed included Executive Summary, Pharmacy Call Report, Operation Metrics, Top 30 Medication Prior Authorization (PA) Requests, Pharmacy Interrater Reliability Results (IRR), and quarterly Formulary changes. All Q1 pharmacy prior authorization metrics were within 5% of standard. HEDIS® Activity: In Q2, HEDIS® related activities focused on finalizing and preparing Measurement Year (MY) 2020 full HEDIS® Data for submission to HSAG & DHCS for the Managed Care Accountability Set (MCAS). Final Attestations and IDSS submission were completed by the June 15th deadline. Medi-Cal Managed Care (MCMC) health plans currently have 18 quality measures (MCAS) that we will be evaluated on this year. The Minimum Performance Level (MPL) remains at the 50th percentile. Current improvement projects include: • Breast Cancer Screening (BCS) PIP (Performance Improvement Project) Mammograms for women 50-74 years • Chlamydia (CHL) Screening in Young Women PDSA Project • Childhood Immunizations (CIS-10)– PIP Immunizations birth to 2 years Each Plan is required to report on 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 second CalViva COVID-19 QIP report was submitted on March 19th, 2021 and accepted by DHCS. **Credentialing Sub-Committee Quarterly Report**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Operations** J. Nkansah, COO	The Credentialing Sub-Committee met on May 20, 2021. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q4 2020 were reviewed for delegated entities, and Q1 2021 for MHN and Health Net. The 2021 Credentialing Sub-Committee Charter was presented and approved without changes. There was no case activity to report for the Q1 2021 Credentialing Report from Health Net. Ongoing monitoring and reporting will continue. **Peer Review Sub-Committee Quarterly Report** The Peer Review Sub-Committee met on May 20, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Q1 2021 were reviewed for approval. There were no significant cases to report. The 2021 Peer Review Sub-Committee Charter was reviewed and approved without changes. The Q1 2021 Peer Count Report was presented with a total of 5 cases reviewed. Two (2) cases were closed and cleared. There was one (1) case pending closure for Corrective Action Plan compliance. There were no cases with outstanding CAPs. There were two (2) cases pended for further information. Follow up will be initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue. **<u>Operations Report</u>** For IT Communications and Systems, the Plan's IT vendor reviewed the impact of the ransomware attack affecting Microsoft and Kaseya organizations. It was confirmed the Plan's systems are safe, and remain safe. Ongoing monitoring will continue via the Plan's IT vendor. For Privacy and Security, there was one high risk case reported in June 2021 which	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• **Executive Report** G. Hund, CEO	impacted one member. The Plan's Notice of Privacy Practices is included in the Plan's Member Handbook/Evidence of Coverage. The Plan implemented the annual mailing of the Member Handbook/Evidence of Coverage in June 2021. No new updates to report for the Member Call Center, and the CVH Website. The Provider Network Activities remain stable. Compliance goal of 85% was met for % of PCPs, Specialists and Behavioral Health Providers Accepting New Patients, for Quarter 1 2021. Quarter 1 2021 numbers now available for Claims Processing; all areas met goal as it relates to claims timeliness. PPG 4 continues to report deficiency disclosures; management continues to monitor the CAP submitted to bring them into compliance. Quarter 1 2021 numbers available for Provider Disputes. All areas met goal with the exception of PPG 3; management is in review of a CAP and activities they are taking to obtain compliance. **<u>Executive Report</u>** CVH Membership continues to grow and currently marks the highest number to date since inception. Future growth will be impacted by both redetermination and undocumented residents over 50 who will be participating in the future. Market share continues to trend down for the reasons stated in review of 2021 Goals stated in Agenda Item #5.	
#8 Closed Session	Jason Epperson, General Counsel, reported out of Closed Session.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
A. Government Code section 54956.9(b) – Conference with Legal Counsel – Anticipated Litigation.	Regarding Government Code section 54956.9(b) – conference with legal counsel – anticipated litigation. Discussion was held and direction was given to staff. Closed Session concluded at 2:45 pm.	
#9 Final Comments from Commission Members and Staff	Retirement awards and congratulatory commentaries were presented to Greg Hund, CEO, and Mary Beth Corrado, CCO.	
#10 Announcements	None.	
#11 Public Comment	None.	
#12 Adjourn	The meeting was adjourned at 3:02 pm The next Commission meeting is scheduled for September 16, 2021 in Fresno County.	

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

Item #3

Attachment 3.B

Finance Committee Minutes
dated 5/20/2021

CalViva Health
Finance
Committee Meeting Minutes

May 20, 2021

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	The minutes from the March 18, 2021 Finance meeting were approved	Motion: *Minutes were approved*

dated March 18, 2021 Attachment 2.A Action D. Maychen, Chair	as read.	*5 – 0 – 0 – 2* *(Nikoghosian / Hund)* A roll call was taken.
#3 Financial Statements as of March 31, 2021 Action D. Maychen, Chair	Total current assets were approximately $257.6M; total current liabilities were approximately $155.4M. Current ratio is 1.66. TNE as of March 31, 2021 was approximately $112.3M, which is approximately 699% above the minimum DMHC required TNE amount. For the first nine months of current fiscal year 2021, investment income was under what was budgeted by approximately $209K, primarily due to declining yields on money market accounts. Premium capitation income recorded was approximately $989M which is approximately $71.2M above budgeted amounts, primarily due to FY 2021 budget including Pharmacy Carve-out which reduced capitation rates noting that the Pharmacy Carve-out was budgeted to be effective January 2021 as proposed by DHCS; that date has been delayed to a yet to be determined date and most likely will not be effective this fiscal year. Actual revenues are projected to continue to grow larger than budgeted revenues. Pharmacy Carve-out in conjunction with enrollment being higher than projected, is the cause of revenues being higher than projected. Total cost of medical care expense actual recorded is approximately $828.4M which is approximately $71.2M more than budgeted due to enrollment being higher than projected. Admin service agreement fees expense recorded was $36.9M, which is approximately $879K more than budgeted due to actual enrollment being higher than projected. Taxes are approximately $93K more than budgeted due to DHCS paying the Plan retroactive capitation payments that had MCO tax associated with those rates. Net income recorded through March was approximately $3.55M which is approximately $566K less than projected due to the MCO tax loss the Plan incurred during the first six months of the current fiscal year, which the Plan expects to be positive	Motion*: Financials as of March 31, 2021 were approved* *5 – 0 – 0 – 2* *(Nikoghosian / Frye)* A roll call was taken.

	by current fiscal year end.	
#4 Finance Charter Annual Review Action D. Maychen, Chair	No edits or revisions were recommended during the annual Charter review. This was approved to move to Commission for final approval.	Motion: *Approval to move to Commission for final approval.* *5 – 0 – 0 – 2* *(Frye / Hund)* A roll call was taken.
#5 Announcements	None.	
#6 Adjourn	Meeting was adjourned at 11:37 am	

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

Dated: July 15, 2021

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 7/15/2021

Item #3

Attachment 3.C

QIUM Committee Minutes
dated 5/20/2021

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

May 20th, 2021

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	✓	**Maria Sanchez**, Compliance Manager
✓•	**Joel Ramirez, M.D.,** Camarena Health Madera County	✓	**Iris Poveda**, Medical Management Administrative 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)**	✓	**Lori Norman,** Senior Compliance Analyst
	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 10:38 am. A quorum was present.	
#2 **Approve Consent Agenda** Committee Minutes: March 18, 2021 - Appeals and Grievances IRR Report (Q1) - Appeals and Grievances Classification Audit Report (Q1) - CCC DMHC Expedited Grievance Report	March 18, 2021 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. Attachments A to H were approved.	Motion: *Approve* - Consent Agenda (Cardona/Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Concurrent Review (IRR) Report (Q1) - California Children's Service Report (CCS) (Q1) - Medical Policies Provider Update (Q1) - Pharmacy Provider Updates (Q2) (Attachments A-H) **Action** Patrick Marabella, M.D Chair	*Dr. Verma arrived at 10:40 am.	
#3 **QI Business** *(PowerPoint Presentation - Presentation handouts available at meeting)* - Appeals & Grievances Dashboard (March) - Appeals & Grievances Executive Summary (Q1) - Appeals & Grievances Quarterly Member Report (Q1) - Quarterly A&G Member Letter Monitoring Report (Q1) - Appeals & Grievances Validation Audit Summary (Q4 2020) (Attachment I-M)	Dr. Marabella presented the Appeals & Grievances Dashboard through March 2021. **Appeals & Grievances Data** ➢ The Appeals & Grievances Dashboard through March 2021 was presented and discussed. In January there were 99 total grievances received and then it increased to 144 in March, for a total of 360 in the first quarter. In contrast with 1107 grievances in all of 2020. ➢ In terms of compliance, 2 acknowledgement letters were out of compliance in February. ➢ In general terms, March was the busiest month and although there are more members, data have improved and stayed on track and remained in compliance. ➢ Transportation category reviewed. Trends noted and cases of missed/late to appointment discussed. Transportation providers with these types of issues are either on an improvement plan or corrective action plan (CAP). Continue to monitor for improvement. Those situations have been elevated to the management and vendors to make sure improvement plans have in place. ➢ Attitude/Service Provider category. 88 grievances for Q1, slightly increased from last year. ➢ Advanced Imagining. Identified an increase in MRI appeals ➢ Pharmacy appeals. Continue with provider education.	Motion: *Approve* - Appeals & Grievances Dashboard - Appeals & Grievances Executive Summary - Appeals & Grievances Quarterly Member Report - Quarterly A&G Member Letter Monitoring Report - Appeals & Grievances Validation Audit

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	The **Appeals & Grievances Executive Summary** for Quarter 1 was presented and reviewed. ➢ When comparing cases from Q1 2021 to Q1 2020, the total number of grievances and appeals decreased to 510 compared to 606 respectively. This decline is believed to be related to the decrease in office visits associated with the pandemic. The **Member Report** for Quarter 1 was presented and reviewed. ➢ There was a decrease in appeals and an increase in Grievances when comparing Q4 2020 to Q1 2021 data. ➢ Pharmacy Denial-RX does not meet Prior Authorization Guidelines and not Medically Necessary-MRI, both continue to be top trends. The **Member Letter Monitoring Report** for Quarter 1 was presented with the following trends noted: ➢ Of the 1,028 Total Letters reviewed, there were 61 letters that required editing prior to mailing. ➢ In review of the 2021 Q1 letter monitoring report the ongoing primary issue appears to be the use of medical terminology. ➢ All errors are corrected prior to mailing to the member. The **Appeals & Grievances Validation Audit Summary report** for Quarter 4 2020 was also presented. ➢ Total Cases Audited is 565. ➢ 493 of 565 cases or 87% of cases had no issues and met all compliance standards. ➢ All documents received and issues resolved before cases are closed.	(Cardona/Verma) 6-0-0-2
#3 **QI Business** - Potential Quality Issues (PQI) (Q1) (Attachment N) **Action** Patrick Marabella, M.D Chair	**Potential Quality Issues (PQI) Report** This report provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review actions. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review Committee. Data for Quarter 1 was reviewed for all cases including the follow up actions taken when indicated. ➢ Non-Member Source. No serious quality issues were reported. ➢ Member Source. All of them under level 2 without additional care. ➢ Peer Review. Total of 5 for the quarter. 2 cases are closed and 3 cases open.	Motion: *Approve* - Potential Quality Issues Report (Ramirez/Foster) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business** - Provider Office Wait Time Report (Q1) (Attachment O) **Action** Patrick Marabella, M.D Chair	**Provider Office Wait Time Report (Q1 2021)** Health plans are required to monitor waiting times in providers' offices to validate timely access to care and services. This report provides a summary that focuses on Quarter 1 2021 wait times for Fresno, Kings and Madera Counties. All counties are within the 30-minute office wait time threshold for both mean and median metrics. Outliers are being tracked. Monitoring and analysis will continue in 2021 to identify opportunities for improvement and any provider specific trends. ➢ For a total of 1,253 patients and 59 providers, the Max Wait Time was 2 hours. ➢ Short staffing the first week of January was one of the most significant causes for the extended wait time.	Motion: *Approve* - Provider Office Wait Time Report (Foster/Verma) 6-0-0-2
#4 **Cultural & Linguistics / Health Education Business** *(PowerPoint Presentation - Presentation handouts available at meeting)* - 2020 Culture & Linguistics Work Plan End of Year Evaluation and Executive Summary - 2021 Cultural & Linguistics Program Description with Change Summary - 2021 Cultural & Linguistics Work Plan - 2021 Cultural & Linguistics Language Assistance Program Report (Attachment P-S) **Action** Patrick Marabella, M.D Chair	The 2020 Cultural and Linguistics Work Plan End of Year Evaluation and Executive Summary, 2021 Cultural & Linguistics Program Description with Change Summary; 2021 Cultural & Linguistics Work Plan; and 2021 Cultural & Linguistics Language Assistance Program were presented and reviewed. **2020 Work Plan End of Year Evaluation- Executive Summary** report provides information on the Cultural and Linguistic (C&L) Services Department work plan activities for 2020, which are based on providing cultural and linguistic support and maintaining compliance with regulatory and contractual requirements. The C&L Work Plan is divided into four sections: 1) Language Assistance Services, 2) Compliance Monitoring, 3) Communication, Training and Education, and 4) Health Literacy, Cultural Competency, and Health Equity. The following is the summary of activities accomplished and improvements made over the last calendar year. ➢ Language Assistance Services ➢ 116 translation reviews completed. ➢ Bilingual certification/re-certification completed for 81 staff (97% pass rate). ➢ Compliance Monitoring ➢ Investigated and completed follow up on 60 grievances in 2020. ➢ Updated all C & L Policies. ➢ Communication, Training and Education ➢ Nine (9) Call Center new hire classes (129 staff in attendance). ➢ Two trainings on coding & resolution of C & L related cases for A & G Coordinators. ➢ Health Literacy, Cultural Competency, & Health Equity ➢ Coordinated Heritage/CLAS Month activities with almost 3,000 staff engaged.	Motion: *Approve* - 2020 Culture & Linguistics Work Plan End of Year Evaluation and Executive Summary - 2021 Cultural & Linguistics Program Description with Change Summary - 2021 Cultural & Linguistics Work Plan - 2021 Cultural & Linguistics Language Assistance Program Report (Cardona /Ramirez) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	➢ Twelve (12) Staff Trainings covering a variety of topics such as Social Determinants of Health (SDoH), gender neutral language, Adverse Childhood Experiences (ACE), and more. ➢ Breast Cancer Screening Disparity Performance Improvement Project has been restarted. As part of the foundational efforts, C & L team trained 16 staff from The Fresno Center/AmeriCorp on Cultural Competency and Community Resources. **2021 C&L Program Description** is consistent with 2020, in addition has incorporated the following: ➢ Added Video Remote Interpreting (VRI) services to the list of interpreter services available. ➢ Updated "protected classes" to the expanded standard comprehensive list. ➢ Other minor edits including department and individual title/name changes. **2021 C&L Work Plan** is consistent with the 2020 Work Plan while incorporating and enhancing the following: ➢ Complete the Action Plan activities that were identified by the 2020 Population Needs Assessment (PNA) to expand language assistance program awareness and utilization. ➢ Develop behavioral health/Adverse Childhood Experiences (ACE) resources and tools for providers. ➢ Implement two (2) part Provider Implicit Bias Training Series offering up to four CME/CE credits. ➢ Develop a series of Cultural Tip Sheets for providers on various health topics providing culturally competent patient care guidance.	
#4 **Cultural and Linguistics / Health Education Business** *(PowerPoint Presentation - Presentation handouts available at meeting)* - 2020 Health Education Work Plan end of Year Evaluation and Executive Summary - 2021 Health Education Program Description - 2021 Health Education	2020 Health Education Work Plan End of the Year Evaluation and Executive Summary and 2021 Health Education Work Plan were presented and reviewed. **Health Education Work Plan end of Year Evaluation.** Overall, 11 of 19 key Program Initiatives met or exceeded the year-end goal. Eight initiatives partially met the year-end goals. **The eleven initiatives that were fully met are:** 1. Chronic Disease-Asthma 2. Community Health 3. Health Equity Projects 4. Immunization Initiative 5. Member Newsletter	Motion: *Approve* - 2020 Health Education Work Plan end of Year Evaluation and Executive Summary - 2021 Health Education Program Description - 2021 Health

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Work Plan (Attachment T-V) **Action** Patrick Marabella, M.D Chair	6. Behavioral Health 7. Pediatric Education 8. Perinatal Education 9. Compliance 10. Department Promotion & Materials 11. Operations **The eight initiatives partially met were:** 1. Chronic Disease Education: Diabetes 2. Digital Health 3. Fluvention 4. Know Your Numbers 5. Obesity Prevention 6. Promotores Health Network 7. Tobacco Cessation Program 8. Women's Health **The barriers** identified are related to: ➢ Regulatory approval delays ➢ Pandemic preventing in-person sessions Action plans have been developed for each and are included in the 2021 Work Plan. **Changes to the 2021 Program Description** include: 1. Updated Goals & added Vision Statement 2. Removed FFFL Community Classes, Know Your Numbers, myStrength, and updated Disease Management. Added myStrength as its own program. 3. Deleted Community Health Fairs, Updated Health Ed Class Description, and Added Information on Krames online – 4,000 topics. 4. Changed "disease management program" to Diabetes Prevention Program. 5. Added "Population Needs Assessment" to QI description. 6. Other minor edits throughout including correction of department names, individual titles, and a description of "Community Engagement".	Education Work Plan (Foster/Verma) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2021 Health Education Work Plan. 2020 initiatives will continue in 2021 with the following enhancements: 1. Implement Asthma In-Home visitation program with CCAC (Central California Asthma Collaborative) 2. Launch Diabetes Prevention Program 3. Launch Fluvention & COVID 19 Communication Campaign 4. Enhance offerings for Behavioral Health Services. 5. Explore and launch email campaigns for wellness promotion. Collaborate with Marketing to update Educational Resources.	
#5 **UM/CM Business** - Key Indicator Report & Turn Around Time Report (March) - UM Concurrent Review Report (Q1) - PA Member Letter Monitoring Report (Q1) - TurningPoint Musculoskeletal Utilization Review (Q4) (Attachment W-Z) **Action** Patrick Marabella, M.D Chair	The **Key Indicator Report & Turn Around Time Report** were presented by Dr. Marabella through March 31st. 2021. Overall membership continues to increase. ➢ In-hospital utilization rates increased in March compared to previous months. ➢ The readmission rate slightly decreased in March. ➢ The number of ER Visits for Q1 2021 represents a slight decrease from previous year. ➢ The average "Length of Stay" decreased in March, compared to previous months. ➢ Turn-around-time compliance dropped slightly to 98% in 3 metrics due to technical and training issues. Technical and training issues have been addressed. ➢ Case Management results for Q1 2021 demonstrate positive results in all areas consistent with previous months. The **Utilization Management Concurrent Review** Report (Q1) presents inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning and medical appropriateness during Quarter 1 2021. ➢ TANF, SPD, and MCE show increase in admits per 1000 and bed days per 1000 when compared to Quarter 4, 2020. The admission fluctuations are likely to be related to the pandemic. ➢ The average length of stay showed a slight increase in all areas. We attribute these fluctuations to an increase in ICU admissions related to COVID-19. ➢ Readmissions show decreases in all populations. The Concurrent review department will continue with the above steps taken and report impact as identified above. Planning pilot Non-clinical Discharge Navigators in Quarter 2 2021.	Motion: *Approve* - Key Indicator Report & Turn Around Time Report (March) - UM Concurrent Review Report (Q1) - PA Member Letter Monitoring Report (Q1) - TurningPoint Musculoskeletal Utilization Review (Q4) (Ramirez/Foster) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The **PA Member Letter Monitoring Report** (Q1) represents data that has been monitored over time. Monitoring of Notice of Action (NOA) letters includes Prior Authorizations, Concurrent, and Post Service denials. Internal goal for all metrics is 100% each month. Medical Management Monitoring and Reporting Team collects CAP information on metrics that fall below the 100% threshold. ➢ All categories had audit scores above 95% except one. ➢ Medical Management implemented and/or continues the following: • Weekly audit meeting for any identified failures. • Weekly progressive coaching to staff with any opportunities identified during audits. The **2020 TurningPoint Musculoskeletal Utilization Review** (Q4) monitors compliance with the musculoskeletal prior authorization (PA) utilization review performance standards as set forth by the health plan. ➢ TurningPoint finalized 113 authorizations in Q4. The denial rates decreased from 46% in Q3 to 25% in Q4 2020. ➢ Call Center service level agreement (SLA) criteria were met. Provider education on the TurningPoint criteria continues along with ongoing monitoring.	
#6 **Policy and Procedure Business** - Quality Improvement Policy Review 2021 (Attachment AA) **Action** Patrick Marabella, M.D Chair	The **Quality Improvement Annual Review Policy & Procedure** grid was presented to the committee. Nine policies were presented: ➢ 7 were reviewed without changes ➢ 1 had minor edits ➢ The Initial Health Assessment (IHA) policy is pending some additional information before final edits can be completed. It will be brought to a future committee meeting for approval.	Motion: *Approve* - Quality Improvement Policy Review 2021 (Cardona/Ramirez) 6-0-0-2
#7 **Pharmacy Business** - Pharmacy Executive Summary (Q1) - CalViva Health Pharmacy Call Report (Q1) - Pharmacy Operations Metrics (Q1) - Pharmacy Top 30 Prior Authorizations (Q1)	Pharmacy Executive Summary, CalViva Health Pharmacy Call Report, Pharmacy Operations Metrics, Pharmacy Top 30 Prior authorizations and Pharmacy Inter-Rater Reliability Results for Quarter 1 were presented and reviewed. The **Pharmacy Executive Summary** (Q1) reviews pharmacy quarterly reports on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests and compliance around PA turnaround time metrics, and to formulate potential process improvements.	Motion: *Approve* - Pharmacy Executive Summary (Q1) - CalViva Health Pharmacy Call Report (Q1) - Pharmacy Operations

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Pharmacy Inter-Rater Reliability Results (IRR) (Q1) (Attachment BB- FF) **Action** Patrick Marabella, M.D Chair	➢ Overall TAT for Q1 was 99.77%, met standards. ➢ Opioid and Diabetes control medications continue to be the top drivers of PA volume. ➢ Provider and Formulary Update 21-109 • FDA seeks withdrawal of Makena and its generic from the market. • New prescribing and CURES reporting rules for controlled substances. The **Pharmacy Call Report** (Q1) reviews quarterly reports on operational metrics for the Call Center and reviews the call logs, action items, and resolutions to look at potential trends or barriers to service and to formulate process improvements as needed. ➢ From a total of 3126 calls, 3 calls abandoned. It is in compliance. The **Pharmacy Operations Metrics** (Q1) provides key indicators measuring the performance of the PA Department in service to CalViva Health members. ➢ Pharmacy prior authorization (PA) metrics were within 5% of standard for the 1st Quarter 2021. ➢ Turnaround time (TAT) expectation is 100% with a threshold of 95%. TAT requirement for all pharmacy requests is within 24 hours of receipt by the plan. The **Pharmacy Top 30 Prior Authorizations** (Q1) identifies the most requested medications to the PA Department for CalViva Health members, and assess potential barriers to access of medications through the PA process. ➢ 1st Quarter 2021 top 30 medication PA requests were slightly lower compared to 4th Quarter 2020. ➢ Narcotic Pain Medication requests were lower in 1st Quarter 2021 compared to 4th Quarter 2020. ➢ Diabetes management Prior Auth requests continue to be high and closely behind Narcotic Pain Medications. The **Pharmacy Inter-Rater Reliability Results** (Q1) provides a quarterly summary of a sample of prior authorization denials that are reviewed quarterly to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. ➢ 95% accuracy is the goal and 90% is the minimum threshold. This was met. ➢ Follow up was completed on all outliers.	Metrics (Q1) - Pharmacy Top 30 Prior Authorizations (Q1) - Pharmacy Inter-Rater Reliability Results (IRR) (Q1) (Foster/Cardona) 6-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#8 **Compliance Update** - Compliance Regulatory Report (Attachment GG) **Information** Patrick Marabella, M.D Chair	Mary Beth Corrado presented the Compliance Report. ➢ Due to the COVID-19 declaration of emergency, no on-site audits were conducted in 2020. ➢ Overall, Health Net and their subcontractors performed well and fully complied with most requirements. ➢ Audit deficiencies requiring CAPs did not rise to a level that could potentially result in a failure to pass the audit. Issues primarily affected only one or two individual elements within the overall area audited. All other audits were favorable. ➢ For Fraud, Waste and Abuse activity, there have not been any new MC609 cases filed in 2021.	
#9 **Old Business**	None.	
#10 **Announcements**	Next meeting July 15th, 2021	
#11 **Public Comment**	None.	
#12 **Adjourn**	Meeting was adjourned at 12:08pm.	

NEXT MEETING: July 15th, 2021

Submitted this Day: July 15th, 2021

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

Acknowledgment of Committee Approval:

_____
Patrick Marabella, MD Committee Chair

Item #3

Attachment 3.D

Public Policy Committee Minutes
dated 6/9/2021

Public Policy Committee
Meeting Minutes
Jun 9, 2021

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
		✓	Maria Sanchez, 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 Commissioners' physical attendance at the public location or by teleconferencing.	A roll call was taken.

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#2 Meeting Minutes from March 3, 2021 **Action** Joe Neves, Chair	The March 3, 2021 meeting minutes were reviewed. There were no discrepancies.	**Motion:** Approve March 3, 2020 Minutes 8-0-0-1 (D. Phillips / R. Garcia) A roll call was taken.
#3 Enrollment Dashboard Information Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the enrollment dashboard through April 30, 2021. Membership as of the end of April 2021 was 382,052. CalViva Health maintains a 69.74% market share.	**No Motion**
#4 Health Education **Information** Steven Si, Operations & Privacy Specialist	The 2020 Health Education Work Plan Year-End Evaluation report documents progress of 19 initiatives with 44 performance objectives. Within each initiative, there are multiple objectives. Of the 19 initiatives, 11 initiatives with 27 objectives met the year-end goal. The remaining 8 initiatives with 17 objectives did not fully meet the year-end goal. Of the 17 objectives, 7 were impacted by the COVID-19 pandemic, 5 were impacted by DHCS delays in providing contract approval and new guidance regarding text messaging programs, 2 were caused by Madera County Department of Public Health losing funding to offered DSME classes and 3 did not meet performance goals. Notable changes to the 2021 Health Education Program Description consist of internal department changes from Provider Relations to Provider Engagement, added Community Engagement, and updated various program descriptions. In addition, the department's vision was added to the Policy Statement and Purpose, and department goals were updated.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#5 Appeals, Grievances, and Complaints **Information** Mary Lourdes Leone, Director of Compliance	Mary Lourdes Leone presented the appeals, grievances and complaints report for Q1 2021. Total appeals and grievances for Q1 2021 were 586. There was a total of 226 appeals. There was a total of 360 grievances. Turnaround time for resolved grievance and appeal cases was met at 100% in all areas with the exception of Standard Appeals at 99.4%. The majority of appeals and grievances were from members in Fresno County which has the largest CalViva Health enrollment.	**No Motion**
#6 Cultural and Linguistics **Information** Steven Si, Operations & Privacy Specialist	All 2020 Work Plan activities were completed as follows: Language Assistance Services: • 116 translation reviews completed • Bilingual certification/re-certification completed for 81 staff Compliance Monitoring: • Investigated and completed follow up on 60 grievances • Updated all C&L Policies Communication, Training and Education: • Training on C&L services conducted for nine Call Center new hire classes (129 staff in attendance) • Conducted two trainings on coding & resolution of C&L related cases for A & G Coordinators Health Literacy: • Completed 145 English material review for readability level, content and layout, and conducted C&L Database trainings (41 staff in attendance) • Completed Health Literacy Month activities with 2,000 staff having participated Cultural Competency: • Conducted Implicit Bias training series for providers with 234 attendees • Heritage/CLAS Month activities (articles, webinars, and a virtual activity completed) with nearly 3,000 staff having participated Health Equity:	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
	• Continued work on the BCS Health Equity PIP targeting Hmong women • Provided trainings to 16 Fresno Center Staff/AmeriCorp members on Cultural Competency Awareness, SDoH, Aunt Bertha-Community Connect, Interpreter Services and Bilingual Assessment for the BCS Health Equity Project Notable changes for the 2021 C&L Program Description along with the 2021 Work Plan consist of the following: Interpreter Services: • Added video remote interpreting services to the list of interpreter service available • Staffing structure updated to reflect the change in organizational structure. • Updated protected classes to the standard comprehensive list with expanded classes • Complete 2020 PNA action plan activities to expand language assistance program awareness and utilization. • Development of behavioral health/ACEs resources and tools for providers. • Implementation of two-part provider implicit bias training series offering up to four CME/CE credits. • Developing a series of cultural tip sheets for providers on various health topics providing culturally competent patient care guidance.	
#7 Population Needs Assessment (PNA) Update **Information** Steven Si, Operations & Privacy Specialist	The Population Needs Assessment is published annually and due to DHCS on June 30, 2021. CVH requested an extension to the due and was granted the extension to August 2, 2021.	**No Motion**
#8 2019 DMHC Follow-Up Audit Update	No new updates to report.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
Information Mary Lourdes Leone, Director of Compliance		
#9 2020 DHCS Audit Update **Information** Mary Lourdes Leone, Director of Compliance	CVH continues to provide monthly updates to DHCS.	**No Motion**
#10 Annual Public Policy Committee Charter Review **Action** Courtney Shapiro, Community Relations Director	The PPC Committee reviewed the Charter and approved to move forward to Commission for approval with no revisions.	**Motion:** Approved PPC Charter to move to Commission for full approval 9-0-0-0 (J. Garner / K. Vu) A roll call was taken.
#11 2021 CalViva Health Member Handbook/Evidence of Coverage Update **Information** Steven Si, Operations & Privacy Specialist	As of early June, the 2021 CVH Member Handbook is available on the CVH Website and is currently active for mailing for all members.	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	ACTION TAKEN
#12 Final Comments from Committee Members and Staff	David Phillips reported UHC continues to administer COVID vaccines. Open House celebrations to take place for new UHC sites that opened in 2020. New site facility to open in Clovis prior to September 2021. CVH office temporarily lost connection during final comments from Committee Members.	
#13 Announcements	Greg Hund announced his retirement effective July 31, 2021 and this will be his last Public Policy Meeting. CVH 10 Year Anniversary video has been posted on the CVH website. Commission will be reviewing guidelines to return to in-person meetings; the PPC will be notified of final decision for in-person meeting in September.	
#14 Public Comment	None.	
#15 Adjourn	Meeting adjourned at 12:24 pm.	

NEXT MEETING **September 1, 2021 in Fresno County**
11:30 am - 1:30 pm

Submitted This Day: September 1, 2021

Submitted By: C. Shapiro
Courtney Shapiro, Director Community Relations

Approval Date: September 1, 2021

Approved By: Joe Neves
Joe Neves, Chairman

Item #5

Attachment 5.A

2021 Quality Improvement
Work Plan Mid-Year 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 Amy R. Schneider, RN, Director Medical Management
COMMITTEE DATE:	September 16, 2021
SUBJECT:	Quality Improvement Mid-Year Work Plan Evaluation Executive Summary 2021

Summary:
CalViva Health's 2021 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 2021, 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.

Purpose of Activity:
The QI Mid-Year 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 outcomes are included in the 2021 QI Work Plan Mid-Year Evaluation. Key highlights include:

1. Access, Availability, and Service

1.1 Improve Access to Care: CalViva continues to monitor appointment access annually through the Provider Appointment Availability Survey (PAAS). After Hours Access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS). Sutherland Global conducted the MY 2020 surveys between September and December 2020. Results indicate a need for improvement in several areas.

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 2020, CalViva Health will be addressing non-compliance via a targeted PPG approach and a refined escalation process for non-responding PPGs. Targeted PPGs (also known as Tier 1 groups) will be identified and CAP packets will be sent no later than 8/31/21. A request to complete an Improvement Plan will be included in the CAP packet. Completed Improvement Plans will be due by 9/30/21. Any Improvement Plan not received by the due date will be immediately escalated to the Provider Network Management (PNM) team for assistance and assessment of next steps.

All other non-compliant FFS groups, clinics and Direct Network providers (also known as Tier 2 groups) will be sent Education packets which will include a report card outlining the measures

they were non-compliant for and resource materials for review. Any Tier 2 group or provider identified as non-compliant two or more years in a row will be escalated to a Tier 1 CAP and will be required to complete an Improvement Plan.

Additionally, the Access & Availability team conducted quarterly online Provider training webinars specific to timely access in March and June 2021. Low attendance was noted and is expected to increase in Q3 & Q4 with the distribution of the CAP and Education packets. Non-compliant Tier 1 PPGs are required to attend one webinar session as part of their Improvement Plan activities.

1.2 I**mprove Member Satisfaction**: The annual CalViva Access Survey was launched to members late March 2021. Root cause analysis on appeals and grievances data continue to be done on a quarterly basis to identify trends in member pain points, as well as areas for improvement. Findings are shared with appropriate, internal stakeholders and teams. The CAHPS Team continues to meet regularly with partner departments to track progress of the various activities around member experience improvement. Examples of activities include: the Language Assistance Program, monitoring of Culture & Linguistics-related grievances, Timely Access Corrective Action Plans, and Access & Availability Webinars. These meeting spaces are also a platform to brainstorm any new ideas/projects to address any member issues that come up during the year.

2. Quality and Safety of Care

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

Cervical Cancer Screening (CCS)	Kings and Madera counties exceeded MPL of 61.31%, and Fresno County fell below the MPL in MY 2020.
Childhood Immunization Combo 10 (CIS-10)	One county (Madera) exceeded MPL of 37.47%. Kings and Fresno counties fell below the MPL in MY 2020. A Performance Improvement Project (PIP) has been implemented to improve rates in Fresno County.
Comprehensive Diabetes Care HbA1c Poor Control	For MY 2020, Kings County met the 50th percentile (37.47%). Fresno and Madera Counties did not meet the MPL.
Controlling High Blood Pressure (CBP)	Kings & Madera counties exceeded MPL 61.80% in MY 2020. Fresno County fell below the MPL.
Timeliness of Prenatal Care (PPC-Pre)	All three counties exceeded MPL of 89.05% in MY 2020.

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

Antidepressant Medication Management - Acute Phase (AMM)	All counties fell below the MPL of 53.57%.
Antidepressant Medication Management - Continuation Phase (AMM)	All counties fell below the MPL of 38.18%.

Breast Cancer Screening (BCS)	Madera County exceeded the MPL of 58.82%. Fresno and Kings Counties did not meet the MPL. A Disparity PIP was implemented in Fresno County, and will be continued in 2021.
Chlamydia Testing – TOTAL (CHL)	Kings County met the MPL of 58.44% in MY2020. Fresno & Madera Counties fell below the MPL.

3. Performance Improvement Projects

Two PIPs, in Fresno County have been restarted and the first modules have been submitted to HSAG:

- Breast Cancer Screening (BCS) Disparity Performance Improvement Project
- Childhood Immunizations, Combination 10 (CIS-10) Performance Improvement Project

3.1 Childhood Immunization (CIS-10):

In Q1 and Q2, 2021 CalViva Health Medical Management staff continued the CIS-10 Performance Improvement Project in collaboration with one high volume, low performing clinic in Fresno County. Through 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 the immunization completion rates for our youngest members. An educational campaign is being initiated that will utilize text messaging to connect with parents/guardians as our first intervention. This intervention is currently in the planning phases, and will be implemented in Q3. Modules 1 & 2 are approved by HSAG.

3.2 Breast Cancer Screening (BCS) Disparity

In Q1 and Q2, 2021 CalViva Health Medical Management staff continued a Breast Cancer Screening (BCS) Disparity Improvement Project focused on Hmong women 50 – 74 years of age. The project has been developed in collaboration with one high volume, low performing FQHC in Fresno County, a women's imaging center, and a community-based organization that supports the Hmong Community. Medical Management staff, along with representation from all constituents met during the first 6 months of 2021 to develop and finalize a process map in order to identify gaps in the process for potential interventions. Then through a barrier identification process (i.e. Failure Modes and Effects Analysis, Failure Mode Priority Ranking, and a Key Driver Diagram activities), the team determined that education is the first priority. It was determined that an in-person Educational Event to include a video in the Hmong language would be the best approach to address health literacy barriers among the Hmong population. CalViva will integrate a member friendly approach into the event that addresses cultural and language issues, along with transportation needs and other potential barriers.
Module 1 was submitted to DHCS; Module 2 is currently in development.

Item #5

Attachment 5.B

2021 Quality Improvement
Work Plan Mid-Year Evaluation
Work Plan Evaluation

CalViva Health
Quality Improvement
Mid-Year Work Plan 2021

09.09.21

CalViva Health 2021 Quality Improvement Mid-Year Work Plan

TABLE OF CONTENTS

QUALITY IMPROVEMENT 1

MID YEAR WORK PLAN 2021 1

I. PURPOSE 4

II. CALVIVA HEALTH GOALS 4

III. SCOPE 4

I. ACCESS, AVAILABILITY, & SERVICE 6

1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access 6

1-2: Improve Member Satisfaction 11

II.QUALITY & SAFETY OF CARE 17

2-1: Chlamydia Screening (CHL) 17

III. PERFORMANCE IMPROVEMENT PROJECTS 21

3-1: Addressing Breast Cancer Screening Disparities 21

3-2: Improving Childhood Immunizations (CIS-10) 25

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES 30

CalViva Health 2021 Quality Improvement Mid-Year Work Plan

Submitted by:

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CalViva Health 2021 Quality Improvement Mid-Year Work Plan

I. Purpose

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

II. CalViva Health Goals

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

III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2021. The development of this document requires resources of multiple departments.

CalViva Health 2021 Quality Improvement Mid-Year Work Plan

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances	**HPL:**	High Performance Level
A&I:	Audits and Investigation	**HN:**	Health Net
AH:	After Hours	**HSAG:**	Health Services Advisory Group
AWC:	Adolescent Well-Care	**IHA:**	Initial Health Assessment
BH:	Behavioral Health	**ICE:**	Industry Collaborative Effort
C&L:	Cultural and Linguistic	**IP:**	Improvement Plan
CAHPS:	Consumer Assessment of Healthcare Providers and Systems	**IVR:**	Interactive Voice Response
		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 (PAAS). 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

Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability.	P	Q3-Q4	CVH/HN
Develop and distribute Provider Updates, as applicable, informing providers of upcoming training webinars, surveys, survey results, and educational information for improvement.	P	Q1 - Q4 Q1 – Provider Webinar Trainings Q3 – MY 2021 Survey Prep Q3 – MY 2020 Survey Results	CVH/HN
Conduct provider training webinars related to timely access standards and surveys.	P	Q1-Q4	CVH/HN
Conduct Telephone Access 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
Leverage results from the quarterly DHCS Medi-Cal Managed Care Timely Access Report to identify PCPs and specialists that do not meet timely access standards and conduct outreach to these providers.	P	Q1-Q4	CVH/HN
Complete a CAP as necessary when CalViva providers are below standard, including additional interventions for providers not meeting standards for 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	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	**Section B: Analysis of Intervention Implementation (due end of Q4)**
• MY 2021 PAAS & PAHAS Surveys – slated to begin in September and being conducted by Sutherland • Provider Updates ○ MY 2020 PAAS & After-Hours Survey Results – DRAFT currently in process (June). • Provider Webinars – two sessions held in Q1 (March) and two sessions held in Q2 (June). Total of 11 attendees. • Telephone Access Survey – decision made to move from quarterly to annually to alleviate provider survey abrasion. Survey will be conducted in Q4 by Sutherland.	

• Appointment Access P&P Updates – updates made to P&P in Q2 regarding Telephone Access Survey changes and other minor edits. Will be brought to CalViva Health Access workgroup for review in Q3 (September meeting).
• DHCS Medi-Cal Managed Care Timely Access Report – DHCS has not resumed surveys yet and no ETA on when they will resume.
• MY 2020 PAAS & After-Hours Results & CAP – survey results shared with CalViva at June Access WG Ad-hoc meeting. MY 2020 CAP will be presented at July Access WG meeting.
  o Tier 2 groups or Direct Network providers found to be non-compliant two or more years in a row will be moved to a Tier 1 CAP and will be required to complete and Improvement Plan.
• Resources Update
  o Timely Access Webinar Flyer: minor updates; finalized February
  o Timely Appointment Access Flyer: minor updates; finalized June
  o Timely Appointment Access & After-Hours: Understand Your Survey Results – title change (formerly known as Timely Appointment Access & After-Hours Report Card) and other minor updates; finalized June
  o After-Hours Scripts – reviewed Q2; no changes needed
  o Improve Health Outcomes – Provider Toolkit – under review.
• After-Hours Physician Callback Rate
  o In MY 2019, a new survey vendor was used (Sutherland) to conduct the After-Hours survey. Drop in the rate in MY 2020 is likely attributed to a survey administration change, which was a slight modification to the survey tool. MY 2020 results are more consistent with results seen in MY 2018.	

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 2021)					
Measure(s)	**Performance Goal** (Goal for MY 2018 = 80%)	**Rate (%) MY 2020** (Populated mid-year)	**Rate (%) MY 2019**	**Baseline Value Source**	**Baseline Value (%) MY 2018**
Overall Combined: Urgent Care – PCP & SCP Non-Urgent Care – PCP & SCP First Visit – PCP or SCP Prenatal	90%	Urgent = 55.9 (-4.4) Non-Urgent = 81.9 (3.2) Prenatal = 85.3 (-4.8)	Urgent = 60.3 Non-Urgent = 78.7 Prenatal = 90.1	CVH Performance MY 2018	Urgent = 65.6 Non-Urgent = 72.4 Prenatal = 89.6
Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request	90%	Overall= 68.9 (-2.0) Fresno= 71.3 Kings= 58.9 Madera= 67.7	Overall=70.9^ Fresno=71.9 Kings=67.3 Madera=70.3	CVH Performance MY 2018	Overall= 71.4** Fresno=74.2** Kings=59.3 Madera=81.3
Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request	90%	Overall=44.4↓ (-7.8) Fresno= 47.0 Kings= 38.5 Madera= 39.0	Overall=52.2^ Fresno=53.8 Kings=42.3 Madera=50.9	CVH Performance MY 2018	Overall=62.8** Fresno=68.0** Kings=44.4** Madera=53.2**
Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	90%	Overall= 85.9 (1.2) Fresno= 83.7 Kings= 91.1 Madera= 93.9	Overall=84.7 Fresno=85.5 Kings= 84.9 Madera= 79.5	CVH Performance MY 2018	Overall=82.1** Fresno=85.7** Kings=85.2** Madera=62.5 **
Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	90%	Overall= 78.4 (3.0) Fresno= 78.1 Kings= 82.5 Madera= 77.5	Overall=75.4 Fresno=77.1 Kings=64.3 Madera=74.2	CVH Performance MY 2018	Overall= 68.1** Fresno=72.2** Kings= 73.7** Madera=43.1**
First Prenatal Visit (PCP) – Within 2 weeks of request	90%	Overall= 87.1 (-1.3) Fresno= 86.7 Kings= 94.7 Madera= 71.4*	Overall=88.4 Fresno=90.0 Kings=91.3 Madera=70.0	CVH Performance MY 2018	Overall=90.3 ** Fresno=94.4** Kings=90.0** Madera=66.7**
First Prenatal Visit (SCP) – Within 2 weeks of request	90%	Overall= 80.9 (-10.3) Fresno= 81.8 Kings= 57.1* Madera= 100*	Overall=91.2 Fresno=90.3 Kings=100* Madera=NR	CVH Performance MY 2018	Overall=88.9** Fresno=87.5** Kings=100** Madera=100**
Well-Child Visit with PCP – within 10 business days of request	90%	Overall= 80.9 (4.0) Fresno= 77.1 Kings= 97.1↑ Madera= 87.5	Overall=76.9 Fresno=77.5 Kings=79.6 Madera=70.3	CVH Performance MY 2018	Overall=73.6** Fresno=69.8** Kings=85.2** Madera=68.8**

Measure(s)	Performance Goal (Goal for MY 2018 =80%)	Rate (%) MY 2020 (populated mid-year)	Rate (%) MY 2019	Baseline Value Source	Baseline Value (%) MY 2018
Physical Exams and Wellness Checks – within 30 calendar days of request	90%	Overall= 89.0 (1.2) Fresno= 86.7 Kings= 94.4 Madera= 100	Overall=87.8 Fresno=88.1 Kings=91.5^ Madera=81.6	CVH Performance MY 2018	Overall=88.5** Fresno=85.2** Kings=92.6** Madera=93.8**
Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	90%	Overall= 100 (6.7) Fresno= 100 Kings= 100* Madera=100*	Overall=93.3 Fresno=90.9 Kings=100* Madera=100*	CVH Performance MY 2018	Overall=66.7 Fresno=60.0 Kings=100 Madera= NR
Appropriate After-Hours (AH) emergency instructions	90%	Overall=96.0↓ (-1.9) Fresno= 95.0↓ Kings= 99.1 Madera= 100	Overall=97.9 Fresno=97.9 Kings=99.0 Madera=96.1	CVH Performance MY 2018	Overall=93.9 Fresno=95.2 Kings=95.0 Madera=80.5
AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes	90%	Overall= 84.2↓ (-15.2) Fresno= 85.4↓ Kings= 70.9↓ Madera=95.6	Overall=99.4 Fresno=99.4 Kings=99.0 Madera=100	CVH Performance MY 2018	Overall=82.0 Fresno=82.3 Kings=77.8 Madera=85.0

^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 2020 vs RY 2019, 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

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w/ Barrier Analysis	
Initiative Continuation Status (Populate at year end)	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

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

Rationale and Aim(s) of Initiative

Member satisfaction 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.

Member Experience for CalViva is monitored in two ways:

1. **CalViva Access Survey**
    a. Purpose: Scaled-back CAHPS survey to assess access areas of opportunity.
    b. Administered by: Health Net QI-CAHPS Team through survey vendor, SPH Analytics.
    c. Frequency: Annually.
    d. Look-back Period: Year prior to survey administration date.
        i. Look-back Period for MY2019 Result Rates: October 2019 – April 2020
        ii. Look-back Period for MY2020 Result Rates: October 2020 – April 2021
    e. Results: Final results are shared with CalViva & the Provider Network Management Department (HN internal department).
2. **DHCS CAHPS Survey**
    a. Purpose: Regulatory CAHPS Survey.
    b. Administered by: HSAG (DHCS CAHPS Survey Vendor).
    c. Frequency: Every 2 years.
    d. Look-back Period: Year prior to survey administration date.
        i. Look-back Period for MY2016 Result Rates: August 2015 – May 2016
        ii. Look-back Period for MY2019 Result Rates: August 2019 – May 2020
    e. Results: Results are posted on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx

The CalViva CAHPS Survey is completed every two years and thus, annual rate updates will not be available. The most recent set of CAHPS Rates can be found below in Section C. The CalViva Access Survey is conducted annually, with updated results available in May/June each year (to be included in the mid-year update).

Measure rates captured below for both the CalViva Access Survey and the DHCS CAHPS Survey represent rates based on the percentage of members who chose “Always/Usually” as their response.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.
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 **Through the DHCS 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 DHCS/HSAG-administered CAHPS survey is to be at or above the Quality Compass 50th percentile.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Annually review Provider Tool Kit resources related to member experience. Ensure all are up-to-date and relevant.	P	Q4 2021	CVH/HN
Annually review, update, and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide.	P	Q1-Q2 2021	CVH/HN
Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the Performance Excellence Toolkit to educate and empower members and improve their overall experience.	P/M	Q1-Q2 2021	CVH/HN

Annually review, update and enhance materials on Interpreter services availability 24/7 to remind providers of the availability of these services and how to access them.	P	Q1-Q2 2021	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services.	M	Q2 2021	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 2021	CVH/HN
Update (as needed) and conduct scaled-back member survey/Annual CalViva Access Survey to assess effectiveness of interventions implemented. Share and review results once they are made available.	M	Q1 – Q2 2021	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 2021	CVH/HN
Quarterly perform a root cause analysis on appeals and grievances data to highlight member pain points, trends and opportunities for improvement. Share these results and recommendations with Medical Management leadership at least quarterly.	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 Provider Tool Kit was reviewed and updated for 2021. The following Member experience articles were included in the 2021 version: Appointment Scheduling Tip Sheet and Quick Reference Guide, Talking with my Doctor, Interpreter Services and the Nurse Advice Line. Due to the re-branding efforts, the launch of the 2021 tool kit had to be pushed back to Q4 2021. In addition, because of delay to in-person engagement, the Tool Kit will only be available in an e-version that will be sent to providers and staff. • Content for the annual Member Newsletter was reviewed for edits and updated. The 2021 Member Newsletter will include articles on the following topics: Questions to Ask Your Health Care Provider, Interpreter Services, Access Standards, and the Nurse Advice Line. The Member Newsletter launched on 7/22/2021.	

• The annual CalViva Access Survey was launched late March and was fielded for 1.5 weeks until the target number of respondents was met. Results will be presented at the July 2021 CVH Access Workgroup Call.
  ○ There were no statistically significant changes in any of the measures rates in comparison to last year.
  ○ The following measures saw percentage rate decreases in comparison to last year: Getting Urgent Care as Soon as Needed; Getting Routine Care as Soon as Needed, and Easy of Getting Tests, Care, Treatment.
  ○ Ease of Getting Specialist Appointment increased from 2020, seeing a 6-percentage point increase.
  ○ Based on the 2021 results, areas of focus will continue to revolve around improving members' access to routine, urgent, and overall care.
• The 2021 PPG CAHPS Webinar is slated to be held in late September across 2 sessions (AM, PM).
 	
The Q1 root cause analysis on member pain points was completed and shared internally with the appropriate stakeholders. Based on review and analysis of the results, the following areas of opportunity have been identified: Transportation, appointment availability, and referral approvals. The member pain points data will also be brought into the QI-MCAL 2022 planning discussions as a way to take a more holistic view into members' care experience and help identify future improvement activities.	

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 2021)

CalViva Access Survey Measure(s)	**Specific Goal**	**MY2019**	**MY2020**	**Baseline Source** (Source: Previous Year CalViva Access Survey)	**Baseline Value**

Got urgent care as soon as needed	Improve YOY	78%	77%	MY 2018 Rate	76%
Got routine care as soon as needed	Improve YOY	67%	62%	MY 2018 Rate	65%
Ease to get specialist appointment	Improve YOY	59%	65%	MY 2018 Rate	59%
Ease of getting care/test/treatment	Improve YOY	76%	69%	MY 2018 Rate	77%
DHCS CAHPS Survey Measure(s)	**Specific Goal**	**MY2016**	**MY2019**	**Baseline Source** (Source: Quality Compass Percentiles)	**Baseline Value**
Getting Needed Care	Meet or Exceed Quality Compass 50th Percentile	69%	69.10%	MY2019 50th Percentile	83.06%
Getting Care Quickly	Meet or Exceed Quality Compass 50th Percentile	73%	73.31%	MY2019 50th Percentile	82.34%
How Well Doctors Communicate	Meet or Exceed Quality Compass 50th Percentile	87%	86.52%	MY2019 50th Percentile	92.0%
Customer Service	Meet or Exceed Quality Compass 50th Percentile	NA	NA	MY2019 50th Percentile	88.8%
Shared Decision Making	Meet or Exceed Quality Compass 50th Percentile	77%	77.00%	MY2019 50th Percentile	79.84%
Rating of All Health Care	Meet or Exceed Quality Compass 50th Percentile	63%	63.41%	MY2019 50th Percentile	75.43%
Rating of Personal Doctor	Meet or Exceed Quality Compass 50th Percentile	75%	75.46%	MY2019 50th Percentile	82.34%
Rating of Health Plan	Meet or Exceed Quality Compass 50th Percentile	73%	73.35%	MY2019 50th Percentile	78.45%

Rating of Specialist	Meet or Exceed Quality Compass 50th Percentile	74%	74.44%	MY2019 50th Percentile	82.62%
Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered					
Analysis: Intervention Effectiveness With Barrier Analysis					
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**				

II.QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)				
2-1: 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** **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, caused by infection with Chlamydia trachomatis, is the most common notifiable disease in the United States. Untreated infection can result in pelvic inflammatory disease (PID), which is a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. (CDC, 2018).[1] Among sexually-active women aged 16-24 years covered by Medicaid, screening rates increased from 40.4% in 2001 to 57.6% in 2017.[2] 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).[3] 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)[4]

1 Centers for Disease Control and Prevention (2018). Sexually Transmitted Disease Surveillance 2018. Chlamydia Background. https://www.cdc.gov/std/stats18/chlamydia.htm#ref8

2 National Committee for Quality Assurance (2019) The State of Healthcare Quality: Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/

3 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

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

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 identified as sexually active and who had least one test for chlamydia during the measurement year.

Planned Activities			
Activities	**Target of Intervention: Member (M) / Provider (P)**	**Timeframe for Completion**	**Responsible Party(s)**
Work with a high volume, low compliance FQHC in Madera County to improve CHL screening rates.	P/M	Q1-Q2	CVH/HN
Conduct regular meetings with Madera County provider to plan improvements to increase the frequency of CHL screening in young women.	P	Q1-Q2	CVH/HN
Initiate an EHR flag/alert for women between 18 and 24 years of age for inclusion on Daily Huddle sheet, to facilitate completion of the screening test through collaboration between the MA and the provider.	P/M	Q1-Q2	CVH/HN
Develop a Provider Profile (Excel format) in collaboration with the clinic leadership/staff that will be populated with the demographic information of members due for screening. The Profile will facilitate documentation of member outreach attempts and test completion.	P/M	Q1-Q2	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
• In Q1 and Q2 2021, CalViva Health led a Chlamydia Screening (CHL), Performance Improvement Team in collaboration with one high volume, low performing clinic in Madera County. • The partner organization and CalViva Health established a multidisciplinary CHL improvement Team that met bi-weekly to determine the current process, identify potential barriers, and establish a plan for improvement to address potential barriers with the project.	

• In Q1 2021, CalViva Health developed a Provider Profile to target non-compliant members. The team focused initially on the 21-to-24-year-old age band; this group had a larger population to impact our rates, The clinic implemented the EMR Flag alert and a Daily Huddle report to facilitate collaboration with the MA and MD. These PDSA interventions were successful with the 21-24-year-old age band. • In Q2, the PDSA added the members in the 17-20-year-old age band to the cohort, to determine the effectiveness of the approach across a wider age range and learn if there are new barriers to address. The PDSA is also testing for sustainability and reproducibility with this younger population. • The primary barrier identified by the clinic is that patients are not being screened when they are seen by their PCP or other clinic provider. The PCP's were deferring to the "Annual Women's Exam" for this type of screening, though a CHL screen can be ordered and completed at any visit, by collecting a urine specimen. • The intervention identified the patient on the Daily Huddle report for all visits and the medical assistant is responsible for facilitating this type of testing in collaboration with the provider. The team is investigating opportunities in the CHL Screening process to improve the overall sustainability and performance of the health plan.	
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 MY 2018	Rate MY 2019	Rate MY 2020	Baseline Source	Baseline Value
HEDIS® Chlamydia Screening in Women (CHL) – County Goal	Meet or Exceed DHCS 50th Percentile 58.34%	Madera: 53.05%	Madera: 55.42%	Madera: 52.85%	MY2019 HEDIS Data	55.42%
HEDIS® Chlamydia Screening in Women (CHL) – Provider Goal	By 6/28/2021 increase the Screening Rate by 15% (60/402)	N/A	43.53%	58.33%	MY2019 Provider Results	43.53%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	
Initiation Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

III. PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)				
3-1: 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 the most common cancer in American women, except for skin cancers. Currently, the average risk of a woman in the United States developing breast cancer sometime in her life is about 13%. This means there is a 1 in 8 chance she will develop breast cancer. The American Cancer society's estimates for breast cancer in the United States are:

- About 276,480 new cases of invasive breast cancer will be diagnosed in women.
- About 48,530 new cases of carcinoma in situ (CIS) will be diagnosed (CIS is non-invasive and is the earliest form of breast cancer).
- About 42,170 women will die from breast cancer. (American Cancer Society, 2020).[1]

The COVID-19 pandemic is expected to have a devastating impact on cancer rates. Experts predict an unprecedented increase in the numbers of cancer cases and deaths because of delays in screening and care, intensifying the disparities already felt by underserved communities. (Kollmer, 2020).[2]

Barriers to breast cancer screening include personal attitudes and beliefs such as fear of positive mammogram result, and the misconception that a lack of breast cancer symptoms indicates lack of disease. Accessibility and associated factors such as concerns about mammogram cost and lack of transportation are additional barriers. Cultural related barriers were connected to racial and ethnic community cultures and immigration status, and included issues such as language barriers that stem from limited English proficiency, and cultural beliefs around modesty. Social and interpersonal barriers, or barriers created by women's interactions with others, include lack of encouragement for screening by friends or family. The most commonly reported barriers were perceived pain from the screening and embarrassment. Lack of physician recommendation was the most commonly identified social barrier. (Miller et al., 2019).[3]

The Hmong population'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.[4]

1 American Cancer Society (2020). About Breast Cancer. https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html

2 Kollmer, J. (2020). Breaking down the barriers to breast cancer screening for high-risk individuals. https://www.uchicagomedicine.org/forefront/cancer-articles/breaking-down-barriers-to-breast-cancer-screening-for-high-risk-individuals

3 Miller, B., Bowers, J., Payne, J. and Moyer, A. (2019). Barriers to mammography screening among racial and ethnic minority women. Social Science & Medicine.
https://www.uchicagomedicine.org/forefront/cancer-articles/breaking-down-barriers-to-breast-cancer-screening-for-high-risk-individuals
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 MY 2019 was 55.26%. The improvement goal is to increase the breast cancer screening rate among the Hmong speaking population at the targeted provider site from a baseline of TBD% to a goal rate of TBD%.

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 FQHC in Fresno County to implement targeted BCS interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Collaborate with a women's imaging center to improve BCS rates.	P	Q1-Q4	CVH/HN
Design and deploy a culturally competent community educational session for the Hmong speaking BCS non-compliant CalViva members, which will be moderated by a female Hmong physician, include a video presentation, introduction to imaging center staff, and address potential barriers such as transportation at a community-based organization to improve BCS rates for this population.	M	Q1-Q4	CVH/HN

Complete Key Driver Diagram with potential interventions (Module 1). Submitted to HSAG 3/1/21; pending approval.	P/M	Q1-Q2	CVH/HN
Complete process map activity with high volume, low compliance clinic in Fresno County (Module 2).	P	Q1	CVH/HN
Develop interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 2).	P/M	Q2-Q3	CVH/HN
Implement and test interventions with the clinic which includes PDSA cycles (Module 3)	P	Q2-Q4	CVH/HN
Health Education to distribute educational materials on the importance of breast cancer screening to members at the educational sessions, cultural center, and women's imaging center.	M	Q2-Q4	CVH/HN
Implement provider incentives to close the gaps and improve HEDIS rates for BCS.	P	Q1-Q4	CVH/HN
Implement member incentive for completion of breast cancer screening to improve HEDIS BCS rates.	M	Q1-Q4	CVH/HN
Deploy cultural and linguistic strategies at targeted convenient and culturally competent provider sites to support members in accessing their breast cancer. screening services. Strategies include: on-site interpreters, and transportation services.	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 2021, CalViva Health led a Breast Cancer Screening (BCS) Disparity Improvement Team in collaboration with Greater Fresno Health Organization (GFHO) (FQHC), which is a high volume, low performing clinic; an imaging center; and a Hmong cultural center in Fresno County. • The partner organizations and CalViva Health established a 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 with the project. • In Q2, the team completed the Key Driver, Process Map, and FMEA Tables; to be submitted to HSAG in Q3.	

• Through a barrier identification process, an Educational Event which includes a video in the Hmong language was developed to address health literacy barriers among the Hmong population. CalViva will use a member friendly approach that addresses cultural and language issues, along with transportation needs and other potential barriers. A member incentive will be offered to event attendees for completion of breast cancer screening. Modules 1 was submitted to HSAG and approved. Module 2 is submitted to HSAG and awaiting approval. • Provider Tip Sheets were developed in Q2 2021 and made available through the Provider Portal. The tip sheet outlines HEDIS Specifications, best practices, and recommended screening guidelines. • All Providers in Fresno County will be offered an incentive to encourage outreach to members for completion of their breast cancer screening.	

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 2021)

Measure(s)	Specific Goal	Rate MY2018	Rate MY2019	Rate MY2020	Baseline Source	Baseline Value
HEDIS® Breast Cancer Screening – County Goal	Meet or Exceed the MPL (50th Percentile) 58.73%	Fresno: 51.12 %	Fresno: 55.26%	52.64%	MY2019 HEDIS Data	55.26%
HEDIS® Breast Cancer Screening – Provider Goal	Meet or Exceed SMART Aim Goal of 47.8%	18.5%	28.46%	38.4%	MY2019 Provider Results	28.46%

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

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

Section A: Description of Intervention (due Q1)				
3-2: 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 pediatric health in Fresno County; specifically, to improve the health and safety of our youngest children and other at-risk populations in Fresno County by reducing the chance of preventable infection/illness through immunization.

Rationale: Vaccines are essential for protecting children against infectious diseases such as measles, mumps, rubella and whooping cough. Many of these diseases are largely forgotten in our country. Before vaccines became available, these diseases exacted a huge toll. For example, before the measles vaccine was licensed in 1963, the virus infected at least 2 million Americans a year, causing 500 deaths and 48,000 hospitalizations. When children are vaccinated, their immune system develop infection-fighting antibodies to protect them from contracting the targeted disease if they are exposed to it later in life. (Fauci, 2019).[1]

Many diseases which children in the United States are immunized against are rare in this country because of mass vaccination programs. However, these diseases are still found in other parts of the world and can be reintroduced into the United States by travelers, and then spread within our communities among people who have not been vaccinated. The current resurgence of measles, a highly contagious and potentially deadly disease that was declared eliminated in the United States in 2000, is a painful reminder of the need for vaccination. (Fauci, 2019). According to the US Department of Health and Human Service, five important reasons to vaccinate your child are:

1. Immunizations can save a child's life,
2. Vaccination is very safe and effective,
3. Immunization protects others we care about,
4. Immunizations can save families time and money.
5. Immunizations protects future generations. (HHS.gov, 2018).[2]

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).[3]

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).[4] 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).

Primary care providers play a key role in ensuring that children and the community receive vaccines on time. Because of the ongoing COVID-19 pandemic, providers are presented with the additional challenge of maintaining and strengthening routine vaccination during a global pandemic. As COVID-19 cases increased and states implemented stay-at-home orders, outpatient visits declined significantly. Increasing communication efforts regarding the importance of vaccination will be worthwhile, as the COVID-19 pandemic has highlighted the threat of infectious disease and has increased awareness of the vaccine development process.

Prior to the tragic events of 2020, many parents had not seen the devastating consequences of an infectious disease. The COVID-19 pandemic may offer an opportunity to change parents' perspective on vaccinations, particularly as it relates to the influenza vaccine. Providers should continue to promote the importance of well-child and vaccination visits. (McNally & Bernstein, 2020).[5]

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1 Fauci, A. (2019). The Importance of Childhood Vaccinations. National Institute of Health.
https://www.niaid.nih.gov/news-events/importance-childhood-vaccinations
2 United States Department of Health and Human Services. (2018). Five Important Reasons to Vaccinate Your Child.
https://www.vaccines.gov/get-vaccinated/for_parents/five_reasons
3 NCQA National Commission Quality Assurance. (2019) Childhood Immunization Status (CIS). https://www.ncqa.org/hedis/measures/childhood-immunization-status. Accessed December 21, 2020.
4 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
5 McNally, V., Bernstein, H. (2020). The Effect of the COVID-19 Pandemic on Childhood Immunizations: Ways to Strengthen Routine Vaccination. Pediatric Annals. 2020; 49(12):e516-e522.
https://www.healio.com/pediatrics/journals/pedann/2020-12-49-12/%7B594dfc0c-a4c6-4247-8243-39f8ee9e665c%7D/the-effect-of-the-covid-19-pandemic-on-childhood-immunizations-ways-to-strengthen-routine-vaccination

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 to receive 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 27.58% was determined based on the MY 2019 HEDIS hybrid data for one high volume, low performing FQHC in Fresno County; with a goal rate of 34.82%.

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 FQHC in Fresno County to implement targeted BCS interventions and monitor effectiveness.	P	Q1-Q4	CVH/HN
Complete Key Driver Diagram with potential interventions (Module 1). Due to HSAG 3/26/21.	P	Q1-Q2	CVH/HN
Complete process map activity with high volume, low compliance clinic in Fresno County (Module 2).	P	Q1-Q2	CVH/HN
Develop interventions with high volume, low compliance clinic, to address high priority gaps identified in Failure Modes and Effects Analysis Table (Module 2).	P	Q2-Q3	CVH/HN
Implement and test interventions with the clinic which includes PDSA cycles (Module 3)	P	Q2-Q4	CVH/HN
Health Education will design and implement educational activities on the importance of childhood immunizations at the clinic.	M	Q1-Q4	CVH/HN
Create article and distribute in Member newsletter highlighting childhood immunizations annually.	M	Q1-Q4	CVH/HN
Implement direct member incentive for completion of childhood immunizations series to improve CIS-10 measure rates	M	Q1-Q4	CVH/HN
Implement provider incentives to close the care gaps and improve CIS-10 measure rates.	P	Q1-Q4	CVH/HN

Develop Provider Tip Sheet for CIS-10 measure, which is 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 2021, CalViva Health led a Childhood Immunizations (CIS-10) Performance Improvement Team in collaboration with one high volume, low performing clinic in Fresno County. • Based upon 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. Some parents may have questions or concerns about childhood vaccinations. A provider based educational campaign utilizing texting as our first intervention to connect with parents is in the planning phases. • The clinic is working in collaboration with CVH Health Education Department to develop content for the text messages. Modules 1 and 2 were submitted to and approved by HSAG; Module 3 is in development. • The member newsletter will be distributed to members in Q3 of 2021 to educate on the importance of childhood immunizations. • Providers were offered an incentive to encourage outreach to members and completion of their immunizations. • Provider Tip Sheets were 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 2021)

Measure(s)	Specific Goal	Rate MY2018	Rate MY2019	Rate MY2020	Baseline Source	Baseline Value
Childhood Immunization Combo 10 – County Goal	Meet or Exceed the MPL (50th Percentile) 34.79%	Fresno: 32.16%	Fresno 33.82%	Fresno 32.12%	MY2019 HEDIS Results	33.82%
Childhood Immunization Combo 10 – Provider Goal	Meet or Exceed SMART Aim Goal of 34.82%	N/A	27.58%	20.97%	MY2019 Provider Results	27.58%

Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered	
Analysis: Intervention Effectiveness w Barrier Analysis	
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☒ **Continue Initiative with Modification**

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	Health Education	The PSG is being sent to CalViva Health members as part of the New Members Packet, and will be submitted to CalViva's QI/UM Committee on 11/18/2021.	☐		
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN	Clinical Practice Guidelines were disseminated March 2021, and was submitted to CalViva's QI/UM Committee on 7/15/2021.	☐		
3. Monitor CalViva Pregnancy Program and identify high risk members via Case Management	Case Management	The CalViva Pregnancy Program remains in place. 2021 YTD through May, 298 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.	☐		
4. Promote CA Smokers' Helpline to smokers	Health Education	Propose a collaboration with CA Smokers' Helpline to do direct outreach to smokers. Program needs DHCS approval before implementation.	☐		
5. Launch a Diabetes Prevention Program	Health Education	DPP program implementation pending submission to DHCS.	☐		

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. Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016.	Quality Improvement/ Case Management	Lead Screening for Children (LSC) measure added to performance trackers to monitor county and provider level performance. Monthly provider care gap reports with customized LSC measure implemented to notify providers of missing lead screenings. Provider report cards for lead screening were also implemented.	☐		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program for appropriate member outreach	Disease Management	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.	☐		
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	C&L	Completed. The C&L LAP report and work plan update was presented to UM/QI committee on 5/20/2021. The Timely Access Report (TAR) was completed and	☒	5/20/2021	

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Year End (YE) Date	Year End (YE) YE Update or Explanation *(if not complete)*
		submitted for filing during Q1.			
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	Access & Availability	Slated to begin in September and being conducted by Sutherland	☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date	Access & Availability	MY 2020 TAR submitted timely.	☒	3/31/21	
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers	Access & Availability	MY 2020 survey results shared with CalViva at June Access Workgroup Ad-hoc meeting. MY 2020 CAP will be presented at July Access WG meeting. • Tier 2 groups or Direct Network providers found to be non-compliant two or more years in a row will be moved to a Tier 1 CAP and will be required to complete and Improvement Plan.	☐		
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars	Access & Availability	Two sessions held in Q1 (March) and two sessions held in Q2 (June) with a total of 11 attendees. Low turnout can be attributed to “off-season” for CAP activities. Sessions will be held in Q3 & Q4 and should generate a	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
		higher turnout since this will be held during MY 2020 CAP distribution. Webinar attendance is a required activity for Tier 1 non-compliant PPGs.			
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	Access & Availability	Decision made to move from quarterly to annually to reduce provider survey abrasion. Survey will be conducted in Q4 by Sutherland.	☐		
7. DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey.	Access & Availability	DHCS has not resumed surveys yet and no ETA on when they will resume.	☐		
8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review	A&G	A&G has worked with providers and internal departments as needed to help resolve member appeals and grievances. Data is a consistent component of QI/UM and tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.	☐		
9. Population Needs Assessment Update: Evaluate members' health risks and identify their highest priority health care needs, as basis of targeted Cultural & Linguistics, Health Education and Quality Improvement (QI) programs.	C&L	On track to be submitted by 8/2/2021.	☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
10. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement. Analyze and inform Provider Network Management of areas needing increased contracting with a particular provider to improve availability.	C&L	Data collection and analysis in progress for GEO Access report. Report on track for completion in Q3. The findings will be shared with QI/UM Committee and Provider Network Management (PNM) in Q4.	☐		
11. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	Quality Improvement	CVH still under DHCS CAP for IHA. QI Project underway w/ high volume low performing clinic and determined that code 96156 is effective to document IHEBA completion. Implementation is planned for Q3 & Q4 2021. We will monitor for effectiveness.	☐		
12. Engage with CVH provider offices to complete MY2021 MCAS training focused on best practices for closing care gaps.	Quality Improvement	Completed 15 HEDIS trainings with 13 high-volume provider offices in Fresno, Kings and Madera Counties in Q1-Q2.	☐		
13. Engage with high volume CVH provider offices to complete interventions addressing systemic barriers to HEDIS performance.	Quality Improvement	Launched 39 interventions with 13 provider organizations in Fresno, Kings and Madera Counties in Q2. Intervention areas of focus included coding training and review, clinical workflow training, telehealth training, and Well Woman clinics.	☐		
QUALITY AND SAFETY OF CARE					

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
Integrated Case Management (ICM) • Implement 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	Case Management	The ImpactPro data remains 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.	☐		
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	Credentialing	On target to meet year end metrics 7/9/2021. Credentialing Oversight Audit in progress.	☐		
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	MHN	Managed Health Network Services (MHNS) initiated the annual member and provider satisfaction surveys in Q2. The team will analyze the results, conduct barrier analysis, and make plans for improvements, where necessary, by December 2021.	☐		
QUALITY IMPROVEMENT					

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure provider 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.	FSR	Not on track due to pandemic- no onsite visits per APL2-011. This APL was rescinded. Onsite audits expected to resume July 26, 2021. Plan for catch up on missed reviews in development.	☐		
2. Evaluation of the QI program: Complete QI Work Plan evaluation annually.	Quality Improvement	Ongoing. QI continues to complete Work Plan evaluation at Mid-Year as well as annually. The 2021 QI Workplan was completed and approved on March 18, 2021.	☐		

Item #6

Attachment 6.A

2021 Utilization Management Work Plan Mid-Year Evaluation Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee
FROM:	Jennifer Lloyd, Vice President Medical Management
COMMITTEE DATE:	September 16, 2021
SUBJECT:	2021 CalViva Utilization Management/Case Management Work Plan Mid-Year Evaluation Executive Summary

Summary:

Activities are currently on target for this mid-year evaluation with the exception of the following metrics listed below. These metrics are indicated as Too soon To Tell for the mid-year evaluation reporting:

- 2.2 Timeliness of processing the authorization request
- 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance

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.

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 Mid 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 are currently on target for this mid-year evaluation. No barriers have been identified.

II. Monitoring the Utilization Management Process

UM Process Monitoring activities listed as Too Soon To Tell for the mid-year evaluation reporting are outlined below. Other UM Process Monitoring elements are currently on track for this mid year evaluation with no barriers identified.

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

The plan met all TAT goals of 95% or better except for PreService Expedited with Extension/Deferral. For Q2 the sample size was 4 and one authorization did not meet in May 2021. Due to the extremely low sample size (4 authorizations), failures affect the percentage more strongly. The Referral Specialist (RS) mis-identified the pend request as standard and incorrect TAT dates were applied. The RS was coached and the pend process reviewed. There were no failures in June.

III. Monitoring Utilization Metrics

Work plan elements 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance is listed as Too Soon To Tell for the mid-year evaluation reporting. Other UM metric monitoring activities are currently on target for this mid-year evaluation.

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

It is too soon to tell whether the goals to reduce admissions by 10% over the prior year and reduce length of stay by 10% overall will be met in 2021. We continue to experience impact from the COVID-19 pandemic that impact our targets.

IV. Monitoring Coordination with Other Programs and Vendor Oversight

All activities related to monitoring coordination with other programs and vendor oversight are currently on target for this mid-year evaluation. No barriers have been identified.

V. Monitoring Activities for Special Populations

All monitoring activities for special populations are currently on target for this mid-year evaluation. No barriers have been identified.

Next Steps:

Teams are continuing progress towards completion of all activities. Ongoing monitoring of interventions will be essential for all areas to ensure appropriate actions are being taken to meet goals.

Item #6

Attachment 6.B

2021 Utilization Management
Work Plan Mid-Year Evaluation
Work Plan Evaluation

CalViva Health
2021
Utilization Management (UM)/ Case Management (CM)
Mid Year Work Plan Evaluation

Last updated: September 1, 2021

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements 5
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions 6
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements. 8
1.3 Separation of Medical Decisions from Fiscal Considerations 10
1.4 Periodic audits for Compliance with regulatory standards 12
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS) 14
1.6 Review, revision, and updates of CalViva UM /CM Program Description, UMCM Work plan, and associated policies and procedures at least annually. 16
2. Monitoring the UM Process 18
2.1 The number of authorizations for service requests received 19
2.2 Timeliness of processing the authorization request 21
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making 23
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals 25
3. Monitoring Utilization Metrics 27
3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance 28
3.2 Over/under utilization 30
3.3 PPG Profile 32
4. Monitoring Coordination with Other Programs and Vendor Oversight 35
4.1 Case Management (CM) Program 36
4.2 Referrals to Perinatal Case Management 39
4.3 Behavioral Health (BH) Case Management Program 42
4.4 Disease Management (DM) 44
4.5 MD interactions with Pharmacy 46
4.6 Behavioral Health (BH) Care Coordination 48
4.7 Behavioral Health Performance Measures 50

5. Monitoring Activities for Special Populations 52
5.1 Monitor of California Children's Services (CCS) identification rate. 53
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements 55

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Monthly As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	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: COVID-19 Updates • February: Overview of Telehealth Services • March: Resuming Cancer Screening in COVID • April: Palliative Care: • May: Diabetes and CVD Best Practices • June: Addressing HPV hesitancy • June: Implicit Bias and Microaggression in Patient Care Interactions 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	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements .	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, received from the Compliance Department and/or the Regulatory and Legislative Implementation committee. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in 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 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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

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 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 2021, July 2021, October 2021, January 2022

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues of 30 sample size per metric. When a variance from compliance standards is identified, sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented Program Metrics Reporting (PMR) meeting.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2021. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	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 the first two quarters in the year.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 2021 UM and CM Program Descriptions. Write and receive CalViva approval of 2020 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2021 UMCM Work Plan. Write and receive CalViva approval of 2021 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 2021 Q 1 2021 Q 1 2021 Q 3 2021 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2020 Year End UM/CM Work Plan Evaluation, 2021 UMCM Work Plan, 2021 UM Program Description and the 2021 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 2022**				

2. Monitoring the UM Process

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

<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.

<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>5,577</td><td>27</td><td>771</td></tr>
<tr><td>February</td><td>5,326</td><td>28</td><td>895</td></tr>
<tr><td>March</td><td>6,255</td><td>31</td><td>928</td></tr>
<tr><td>April</td><td>5,813</td><td>30</td><td>820</td></tr>
<tr><td>May</td><td>5,499</td><td>18</td><td>757</td></tr>
<tr><td>June</td><td>5,794</td><td>18</td><td>779</td></tr>
<tr><td>Totals</td><td>34,264</td><td>152</td><td>4,950</td></tr>
</table></td><td>None identified</td><td>None</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2022</td><td></td><td></td><td></td><td></td></tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

<table>
<tr><th>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 met all TAT goals of 95% or better except for PreService Expedited with Extension/Deferral. For Q2 the sample size was 4 and one authorization did not meet in May 2021. The Referral specialist was coached and the pend process reviewed. There were no failures in June.

<table><tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th></tr><tr><td>Pre-Service Routine</td><td>99.09%</td><td>100%</td></tr><tr><td>Pre-Service Routine with Extension/Deferral</td><td>98.02%</td><td>100%</td></tr><tr><td>Pre-Service Expedited</td><td>97.69%</td><td>99.09%</td></tr><tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>75%</td></tr><tr><td>Post Service</td><td>98.46%</td><td>100%</td></tr><tr><td>Post Service with Extension/Deferral</td><td>100%</td><td>100%</td></tr><tr><td>Concurrent</td><td>99.09%</td><td>100%</td></tr></table></td><td>Due to the extremely low sample size (4 authorizations), failures affect the percentage more strongly. The Referral Specialist mis-identified the pend request as standard and incorrect TAT dates were applied.</td><td>N/A</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2022</td><td></td><td></td><td></td><td></td></tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 Change Healthcare 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 Change Healthcare InterQual® IRR tool in Q3-4 2021. <u>Non-Physician IRR</u> Administer annual non-physician IRR test using Change Healthcare InterQual® IRR tool in Q3-4 2021.	Q3-4 2021 Q3-4 2021

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 2021	None identified	New optional annual training was developed in preparation for annual IRR testing.	12/31/2021
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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. The data from appeals and grievances is shared with the Provider Network Management, Adverse Action Team, and Quality Improvement / Utilization Management (QI/UM) committees and is aggregated and reviewed for additional actions and recommendations.	Ongoing

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

☒ ACTIVITY ON TARGET

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

Turnaround Time Compliance for resolved expedited and standard appeals = 99.76% or 421 out of 422 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>174</td><td>41.23%</td></tr><tr><td>Partial Uphold</td><td>6</td><td>1.42%</td></tr><tr><td>Uphold</td><td>237</td><td>56.16%</td></tr><tr><td>Withdrawal</td><td>5</td><td>1.18%</td></tr><tr><td>Case Total</td><td colspan="2">422</td></tr></table></td><td>Pharmacy & NIA appeals remain two top trends during the review period. A barrier can be attributed due to insufficient documentation and records submitted by the providers requesting the services and triggering the initial denial.</td><td>A&G facilitates any needed member care during the review. Additionally, NIA and Pharmacy appeals are reviewed and reported on the monthly CVH A&G Dashboard and on the UMQI quarterly reports.</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2022</td><td></td><td></td><td></td><td></td></tr>
</table>

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 2021 Goals: • 10% reduction in admissions over 2019 • 10% reduction in LOS overall over 2019	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement.	Ongoing

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 CalViva Health and Daily with Case Management and Public Programs teams.	COVID-19 and the various states of emergency continue to impact utilization patterns and our target reduction of admissions and length of stay. The CalViva Health service has experienced the following impacts as of mid-year: 1. Central Valley Hospital surges beyond capacity requiring transfer of members beyond their service area for treatment. 2. Significant increase in ICU admissions which to an overall increase in length of stay. 3. Decreased available post-acute beds due to facility staffing being impacted by COVID-19.	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 2021 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Quarterly PPG UM data presented at CalViva Management Oversight Meetings. Quarterly JOMs with PPGs reviewed shifts in utilization.	COVID-19 has greatly shifted utilizations patterns and normal UM workflows.	ADT data feed made available to each PPG to allow for tracking of discharges. Population Health spreadsheets shared with PPGs with members stratified by acuity.	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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. 3. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. 5. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Q1 2021 PPG Profile and Narrative was provided 05/24/21 and reviewed at MOM on 06/08/21 PPG's profile reports are made available quarterly. Q2 - 8/30/21 Q3 - 11/29/21, Q4 - TBD Q1 & Q2 Annual Reviews - La Salle Medical Providers had 2 CAPs for Timeliness and Denial issues. - Central Valley Medical Providers had 2 CAPs for Denial and Accuracy issues. Pending Annual Reviews for Q3 & Q4 - Adventist Health Plan - First Choice Medical Group - Independence Medical Group - Santé Community Physicians Delegation oversight monitors CAPS to insure actions are implemented, documented and followed to completion. Both PPGs have implemented an action plan to ensure compliance with denial letters/template.	Due to COVID-19, some PPGs experienced staff turnover and shortage, which caused Decision TAT to drop below the 97%, required benchmark however stayed above 93%. Delegation oversight is working closely to improve the TAT to meet 100%. Some PPGs experienced denial issues. Due to a regulation change, PPGs also experienced accuracy issues, which resulted incorrect templates.	To address denial issues, Delegation Oversight provided La Salle and Central Valley with current denial templates. To address NOA issues Delegation Oversight developed a new training. La Salle, Central Valley, Adventist, First Choice, IMG and Santé will have completed the training in August 2021. Delegation Oversight launched a new Web based audit application that is interactive with the PPGs. The new application has expanded audit scope and new audit modalities such as inspection, evidence submission, interviews and, process walk through. Additionally, the new audit scope scores the delegates by focus areas: Program structure, Decision Criteria, Access to staff, Timeliness, Accuracy, Denials, Care Coordination, and Delegation. Issues identified during an audit are communicated via the tool to the PPG for awareness and opportunity to provide additional evidences. All issues non-remediated during the audit are transferred to an issue management module for tracking of corrective actions and retesting of areas that failed prior to closing the CAR. The New application also enables performance analysis across PPGs to identify improvement opportunities across all delegated groups.	Ongoing

Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

4. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 Emergency Department utilization o Overall health care costs o Member Satisfaction	Dedicated staff of Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs), Licensed Marriage Family Therapists (LMFTs), Program Specialists, Program and Care Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Number of Health Information Forms (HIFs) completed in January-June by member and returned or Envolve People Care outreach was 1,525 and 96 members subsequently referred to Case Management through June. Total members managed through Q2 across physical, behavioral health, and Transitional Case Management programs was 2,021. Outcome measures include: readmission rates, Emergency Department (ED) utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Physical Health, Behavioral Health, & Transitional Case Management & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2021 & 3/31/2021 & remained eligible 90 days after case open date. 463 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 9.3% difference • Volume of ED claims/1000/year decreased by 118 • 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 98 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the Case Management and reported the goals they worked on improved understanding of their health Quality of Life Section 10.2% improvement in ability to care for self/family post CM (53.1%) vs pre Case Management (42.9%); 93.9% (92/98) of respondents reported Case Management exceed their expectations.	None	None identified	Ongoing

Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management (PCM)	☒ 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 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of Notice of Pregnancy (NOP) reports to identify members with moderate and high- risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date

Mid-Year Report
 	
☒ **ACTIVITY ON TARGET**
 	
☐ **TOO SOON TO TELL**
	Referrals decreased from 555 in Q1 to 399 in Q2. Through Q2 449 members managed in PCM program. Quarterly average engagement rate increased from 23%in Q1 to 28% in Q2 with YTD average 25.5%.
	
	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 2021 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed.
	
	• 1,421 members met the outcome inclusion criteria for visits; 442 members met preterm delivery criteria
	• Members enrolled in the High Risk Pregnancy Program demonstrated:
	  ○ 4.4% greater compliance in completing the first prenatal visit within their first trimester,
	  ○ 3.4% greater compliance in completing their post-partum visit
	  ○ 2.4% less pre-term deliveries in high risk members
		None identified	None	Ongoing

Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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 Emergency Department utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFT, and Care Coordinators to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high-risk members for referral to CM. Review outcome measures quarterly.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Data reported is a subset of information provided in 4.1.Referrals to behavioral health program increased from 254 in Q1 to 266 in Q2. Total members managed increased from 220 in Q1 to 236 in Q2. Total members managed through Q2 was 340. Calendar Year engagement rate 49%. Outcome measures include: readmission rates, Emergency Department utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Behavioral Health Case Management & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2021 & 3/31/2021 & remained eligible. Outcome results are consolidated across Physical Health, Behavioral Health, & Transitional Case Management programs and are reported in 4.1.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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, medical claims, and referrals. Plan Disease Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Member facing materials will be re-evaluated. Review prevalence data to affirm selection of Disease Management conditions.	Ongoing Q3 2021 12/31/2021

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. Ongoing program monitoring is conducted to assure that member needs are met. Program elements include: • educational materials and information about the program are sent to enrolled CVH members. • outbound telephonic interventions are conducted • referrals to case management and other programs as needed. Disease management member facing materials transitioned to pre-approved Krames materials. This refreshed the educational information and assured that members receive up-to-date, clinically validated information. Review of prevalence data to affirm selection of Disease Management conditions is in progress.	None identified	None	Ongoing Completed 05/07/2021 On Track
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2021 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

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. Key SHP Quarterly meeting topics include • New Medi-Cal Rx go live date announced as 1/1/22. Workgroup has reinitiated and all deliverables are being reassessed. • AB1114 on hold by DHCS, no ETA on restart date. • A&G trends and concerns reviewed at SHP meeting and tracking is continued. Some improvement seen in some providers. • IRR results for q1 and q2 2021 presented and Envolve met goal of 95% for both quarters.	None identified	Narcotic Limits enacted 10/2019 based on CDC guidelines	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.6 Behavioral Health (BH) Care Coordination	☒ Medi-Cal	CalViva collaborates with BH practitioners to improve coordination between medical and behavioral health care members.	Total number of registrations and referrals.	Review data that indicates when a member was referred to the County for services to ensure that MHN staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	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 July 2021, MHN received 261 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 2022**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	In Q1 2021, 15 of the 15 metrics met or exceeded their targets. In Q2 2021, 15 of the 15 metrics with targets met or exceeded their targets. The ABA authorization timeliness metric result was slightly under 100%, but it rounded to 100% and exceeded the threshold for action of 95%.	None identified	N/A	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2021 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.	Ongoing

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td><td>The CCS identification rates for the CVH under 21 population continue to trend above 5%.

2021 Monthly CCS Identification Rates
<table>
<tr><th></th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>8.39%</td><td>7.32%</td><td>7.34%</td><td>7.68%</td></tr>
<tr><td>Feb</td><td>8.51%</td><td>7.40%</td><td>7.48%</td><td>7.80%</td></tr>
<tr><td>Mar</td><td>8.47%</td><td>7.37%</td><td>7.43%</td><td>7.76%</td></tr>
<tr><td>Apr</td><td>8.42%</td><td>7.35%</td><td>7.41%</td><td>7.72%</td></tr>
<tr><td>May</td><td>8.38%</td><td>7.29%</td><td>7.38%</td><td>7.68%</td></tr>
<tr><td>Jun</td><td>8.53%</td><td>7.47%</td><td>7.61%</td><td>7.87%</td></tr>
</table></td><td>No barriers identified</td><td>N/A</td><td>Ongoing</td></tr>
<tr><td>Annual Evaluation

☐ MET OBJECTIVES

☐ CONTINUE ACTIVITY IN 2022</td><td></td><td></td><td></td><td></td></tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2021 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Case Management, the Pharmacy Program, the Pregnancy Program, or a Disease Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Disease Management and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	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. Timely HRA outreach reported for CalViva SPD members for Q1 and Q2 (100% on time).	None identified.	N/A	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2022**				

Item #7

Attachment 7.A

Financial Report Fiscal Year End
June 30, 2021

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of June 30, 2021

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	142,370,779.82
5	Total Bank Accounts	$ 142,370,779.82
6	Accounts Receivable	
7	Accounts Receivable	122,808,262.57
8	Total Accounts Receivable	$ 122,808,262.57
9	Other Current Assets	
10	Interest Receivable	2,139.99
11	Investments - CDs	0.00
12	Prepaid Expenses	892,963.30
13	Security Deposit	0.00
14	Total Other Current Assets	$ 895,103.29
15	Total Current Assets	$ 266,074,145.68
16	Fixed Assets	
17	Buildings	6,439,897.73
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	98,240.74
21	Total Fixed Assets	$ 9,699,557.57
22	Other Assets	
23	Investment -Restricted	300,923.43
24	Total Other Assets	$ 300,923.43
25	TOTAL ASSETS	$ 276,074,626.68
26	LIABILITIES AND EQUITY	
27	Liabilities	
28	Current Liabilities	
29	Accounts Payable	
30	Accounts Payable	61,450.79
31	Accrued Admin Service Fee	4,236,969.00
32	Capitation Payable	104,076,451.71
33	Claims Payable	23,811.69
34	Directed Payment Payable	3,207,066.98
35	Total Accounts Payable	$ 111,605,750.17
36	Other Current Liabilities	
37	Accrued Expenses	1,415,000.00
38	Accrued Payroll	155,084.02
39	Accrued Vacation Pay	328,230.60
40	Amt Due to DHCS	0.00
41	IBNR	39,586.66
42	Loan Payable-Current	0.00
43	Premium Tax Payable	0.00
44	Premium Tax Payable to BOE	6,052,350.70
45	Premium Tax Payable to DHCS	37,406,250.00
46	Total Other Current Liabilities	$ 45,396,501.98
47	Total Current Liabilities	$ 157,002,252.15
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	$ 157,002,252.15
53	Equity	
54	Retained Earnings	108,757,395.00
55	Net Income	10,314,979.53
56	Total Equity	$ 119,072,374.53
57	TOTAL LIABILITIES AND EQUITY	$ 276,074,626.68

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2020 - June 2021 (FY 2021)

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Investment Income	96,862.42	396,000.00	(299,137.58)
3	Premium/Capitation Income	1,334,445,553.54	1,186,025,071.00	148,420,482.54
4	**Total Income**	**1,334,542,415.96**	**1,186,421,071.00**	**148,121,344.96**
5	Cost of Medical Care			
6	Capitation - Medical Costs	1,114,505,490.71	971,431,469.00	143,074,021.71
7	Medical Claim Costs	825,742.27	1,020,000.00	(194,257.73)
8	**Total Cost of Medical Care**	**1,115,331,232.98**	**972,451,469.00**	**142,879,763.98**
9	**Gross Margin**	**219,211,182.98**	**213,969,602.00**	**5,241,580.98**
10	Expenses			
11	Admin Service Agreement Fees	49,584,535.00	48,048,000.00	1,536,535.00
12	Bank Charges	998.77	6,600.00	(5,601.23)
13	Computer/IT Services	149,908.81	177,696.00	(27,787.19)
14	Consulting Fees	0.00	105,000.00	(105,000.00)
15	Depreciation Expense	286,089.96	306,000.00	(19,910.04)
16	Dues & Subscriptions	164,209.49	180,192.00	(15,982.51)
17	Grants	3,532,500.00	4,200,000.00	(667,500.00)
18	Insurance	177,524.74	182,310.00	(4,785.26)
19	Labor	3,449,304.25	3,492,627.00	(43,322.75)
20	Legal & Professional Fees	106,300.00	190,800.00	(84,500.00)
21	License Expense	747,089.19	855,424.00	(108,334.81)
22	Marketing	1,293,094.30	1,500,000.00	(206,905.70)
23	Meals and Entertainment	18,656.05	20,300.00	(1,643.95)
24	Office Expenses	57,242.14	84,000.00	(26,757.86)
25	Parking	0.00	1,500.00	(1,500.00)
26	Postage & Delivery	2,095.47	3,360.00	(1,264.53)
27	Printing & Reproduction	1,949.93	4,800.00	(2,850.07)
28	Recruitment Expense	24,820.61	36,000.00	(11,179.39)
29	Rent	0.00	12,000.00	(12,000.00)
30	Seminars and Training	1,747.00	24,000.00	(22,253.00)
31	Supplies	8,009.90	10,800.00	(2,790.10)
32	Taxes	149,717,529.56	149,625,001.00	92,528.56
33	Telephone	34,704.90	34,800.00	(95.10)
34	Travel	645.44	29,300.00	(28,654.56)
35	**Total Expenses**	**209,358,955.51**	**209,130,510.00**	**228,445.51**
36	**Net Operating Income/ (Loss)**	**9,852,227.47**	**4,839,092.00**	**5,013,135.47**
37	Other Income			
38	Other Income	462,752.06	480,000.00	(17,247.94)
39	**Total Other Income**	**462,752.06**	**480,000.00**	**(17,247.94)**
40	**Net Other Income**	**462,752.06**	**480,000.00**	**(17,247.94)**
41	**Net Income/ (Loss)**	**10,314,979.53**	**5,319,092.00**	**4,995,887.53**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2021 vs FY 2020

		Total	
		July 2020 - June 2021 (FY 2021)	July 2019 - June 2020 (FY 2020)
1	**Income**		
2	**Investment Income**	96,862.42	244,893.71
3	**Premium/Capitation Income**	1,334,445,553.54	1,195,614,009.34
4	**Total Income**	**$ 1,334,542,415.96**	**$ 1,195,858,903.05**
5	**Cost of Medical Care**		
6	**Capitation - Medical Costs**	1,114,505,490.71	1,033,815,747.62
7	**Medical Claim Costs**	825,742.27	2,396,561.35
8	**Total Cost of Medical Care**	**$ 1,115,331,232.98**	**$ 1,036,212,308.97**
9	**Gross Margin**	**$ 219,211,182.98**	**$ 159,646,594.08**
10	**Expenses**		
11	**Admin Service Agreement Fees**	49,584,535.00	46,868,019.00
12	**Bank Charges**	998.77	1,600.50
13	**Computer/IT Services**	149,908.81	123,379.77
14	**Consulting Fees**	0.00	7,823.00
15	**Depreciation Expense**	286,089.96	288,977.06
16	**Dues & Subscriptions**	164,209.49	163,513.48
17	**Grants**	3,532,500.00	2,429,915.38
18	**Insurance**	177,524.74	178,343.70
19	**Labor**	3,449,304.25	3,111,246.72
20	**Legal & Professional Fees**	106,300.00	96,254.54
21	**License Expense**	747,089.19	763,106.94
22	**Marketing**	1,293,094.30	981,494.64
23	**Meals and Entertainment**	18,656.05	16,224.14
24	**Office Expenses**	57,242.14	65,389.31
25	**Parking**	0.00	1,162.53
26	**Postage & Delivery**	2,095.47	3,035.16
27	**Printing & Reproduction**	1,949.93	2,458.65
28	**Recruitment Expense**	24,820.61	1,837.92
29	**Rent**	0.00	2,700.00
30	**Seminars and Training**	1,747.00	6,528.03
31	**Supplies**	8,009.90	10,111.24
32	**Taxes**	149,717,529.56	66,497,836.38
33	**Telephone**	34,704.90	34,057.10
34	**Travel**	645.44	17,344.43
35	**Total Expenses**	**$ 209,358,955.51**	**$ 121,672,359.62**
36	**Net Operating Income/ (Loss)**	**$ 9,852,227.47**	**$ 37,974,234.46**
37	**Other Income**		
38	**Other Income**	462,752.06	498,912.08
39	**Total Other Income**	**$ 462,752.06**	**$ 498,912.08**
40	**Net Other Income**	**$ 462,752.06**	**$ 498,912.08**
41	**Net Income/ (Loss)**	**$ 10,314,979.53**	**$ 38,473,146.54**

Item #7

Attachment 7.B

Financials as of July 31, 2021

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of July 31, 2021

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	118,414,730.34
5	Total Bank Accounts	$ 118,414,730.34
6	Accounts Receivable	
7	Accounts Receivable	120,704,086.44
8	Total Accounts Receivable	$ 120,704,086.44
9	Other Current Assets	
10	Interest Receivable	972.55
11	Investments - CDs	0.00
12	Prepaid Expenses	905,374.87
13	Security Deposit	0.00
14	Total Other Current Assets	$ 906,347.42
15	Total Current Assets	$ 240,025,164.20
16	Fixed Assets	
17	Buildings	6,417,929.64
18	Computers & Software	0.00
19	Land	3,161,419.10
20	Office Furniture & Equipment	96,390.23
21	Total Fixed Assets	$ 9,675,738.97
22	Other Assets	
23	Investment -Restricted	301,024.83
24	Lease Receivable	3,300,688.74
25	Total Other Assets	$ 3,601,713.57
26	TOTAL ASSETS	$ 253,302,616.74
27	LIABILITIES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	47,898.89
32	Accrued Admin Service Fee	4,256,428.00
33	Capitation Payable	102,086,886.54
34	Claims Payable	4,245.05
35	Directed Payment Payable	3,207,066.98
36	Total Accounts Payable	$ 109,602,525.46
37	Other Current Liabilities	
38	Accrued Expenses	1,390,166.67
39	Accrued Payroll	55,608.04
40	Accrued Vacation Pay	328,230.60
41	Amt Due to DHCS	0.00
42	IBNR	39,586.66
43	Loan Payable-Current	0.00
44	Premium Tax Payable	0.00
45	Premium Tax Payable to BOE	6,052,350.70
46	Premium Tax Payable to DHCS	13,854,166.67
47	Total Other Current Liabilities	$ 21,720,109.34
48	Total Current Liabilities	$ 131,322,634.80
49	Long-Term Liabilities	
50	Renters' Security Deposit	0.00
51	Subordinated Loan Payable	0.00
52	Total Long-Term Liabilities	$ 0.00
53	Total Liabilities	$ 131,322,634.80
54	Deferred Inflows of Resources	$ 3,310,466.00
55	Equity	
56	Retained Earnings	119,072,374.53
57	Net Income/(Loss)	(402,858.59)
58	Total Equity	$ 118,669,515.94
59	TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND EQUITY	$ 253,302,616.74

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2021 (FY 2022)

		Total		
		Actual	Budget	Over/(Under) Budget
1	**Income**			
2	**Investment Income**	2,349.87	8,000.00	(5,650.13)
3	**Premium/Capitation Income**	114,993,280.73	113,478,902.00	1,514,378.73
4	**Total Income**	**114,995,630.60**	**113,486,902.00**	**1,508,728.60**
5	**Cost of Medical Care**			
6	**Capitation - Medical Costs**	95,457,273.79	94,188,094.00	1,269,179.79
7	**Medical Claim Costs**	50,579.00	90,000.00	(39,421.00)
8	**Total Cost of Medical Care**	**95,507,852.79**	**94,278,094.00**	**1,229,758.79**
9	**Gross Margin**	**19,487,777.81**	**19,208,808.00**	**278,969.81**
10	**Expenses**			
11	**Admin Service Agreement Fees**	4,256,428.00	4,180,000.00	76,428.00
12	**Bank Charges**	5.00	600.00	(595.00)
13	**Computer/IT Services**	10,734.22	15,833.00	(5,098.78)
14	**Consulting Fees**	0.00	25,000.00	(25,000.00)
15	**Depreciation Expense**	23,818.60	25,500.00	(1,681.40)
16	**Dues & Subscriptions**	13,612.70	15,016.00	(1,403.30)
17	**Grants**	1,300,000.00	1,300,500.00	(500.00)
18	**Insurance**	14,970.95	14,270.00	700.95
19	**Labor**	271,244.05	307,698.00	(36,453.95)
20	**Legal & Professional Fees**	5,727.67	15,900.00	(10,172.33)
21	**License Expense**	66,422.93	71,305.00	(4,882.07)
22	**Marketing**	111,433.65	120,000.00	(8,566.35)
23	**Meals and Entertainment**	2,329.68	1,800.00	529.68
24	**Office Expenses**	5,293.37	7,000.00	(1,706.63)
25	**Parking**	0.00	125.00	(125.00)
26	**Postage & Delivery**	335.58	280.00	55.58
27	**Printing & Reproduction**	305.51	400.00	(94.49)
28	**Recruitment Expense**	156.55	3,000.00	(2,843.45)
29	**Rent**	0.00	1,000.00	(1,000.00)
30	**Seminars and Training**	3,191.00	3,000.00	191.00
31	**Supplies**	764.56	900.00	(135.44)
32	**Taxes**	13,854,166.67	13,854,167.00	(0.33)
33	**Telephone**	3,022.66	2,990.00	32.66
34	**Travel**	2,004.99	2,000.00	4.99
35	**Total Expenses**	**19,945,968.34**	**19,968,284.00**	**(22,315.66)**
36	**Net Operating Income/ (Loss)**	**(458,190.53)**	**(759,476.00)**	**301,285.47**
37	**Other Income**			
38	**Other Income**	55,331.94	43,333.00	11,998.94
39	**Total Other Income**	**55,331.94**	**43,333.00**	**11,998.94**
40	**Net Other Income**	**55,331.94**	**43,333.00**	**11,998.94**
41	**Net Income/ (Loss)**	**(402,858.59)**	**(716,143.00)**	**313,284.41**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2022 vs FY 2021

		Total	
		July 2021 (FY 2022)	July 2020 (FY 2021)
1	**Income**		
2	**Investment Income**	2,349.87	31,032.39
3	**Premium/Capitation Income**	114,993,280.73	105,776,540.65
4	**Total Income**	**114,995,630.60**	**105,807,573.04**
5	**Cost of Medical Care**		
6	**Capitation - Medical Costs**	95,457,273.79	88,869,684.11
7	**Medical Claim Costs**	50,579.00	78,317.89
8	**Total Cost of Medical Care**	**95,507,852.79**	**88,948,002.00**
9	**Gross Margin**	**19,487,777.81**	**16,859,571.04**
10	**Expenses**		
11	**Admin Service Agreement Fees**	4,256,428.00	3,985,938.00
12	**Bank Charges**	5.00	546.05
13	**Computer/IT Services**	10,734.22	14,419.59
14	**Depreciation Expense**	23,818.60	23,863.06
15	**Dues & Subscriptions**	13,612.70	13,134.50
16	**Grants**	1,300,000.00	1,037,500.00
17	**Insurance**	14,970.95	14,262.07
18	**Labor**	271,244.05	261,534.92
19	**Legal & Professional Fees**	5,727.67	5,162.00
20	**License Expense**	66,422.93	62,057.59
21	**Marketing**	111,433.65	80,191.55
22	**Meals and Entertainment**	2,329.68	415.39
23	**Office Expenses**	5,293.37	8,175.67
24	**Postage & Delivery**	335.58	80.50
25	**Printing & Reproduction**	305.51	299.06
26	**Recruitment Expense**	156.55	0.00
27	**Rent**	0.00	0.00
28	**Seminars and Training**	3,191.00	223.08
29	**Supplies**	764.56	728.34
30	**Taxes**	13,854,166.67	12,468,750.00
31	**Telephone**	3,022.66	2,840.89
32	**Travel**	2,004.99	0.00
33	**Total Expenses**	**19,945,968.34**	**17,980,122.26**
34	**Net Operating Income/ (Loss)**	**(458,190.53)**	**(1,120,551.22)**
35	**Other Income**		
36	**Other Income**	55,331.94	45,707.96
37	**Total Other Income**	**55,331.94**	**45,707.96**
38	**Net Other Income**	**55,331.94**	**45,707.96**
39	**Net Income/ (Loss)**	**(402,858.59)**	**(1,074,843.26)**

Item #7

Attachment 7.C

Compliance Report

Regulatory Filings	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021 YTD Total
# of DHCS Filings													
Administrative/ Operational	16	12	13	13	12	13	19	16	3				117
Member & Provider Materials	5	2	2	3	2	0	0	2	0				16
# of DMHC Filings	7	1	5	5	7	2	4	7	0				38

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

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	2	2	4	6	4	5	2	0	0				
High-Risk	0	1	1	0	0	1	1	0	0				

Since the last Commission report, a new high-risk case was reported in July 2021 in which only one member's PHI was impacted.

Fraud, Waste, & Abuse Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021 YTD Total
# of New MC609 Cases Submitted to DHCS	0	0	0	0	0	1	0	0	0				1
# of Cases Open for Investigation (Active Number)	13	14	13	13	13	18	18	19	22				

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the last report, there has not been any 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. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances and appeals, etc.
Oversight Audits	The following annual audits are in-progress: Credentialing, Emergency Services, Claims, Call Center, Appeals & Grievances, Continuity of Care, and Provider Network/ Provider Relations. The following audits have been completed since the last Commission report: PDR Audit (CAP) and Fraud, Waste and Abuse (No CAP).
Regulatory Reviews/Audits and CAPS	**Status**
Department of Health Care Services ("DHCS") Annual Network Certification ("ANC")	On 8/2/21, DHCS notified the Plan that it had passed the 2021 ANC with no deficiencies.
Department of Health Care Services ("DHCS") Subcontracted Network Certification ("SNC") Readiness Plan	In preparation for the 2022 ANC, DHCS requested all plans to submit a "Subcontracted Network Certification Readiness Plan" by June 1, 2021. The Plan submitted the SNC Readiness Plan on May 27, 2021. The DHCS has since come back with three separate requests for additional information, the last of which the Plan responded to was on 8/17/21. The Plan is awaiting DHCS' final determination on the SNC.
2021 DMHC 18-Month Follow-Up Audit	The DMHC follow-up audit interviews were held 3/30/21. The Plan is awaiting the DMHC final report findings. The next routine DMHC medical survey for CalViva will be on 9/19/22.
Department of Health Care Services ("DHCS") 2020 Medical Audit - CAP	The Plan received the DHCS Final 2020 Audit Report on 6/30/20 which resulted in two deficiencies requiring a corrective action plan (CAP). DHCS accepted the CAP for one deficiency and closed that deficiency on 8/28/20. The second finding was related to provider completion of the Individual Health Education Behavioral Assessment (IHEBA) as part of the Initial Health Assessment (IHA) within 120 days of enrollment. On 8/27/2021, the Plan submitted its final CAP Update to DHCS indicating that all corrective actions have been implemented, and that the results of the actions can be reviewed by DHCS at the next Medical Audit in 2022. Based on this final update, the Plan requested DHCS to accept it as final and close the CAP. The next routine DHCS medical audit for CalViva is expected to be in April 2022 and will cover a 2-year look-back period as the 2021 audit was deferred due to the COVID-19 PHE.

Health and Human Services (HHS) Office of Civil Rights (OCR)	On 8/16/21, the Plan received correspondence from the U.S. Department of Human Services' Office of Civil Rights (OCR) stating that it was in receipt of a breach notification report filed on March 25, 2021. The breach notification was related to the Plan's Administrator's (Health Net's) business associate, Accellion, that reported it had been a victim of a cyber-attack. The correspondence described OCR's intent to investigate whether the Covered Entity (i.e. CalViva Health) is compliant with the applicable Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 C.F.R. Parts 160 and 164, Subparts A, C, and E, the Privacy and Security Rules), and the Breach Notification Rule (45 C.F.R. Parts 160 and 164, Subpart D). The Plan was instructed to provide a response to the OCR's Data Requests within 20 calendar days of the receipt of OCR's letter. The Plan submitted a complete response on 9/2/21. Per the Plan's DHCS contract, notice of the OCR's compliance review was provided to DHCS.
New Regulations / Contractual Requirements	**Status**
Medi-Cal Rx Transition	On 7/29/21 DHCS notified plans that full Medi-Cal Rx implementation will begin 1/1/22.
California Advancing and Innovating Medi-Cal (CalAIM)	CalViva Health continues to participate in DHCS calls, association calls and working with Health Net to implement the following key initiatives by 1/1/22: **A. Enhanced Care Management (ECM) and In lieu of Services (ILOS)** – Effective 1/1/22 in Kings County, and 7/1/22 in Fresno & Madera Counties. The Plan's initial ECM-ILOS Model of Care Part 1 was filed with DHCS 7/1/21. The Plan submitted the MOC Part 2 deliverable on 9/1/21. DHCS has a list of pre-approved ILOS that plans can implement. CalViva through its administrator, Health Net, is planning to offer the following services beginning 1/1/22 in Kings County. • Housing Transition Navigation Services • Housing Tenancy and Sustaining Services • Recuperative Care (Medical Respite) • Meals/Medically Tailored Meals • Sobering Centers • Asthma Remediation **B. Major Organ Transplant (MOT) carve-in** – Effective 1/1/22 for all CalViva counties and membership. The Plan submitted its MOT Network Certification listing California transplant centers on 9/2/21. The Plan's administrator is currently negotiating contracts with these centers to cover transplants for the Plan Medi-Cal membership.

RHA Commission Compliance – Regulatory Report

Plan Administration	
COVID-19 Novel Coronavirus	Due to easing of state and federal restrictions related to the public health emergency, we reopened the Palm office to members and public walk-in visitors on June 15, 2021. Our downtown office for walk-ins is still closed. Our administrator Health Net has indicated they will still continue to carry out operations on a semi-remote basis until December 2021.
Committee Report	
Public Policy Committee	The Public Policy Committee met on September 1, 2021, via telephone conference due to the COVID-19 state of emergency. The following reports were presented: Q2 2021 Grievance and Appeals; Health Education Q1 & Q2 Member Incentive Programs Semi-Annual Report. A Population Needs Assessment Update was also provided to the Committee. There were no recommendations for referral to the Commission. The next meeting will be held on December 1, 2021, at 11:30am and it is still to be determined if the meeting will be in person or if it will be a teleconference due to COVID-19.

Item #7

Attachment 7.D

A & G Report

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2021

Current as of End of the Month: July
Revised Date: 08/18/2021

CalViva - 2021																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2021 YTD**	**2020 YTD**
Expedited Grievances Received	8	15	14	37	9	16	17	42	19	0	0	19	0	0	0	0	98	110
Standard Grievances Received	91	102	130	323	119	117	140	376	139	0	0	139	0	0	0	0	838	997
Total Grievances Received	**99**	**117**	**144**	**360**	**128**	**133**	**157**	**418**	**158**	**0**	**0**	**158**	**0**	**0**	**0**	**0**	**936**	**1107**
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%**	**98.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.76%**	**99.7%**
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	14	14	36	10	16	13	39	23	0	0	23	0	0	0	0	98	111
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	68	88	122	278	112	125	134	371	125	0	0	125	0	0	0	0	774	1033
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Total Grievances Resolved	**76**	**102**	**136**	**314**	**122**	**141**	**147**	**410**	**148**	**0**	**0**	**148**	**0**	**0**	**0**	**0**	**872**	**1144**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**56**	**79**	**106**	**241**	**98**	**119**	**119**	**336**	**123**	**0**	**0**	**123**	**0**	**0**	**0**	**0**	**700**	**878**
Access - Other - DMHC	6	17	21	44	23	24	18	65	27	0	0	27	0	0	0	0	136	63
Access - PCP - DHCS	3	12	9	24	4	6	11	21	12	0	0	12	0	0	0	0	57	107
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	7	3	9	19	6	8	10	24	12	0	0	12	0	0	0	0	55	48
Administrative	8	13	19	40	19	26	20	65	17	0	0	17	0	0	0	0	122	191
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	4	11	8	23	11	5	9	25	3	0	0	3	0	0	0	0	51	82
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	6	7	15	9	8	9	26	4	0	0	4	0	0	0	0	45	80
Pharmacy	1	2	3	6	2	3	1	6	3	0	0	3	0	0	0	0	15	51
Transportation - Access	13	5	16	34	8	25	18	51	25	0	0	25	0	0	0	0	110	116
Transportation - Behaviour	11	10	13	34	15	14	21	50	20	0	0	20	0	0	0	0	104	100
Transportation - Other	1	0	1	2	1	0	2	3	0	0	0	0	0	0	0	0	5	37
Quality Of Care Grievances	**20**	**23**	**30**	**73**	**24**	**22**	**28**	**74**	**25**	**0**	**0**	**25**	**0**	**0**	**0**	**0**	**172**	**266**
Access - Other - DMHC	0	0	0	0	3	0	0	3	0	0	0	0	0	0	0	0	3	4
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	6
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	2	1	4	0	0	0	0	0	0	0	0	0	0	0	0	4	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	6	8	19	5	2	6	13	7	0	0	7	0	0	0	0	39	56
PCP Care	5	5	7	17	4	5	7	16	3	0	0	3	0	0	0	0	36	95
PCP Delay	4	7	9	20	7	10	9	26	7	0	0	7	0	0	0	0	53	42
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	3	2	4	9	3	2	1	6	4	0	0	4	0	0	0	0	19	46
Specialist Delay	2	1	1	4	2	3	5	10	3	0	0	3	0	0	0	0	17	15
Exempt Grievances Received	229	255	325	**809**	335	285	238	**858**	320	0	0	**320**	0	0	0	**0**	**1987**	2877
Access - Avail of Appt w/ PCP	3	3	3	**9**	3	2	7	**12**	0	0	0	**0**	0	0	0	**0**	**21**	93
Access - Avail of Appt w/ Specialist	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	2
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	4	0	6	**10**	7	2	7	**16**	3	0	0	**3**	0	0	0	**0**	**29**	35
Access - Wait Time - in office for appt	0	0	1	**1**	1	2	2	**5**	0	0	0	**0**	0	0	0	**0**	**6**	17
Access - Panel Disruption	5	11	9	**25**	6	3	3	**12**	3	0	0	**3**	0	0	0	**0**	**40**	57
Access - Shortage of Providers	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	1
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	1	1	1	**3**	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	**5**	10
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Interpreter Service Requested	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	1	1	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	0
Attitude/Service - Health Plan Staff	2	3	1	**6**	2	0	0	**2**	3	0	0	**3**	0	0	0	**0**	**11**	17
Attitude/Service - Provider	27	27	34	**88**	79	41	19	**139**	59	0	0	**59**	0	0	0	**0**	**286**	285
Attitude/Service - Office Staff	0	0	0	**0**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	12
Attitude/Service - Vendor	3	0	0	**3**	1	2	1	**4**	3	0	0	**3**	0	0	0	**0**	**10**	11
Attitude/Service - Health Plan	1	0	0	**1**	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	**5**	11
Authorization - Authorization Related	0	1	0	**1**	3	1	3	**7**	2	0	0	**2**	0	0	0	**0**	**10**	25
Eligibility Issue - Member not eligible per Health Plan	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	6
Eligibility Issue - Member not eligible per Provider	4	2	5	**11**	5	5	3	**13**	7	0	0	**7**	0	0	0	**0**	**31**	37
Health Plan Materials - ID Cards-Not Received	28	56	46	**130**	40	36	26	**102**	32	0	0	**32**	0	0	0	**0**	**264**	235
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	3	**3**	1	1	2	**4**	0	0	0	**0**	0	0	0	**0**	**7**	7
Health Plan Materials - Other	0	1	2	**3**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**4**	3
PCP Assignment/Transfer - Health Plan Assignment - Change Request	93	99	138	**330**	133	89	75	**297**	53	0	0	**53**	0	0	0	**0**	**680**	1162
PCP Assignment/Transfer - HCO Assignment - Change Request	11	20	22	**53**	4	49	41	**94**	52	0	0	**52**	0	0	0	**0**	**199**	156
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	3	1	4	**8**	1	4	0	**5**	3	0	0	**3**	0	0	0	**0**	**16**	19
PCP Assignment/Transfer - Rollout of PPG	4	3	5	**12**	3	2	0	**5**	6	0	0	**6**	0	0	0	**0**	**23**	45

CalViva Health Appeals and Grievances Dashboard 2021

PCP Assignment/Transfer - Mileage Inconvenience	4	4	10	**18**	16	7	1	**24**	11	0	0	**11**	0	0	0	**0**	**53**	58
Pharmacy - Authorization Issue	2	0	0	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	5
Pharmacy - Authorization Issue-CalViva Error	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	1
Pharmacy - Eligibility Issue	8	5	8	**21**	10	10	14	**34**	20	0	0	**20**	0	0	0	**0**	**75**	144
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Pharmacy - Rx Not Covered	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Pharmacy - Pharmacy-Retail	8	2	2	**12**	4	2	6	**12**	6	0	0	**6**	0	0	0	**0**	**30**	45
Transportation - Access - Provider No Show	3	3	1	**7**	0	0	1	**1**	1	0	0	**1**	0	0	0	**0**	**9**	24
Transportation - Access - Provider Late	1	1	2	**4**	0	1	1	**2**	8	0	0	**8**	0	0	0	**0**	**14**	52
Transportation - Behaviour	4	4	1	**9**	0	4	9	**13**	11	0	0	**11**	0	0	0	**0**	**33**	119
Transportation - Other	1	0	0	**1**	0	0	1	**1**	2	0	0	**2**	0	0	0	**0**	**4**	12
OTHER - Other	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**2**	7
OTHER - Balance Billing from Provider	8	4	16	**28**	12	15	16	**43**	34	0	0	**34**	0	0	0	**0**	**105**	161

CalViva Health Appeals and Grievances Dashboard 2021

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	8	6	9	23	1	6	5	12	12	0	0	12	0	0	0	0	47	115
Standard Appeals Received	45	68	90	203	58	68	63	189	55	0	0	55	0	0	0	0	447	918
Total Appeals Received	**53**	**74**	**99**	**226**	**59**	**74**	**68**	**201**	**67**	**0**	**0**	**67**	**0**	**0**	**0**	**0**	494	**1033**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	3
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Resolved Compliant	7	8	8	**23**	2	6	5	**13**	12	0	0	**12**	0	0	0	0	48	114
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.1%**
Standard Appeals Resolved Noncompliant	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Standard Appeals Resolved Compliant	51	45	76	172	84	55	74	213	74	0	0	74	0	0	0	0	459	916
Standard Appeals Compliance Rate	**98.0%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.78%**	**100.0%**
Total Appeals Resolved	**59**	**53**	**84**	**196**	**86**	**61**	**79**	**226**	**86**	**0**	**0**	**86**	**0**	**0**	**0**	**0**	**508**	**1031**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**59**	**53**	**84**	**196**	**86**	**61**	**79**	**226**	**86**	**0**	**0**	**86**	**0**	**0**	**0**	**0**	**508**	1029
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	1	4	5	1	1	2	4	3	0	0	3	0	0	0	0	12	17
DME	4	4	6	14	10	5	11	26	7	0	0	7	0	0	0	0	47	47
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	1	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	3	2
Advanced Imaging	22	18	34	74	37	21	36	94	29	0	0	29	0	0	0	0	197	488
Other	7	5	3	15	7	3	8	18	10	0	0	10	0	0	0	0	43	67
Pharmacy	20	24	33	77	24	26	19	69	33	0	0	33	0	0	0	0	179	362
Surgery	5	1	4	10	5	5	3	13	4	0	0	4	0	0	0	0	27	46
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**	2
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	1
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	35	33	47	**115**	53	32	37	122	42	0	0	42	0	0	0	0	279	577
Uphold Rate	**59.3%**	**62.3%**	**56.0%**	**58.7%**	**61.6%**	**52.5%**	**46.8%**	**54.0%**	**48.8%**	**0.0%**	**0.0%**	**48.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**54.9%**	**56.0%**
Overturns - Full	22	17	35	**74**	31	28	41	**100**	43	0	0	**43**	0	0	0	**0**	217	432
Overturn Rate - Full	**37.3%**	**32.1%**	**41.7%**	**37.8%**	**36.0%**	**45.9%**	**51.9%**	**44.2%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**42.7%**	**41.9%**
Overturns - Partials	1	2	2	**5**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	6	12
Overturn Rate - Partial	**1.7%**	**3.8%**	**2.4%**	**2.6%**	**0.0%**	**1.6%**	**0.0%**	**0.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**1.2%**	**1.2%**
Withdrawal	1	1	0	**2**	2	0	1	**3**	1	0	0	**1**	0	0	0	0	**6**	10
Withdrawal Rate	**1.7%**	**1.9%**	**0.0%**	**1.0%**	**2.3%**	**0.0%**	**1.3%**	**1.3%**	**1.2%**	**0.0%**	**0.0%**	**1.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.2%**	**1.0%**
Membership	376,770	378,355	380,179		382,052	383,876	385,467		385,467	-	-		-	-	-			4,316,872
Appeals - PTMPM	0.16	0.14	0.22	0.17	0.23	0.16	0.20	0.20	0.22	-	-	0.22	-	-	-	-	0.19	0.24
Grievances - PTMPM	0.20	0.27	0.36	0.28	0.32	0.37	0.38	0.36	0.38	-	-	0.38	-	-	-	-	0.33	0.27

CalViva Health Appeals and Grievances Dashboard 2021 (Fresno County)

Fresno County																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2021 YTD**	**2020 YTD**
Expedited Grievances Received	7	12	13	32	4	16	14	34	14	0	0	14	0	0	0	0	80	92
Standard Grievances Received	77	79	118	274	96	109	115	320	118	0	0	118	0	0	0	0	712	864
Total Grievances Received	**84**	**91**	**131**	**306**	**100**	**125**	**129**	**354**	**132**	**0**	**0**	**132**	**0**	**0**	**0**	**0**	**792**	**956**
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%**	**97.5%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.7%**	**99.65%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	7	11	13	31	5	16	10	31	18	0	0	18	0	0	0	0	80	93
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	57	73	96	226	104	102	125	331	102	0	0	102	0	0	0	0	659	894
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**64**	**84**	**109**	**257**	**109**	**118**	**135**	**362**	**120**	**0**	**0**	**120**	**0**	**0**	**0**	**0**	**739**	**987**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**47**	**64**	**86**	**197**	**85**	**100**	**107**	**292**	**98**	**0**	**0**	**98**	**0**	**0**	**0**	**0**	**587**	**758**
Access - Other - DMHC	6	15	21	42	19	21	17	57	22	0	0	22	0	0	0	0	121	56
Access - PCP - DHCS	3	10	9	22	3	5	10	18	7	0	0	7	0	0	0	0	47	98
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	2	6	13	4	7	7	18	10	0	0	10	0	0	0	0	41	38
Administrative	8	12	13	33	15	24	20	59	15	0	0	15	0	0	0	0	107	162
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Interpersonal	3	9	4	16	10	4	7	21	3	0	0	3	0	0	0	0	40	73
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	3	6	10	9	7	9	25	2	0	0	2	0	0	0	0	37	61
Pharmacy	1	2	3	6	2	1	1	4	2	0	0	2	0	0	0	0	12	40
Transportation - Access	11	3	14	28	7	20	15	42	24	0	0	24	0	0	0	0	94	104
Transportation - Behaviour	8	8	9	25	15	11	19	45	13	0	0	13	0	0	0	0	83	90
Transportation - Other	1	0	1	2	1	0	2	3	0	0	0	0	0	0	0	0	5	33
Quality Of Care Grievances	**17**	**20**	**23**	**60**	**24**	**18**	**28**	**70**	**22**	**0**	**0**	**22**	**0**	**0**	**0**	**0**	**152**	**229**
Access - Other - DMHC	0	0	0	0	3	0	0	3	0	0	0	0	0	0	0	0	3	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	6
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	2	1	4	0	0	0	0	0	0	0	0	0	0	0	0	4	2
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	5	7	16	5	1	6	12	5	0	0	5	0	0	0	0	33	48
PCP Care	4	4	4	12	4	4	7	15	3	0	0	3	0	0	0	0	30	83
PCP Delay	4	6	7	17	7	9	9	25	7	0	0	7	0	0	0	0	49	37
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	3	2	3	8	3	1	1	5	3	0	0	3	0	0	0	0	16	38
Specialist Delay	1	1	1	3	2	3	5	10	3	0	0	3	0	0	0	0	16	12

CalViva Health Appeals and Grievances Dashboard 2021 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	6	4	9	19	1	4	5	10	11	0	0	11	0	0	0	0	40	96
Standard Appeals Received	37	49	80	166	45	59	53	157	43	0	0	43	0	0	0	0	366	789
Total Appeals Received	**43**	**53**	**89**	**185**	**46**	**63**	**58**	**167**	**54**	**0**	**0**	**54**	**0**	**0**	**0**	**0**	406	**885**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Expedited Appeals Resolved Compliant	5	6	8	19	2	4	5	11	11	0	0	11	0	0	0	0	41	95
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**98.9%**
Standard Appeals Resolved Noncompliant	1	0	0	1	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Standard Appeals Resolved Compliant	46	38	53	137	76	43	63	**182**	62	0	0	**62**	0	0	0	**0**	381	785
Standard Appeals Compliance Rate	**97.8%**	**100.0%**	**100.0%**	**99.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.7%**	**100.0%**
Total Appeals Resolved	**52**	**44**	**61**	**157**	**78**	**47**	**68**	**193**	**73**	**0**	**0**	**73**	**0**	**0**	**0**	**0**	**423**	**881**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**52**	**44**	**61**	**157**	**78**	**47**	**68**	**193**	**73**	**0**	**0**	**73**	**0**	**0**	**0**	**0**	**423**	**880**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	2	2	1	1	2	4	2	0	0	2	0	0	0	0	8	15
DME	4	4	6	14	10	3	8	21	7	0	0	7	0	0	0	0	42	38
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	1	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	3	2
Advanced Imaging	20	17	26	63	34	18	30	82	25	0	0	25	0	0	0	0	170	436
Other	7	5	3	15	5	2	8	15	10	0	0	10	0	0	0	0	40	58
Pharmacy	16	17	21	54	21	18	17	56	26	0	0	26	0	0	0	0	136	291
Surgery	4	1	3	8	5	5	3	13	3	0	0	3	0	0	0	0	24	40
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	1
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	29	27	37	**93**	47	25	33	**105**	35	0	0	**35**	0	0	0	**0**	233	497
Uphold Rate	**55.8%**	**61.4%**	**60.0%**	**59.2%**	**60.3%**	**53.2%**	**48.5%**	**54.4%**	**47.9%**	**0.0%**	**0.0%**	**47.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**55.1%**	**56.4%**
Overturns - Full	21	15	22	**58**	30	22	35	**87**	37	0	0	**37**	0	0	0	**0**	182	364
Overturn Rate - Full	**40.4%**	**34.1%**	**36.7%**	**36.9%**	**38.5%**	**46.8%**	**51.5%**	**45.1%**	**50.7%**	**0.0%**	**0.0%**	**50.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**43.0%**	**41.3%**
Overturns - Partials	1	1	2	**4**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	4	12
Overturn Rate - Partial	**1.9%**	**2.3%**	**3.3%**	**2.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.9%**	**1.4%**
Withdrawal	1	1	0	**2**	1	0	0	**1**	1	0	0	**1**	0	0	0	**0**	4	8
Withdrawal Rate	**1.9%**	**2.3%**	**0.0%**	**1.3%**	**1.3%**	**0.0%**	**0.0%**	**0.5%**	**1.4%**	**0.0%**	**0.0%**	**1.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.9%**	**0.9%**
Membership	304,759	305,990	307,463		308,852	310,191	311,420		311,420									**1700076**
Appeals - PTMPM	0.17	0.14	0.20	0.17	0.25	0.15	0.22	0.21	0.23	-	-	0.08	-	-	-	0.00	0.11	0.19
Grievances - PTMPM	0.21	0.27	0.36	0.28	0.35	0.38	0.43	0.39	0.39	-	-	0.13	-	-	-	0.00	0.20	0.21

Kings County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2021 YTD	2020 YTD
Expedited Grievances Received	1	1	0	2	4	0	1	5	2	0	0	2	0	0	0	0	9	10
Standard Grievances Received	5	9	4	18	14	2	14	30	6	0	0	6	0	0	0	0	54	58
Total Grievances Received	**6**	**10**	**4**	**20**	**18**	**2**	**15**	**35**	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**63**	**68**
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%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	1	0	2	4	0	1	5	2	0	0	2	0	0	0	0	9	10
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	4	7	8	19	2	15	3	20	10	0	0	10	0	0	0	0	49	57
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**5**	**8**	**8**	**21**	**6**	**15**	**4**	**25**	**12**	**0**	**0**	**12**	**0**	**0**	**0**	**0**	58	**67**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**4**	**7**	**6**	**17**	**6**	**13**	**4**	**23**	**11**	**0**	**0**	**11**	**0**	**0**	**0**	**0**	**51**	**56**
Access - Other - DMHC	0	0	0	0	2	1	0	3	3	0	0	3	0	0	0	0	6	3
Access - PCP - DHCS	0	1	0	1	1	0	0	1	3	0	0	3	0	0	0	0	5	2
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	2	1	0	3	2	1	1	4	0	0	0	0	0	0	0	0	7	4
Administrative	0	0	1	1	1	2	0	3	1	0	0	1	0	0	0	0	5	13
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	0	2	2	0	0	1	1	0	0	0	0	0	0	0	0	3	1
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	2	1	3	0	1	0	1	1	0	0	1	0	0	0	0	5	12
Pharmacy	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	2	8
Transportation - Access	0	1	1	2	0	5	0	5	0	0	0	0	0	0	0	0	7	5
Transportation - Behaviour	2	2	1	5	0	2	2	4	2	0	0	2	0	0	0	0	11	6
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Quality Of Care Grievances	**1**	**1**	**2**	**4**	**0**	**2**	**0**	**2**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**7**	**11**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	3
PCP Care	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	5
PCP Delay	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	1	1	0	1	0	1	0	0	0	0	0	0	0	0	2	2
Specialist Delay	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0

CalViva Health Appeals and Grievances Dashboard 2021 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	2	6
Standard Appeals Received	3	3	5	11	4	5	5	14	6	0	0	6	0	0	0	0	31	41
Total Appeals Received	**4**	**3**	**5**	**12**	**4**	**5**	**5**	**14**	**7**	**0**	**0**	**7**	**0**	**0**	**0**	**0**	33	**47**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	1	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	2	6
Expedited Appeals Compliance Rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	1	3	5	9	3	4	6	13	7	0	0	7	0	0	0	0	29	45
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**2**	**3**	**5**	**10**	**3**	**4**	**6**	**13**	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**31**	**51**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**3**	**5**	**10**	**3**	**4**	**6**	**13**	**8**	**0**	**0**	**8**	**0**	**0**	**0**	**0**	**31**	**51**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	1	2	3	0	0	0	0	1	0	0	1	0	0	0	0	4	1
DME	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	2	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	0
Advanced Imaging	1	0	0	1	1	0	3	4	2	0	0	2	0	0	0	0	7	21
Other	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Pharmacy	1	2	3	6	1	4	1	6	4	0	0	4	0	0	0	0	16	20
Surgery	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	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	1	2	1	**4**	2	2	2	**6**	4	0	0	**4**	0	0	0	**0**	14	26
Uphold Rate	**50.0%**	**66.7%**	**20.0%**	**40.0%**	**66.7%**	**50.0%**	**33.3%**	**46.2%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**45.2%**	**51.0%**
Overturns - Full	1	0	4	**5**	0	1	4	**5**	4	0	0	**4**	0	0	0	**0**	14	24
Overturn Rate - Full	**50.0%**	**0.0%**	**80.0%**	**50.0%**	**0.0%**	**25.0%**	**66.7%**	**38.5%**	**50.0%**	**0.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**45.2%**	**47.1%**
Overturns - Partials	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	2	0
Overturn Rate - Partial	**0.0%**	**33.3%**	**0.0%**	**10.0%**	**0.0%**	**25.0%**	**0.0%**	**7.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.5%**	**0.0%**
Withdrawal	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	1	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**33.3%**	**0.0%**	**0.0%**	**7.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.2%**	**2.0%**
Membership	31,802	31,984	32,109		32,332	32,512	32,645		32,645									**273008**
Appeals - PTMPM	0.06	0.09	0.16	0.10	0.09	0.12	0.18	0.13	0.25	-	-	0.08	-	-	-	0.00	0.08	0.14
Grievances - PTMPM	0.16	0.25	0.22	0.22	0.19	0.46	0.12	0.26	0.37	-	-	0.12	-	-	-	0.00	0.15	0.18

Madera County

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2021 YTD	2020 YTD
Expedited Grievances Received	0	2	1	3	1	0	2	3	3	0	0	3	0	0	0	0	9	8
Standard Grievances Received	9	14	8	31	9	6	11	26	15	0	0	15	0	0	0	0	72	75
Total Grievances Received	**9**	**16**	**9**	**34**	**10**	**6**	**13**	**29**	**18**	**0**	**0**	**18**	**0**	**0**	**0**	**0**	**81**	**83**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**97.3%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	0	2	1	3	1	0	2	3	3	0	0	3	0	0	0	0	9	8
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	7	8	18	33	6	8	6	20	13	0	0	13	0	0	0	0	66	82
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**7**	**10**	**19**	**36**	**7**	**8**	**8**	**23**	**16**	**0**	**0**	**16**	**0**	**0**	**0**	**0**	**75**	**90**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**5**	**8**	**14**	**27**	**7**	**6**	**8**	**21**	**14**	**0**	**0**	**14**	**0**	**0**	**0**	**0**	**62**	**64**
Access - Other - DMHC	0	2	0	2	2	2	1	5	2	0	0	2	0	0	0	0	9	4
Access - PCP - DHCS	0	1	0	1	0	1	1	2	2	0	0	2	0	0	0	0	5	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	0	0	3	3	0	0	2	2	2	0	0	2	0	0	0	0	7	6
Administrative	0	1	5	6	3	0	0	3	1	0	0	1	0	0	0	0	10	16
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	2	2	5	1	1	1	3	0	0	0	0	0	0	0	0	8	8
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	1	0	2	0	0	0	0	1	0	0	1	0	0	0	0	3	7
Pharmacy	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	3
Transportation - Access	2	1	1	4	1	0	3	4	1	0	0	1	0	0	0	0	9	4
Transportation - Behaviour	1	0	3	4	0	1	0	1	5	0	0	5	0	0	0	0	10	7
Transportation - Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Quality Of Care Grievances	**2**	**2**	**5**	**9**	**0**	**2**	**0**	**2**	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**13**	**26**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	1	1	3	0	1	0	1	1	0	0	1	0	0	0	0	5	5
PCP Care	1	1	2	4	0	0	0	0	0	0	0	0	0	0	0	0	4	7
PCP Delay	0	0	2	2	0	1	0	1	0	0	0	0	0	0	0	0	3	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	1	0	0	1	0	0	0	0	1	6
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3

CalViva Health Appeals and Grievances Dashboard 2021 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	1	2	0	3	0	2	0	2	0	0	0	0	0	0	0	0	5	13
Standard Appeals Received	5	16	5	26	9	4	5	18	6	0	0	6	0	0	0	0	50	88
Total Appeals Received	**6**	**18**	**5**	**29**	**9**	**6**	**5**	**20**	**6**	**0**	**0**	**6**	**0**	**0**	**0**	**0**	55	**101**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	1	2	0	3	0	2	0	2	0	0	0	0	0	0	0	0	5	13
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	4	4	18	26	5	8	5	**18**	5	0	0	**5**	0	0	0	**0**	49	86
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**5**	**6**	**18**	**29**	**5**	**10**	**5**	**20**	**5**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**54**	**99**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**5**	**6**	**18**	**29**	**5**	**10**	**5**	**20**	**5**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**54**	**98**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	2	1	3	0	0	0	0	0	0	0	0	3	6
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	1	1	8	10	2	3	3	8	2	0	0	2	0	0	0	0	20	31
Other	0	0	0	0	1	1	0	2	0	0	0	0	0	0	0	0	2	5
Pharmacy	3	5	9	17	2	4	1	7	3	0	0	3	0	0	0	0	27	51
Surgery	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	4	9	**18**	4	5	2	**11**	3	0	0	**3**	0	0	0	**0**	32	54
Uphold Rate	**100.0%**	**66.7%**	**50.0%**	**62.1%**	**80.0%**	**50.0%**	**40.0%**	**55.0%**	**60.0%**	**0.0%**	**0.0%**	**60.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**59.3%**	**54.5%**
Overturns - Full	0	2	9	**11**	1	5	2	**8**	2	0	0	**2**	0	0	0	**0**	21	44
Overturn Rate - Full	**0.0%**	**33.3%**	**50.0%**	**37.9%**	**20.0%**	**50.0%**	**40.0%**	**40.0%**	**40.0%**	**0.0%**	**0.0%**	**40.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**38.9%**	**44.4%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Withdrawal	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	1	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**20.0%**	**5.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.9%**	**1.0%**
Membership	40,209	40,381	40,607		40,868	41,173	41,402		41,402									**343989**
Appeals - PTMPM	0.12	0.15	0.45	0.24	0.12	0.24	0.12	0.16	0.12	-	-	0.04	-	-	-	0.00	0.11	0.21
Grievances - PTMPM	0.17	0.25	0.47	0.30	0.17	0.19	0.19	0.19	0.39	-	-	0.13	-	-	-	0.00	0.15	0.20

CalViva SPD only

Grievances	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	2021 YTD	2020 YTD
Expedited Grievances Received	6	5	3	14	2	2	6	10	7	0	0	7	0	0	0	0	31	32
Standard Grievances Received	40	37	59	136	44	41	61	146	54	0	0	54	0	0	0	0	336	401
Total Grievances Received	**46**	**42**	**62**	150	**46**	**43**	**67**	**156**	**61**	**0**	**0**	**61**	**0**	**0**	**0**	**0**	**367**	**433**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.50%**
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	4	4	14	2	2	6	10	7	0	0	7	0	0	0	0	31	28
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	37	36	46	119	51	51	42	144	57	0	0	57	0	0	0	0	320	394
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**43**	**40**	**50**	**133**	**53**	**53**	**48**	**154**	**64**	**0**	**0**	**64**	**0**	**0**	**0**	**0**	351	**422**
Grievance Descriptions - Resolved Cases	**43**	**40**	**50**	**133**	**53**	**53**	**48**	**154**	**64**	**0**	**0**	**64**	**0**	**0**	**0**	**0**	351	**422**
Access to primary care	1	2	4	7	0	1	4	5	3	0	0	3	0	0	0	0	15	35
Access to specialists	3	1	4	8	2	1	3	6	11	0	0	11	0	0	0	0	25	12
Continuity of Care	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	12	11	16	39	12	20	15	47	27	0	0	27	0	0	0	0	113	35
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	8	11	9	28	6	8	5	19	4	0	0	4	0	0	0	0	51	73
QOS Non Access	19	15	17	34	33	23	21	77	19	0	0	19	0	0	0	0	130	234
Exempt Grievances Received	10	5	9	**24**	12	9	4	**25**	1	0	0	**1**	0	0	0	**0**	**50**	113
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Specialist	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	2
Attitude/Service - Provider	0	1	2	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	13
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Vendor	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	5
Attitude/Service - Health Plan	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Health Plan Materials - ID Cards-Not Received	2	1	0	**3**	4	1	0	**5**	0	0	0	**0**	0	0	0	**0**	**8**	12
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	0
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Health Plan Assignment - Change Request	4	1	3	**8**	5	1	2	**8**	0	0	0	**0**	0	0	0	**0**	**16**	24
PCP Assignment/Transfer - HCO Assignment - Change Request	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**3**	7
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**2**	2
PCP Assignment/Transfer - Rollout of PPG	0	0	1	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	2
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	1	3	2	**6**	0	0	0	**0**	0	0	0	**0**	**6**	7
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1

Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	4
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
OTHER - Balance Billing from Provider	0	0	2	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	12

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	YTD
Expedited Appeals Received	2	1	3	6	0	2	1	3	4	0	0	4	0	0	0	0	13	39
Standard Appeals Received	13	18	22	53	16	13	24	53	12	0	0	12	0	0	0	0	118	221
Total Appeals Received	**15**	**19**	**25**	**59**	**16**	**15**	**25**	**56**	**16**	**0**	**0**	**16**	**0**	**0**	**0**	**0**	131	**260**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.5%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	2	5	1	2	1	4	4	0	0	4	0	0	0	0	13	34
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**-300.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	12	14	20	46	20	14	14	**48**	24	0	0	**24**	0	0	0	**0**	118	214
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**14**	**15**	**21**	**50**	**21**	**16**	**15**	**52**	**28**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**130**	**248**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**14**	**15**	**21**	**51**	**21**	**16**	**15**	**52**	**28**	**0**	**0**	**28**	**0**	**0**	**0**	**0**	**131**	**248**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	1	1	1	1	1	3	2	0	0	2	0	0	0	0	6	4
DME	2	2	1	5	5	1	6	12	4	0	0	4	0	0	0	0	21	24
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	1	0	0	1	0	0	0	0	0	0	0	0	1	0
Advanced Imaging	3	4	10	17	7	7	3	17	6	0	0	6	0	0	0	0	40	97
Other	1	2	0	3	2	0	3	5	1	0	0	1	0	0	0	0	9	14
Pharmacy	8	6	9	23	5	7	2	14	13	0	0	13	0	0	0	0	50	100
Surgery	0	1	1	2	0	0	0	0	2	0	0	2	0	0	0	0	4	9
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	7	9	12	**28**	9	7	8	**24**	10	0	0	**10**	0	0	0	**0**	62	123
Uphold Rate	**50.0%**	**60.0%**	**52.4%**	**56.0%**	**42.9%**	**43.8%**	**53.3%**	**46.2%**	**35.7%**	**0.0%**	**0.0%**	**35.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**47.7%**	**49.6%**
Overturns - Full	6	6	8	**20**	11	9	6	**26**	18	0	0	**18**	0	0	0	**0**	64	116
Overturn Rate - Full	**42.9%**	**40.0%**	**38.1%**	**40.0%**	**52.4%**	**56.3%**	**40.0%**	**50.0%**	**64.3%**	**0.0%**	**0.0%**	**64.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**49.2%**	**46.77%**
Overturns - Partials	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	7
Overturn Rate - Partial	**0.0%**	**0.0%**	**9.5%**	**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%**	**1.5%**	**2.8%**
Withdrawal	1	0	0	**1**	1	0	1	**2**	0	0	0	**0**	0	0	0	**0**	3	2
Withdrawal Rate	**7.1%**	**0.0%**	**0.0%**	**2.0%**	**4.8%**	**0.0%**	**6.7%**	**3.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.3%**	**0.8%**
Membership	33,854	33,850	33,872		33,913	33,987	33,964		33,964									**101333**
Appeals - PTMPM	0.41	0.44	0.62	0.00	0.62	0.47	0.44	0.00	0.82	-	-	0.27	-	-	-	0.00	0.07	0.30
Grievances - PTMPM	1.27	1.18	1.45	0.00	1.56	1.56	1.41	0.00	1.88	-	-	0.63	-	-	-	0.00	0.16	0.52

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative Grievance	Balance billing issue, claims delay in processing
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist
APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT
Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy	Denied medication due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy	Denied medication due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.

Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals
EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).
Exempt Grievance tab key – Calviva Dashboard	
Column Definitions.	
Date Opened	The date the case was received
SF #	The internal HealthNet system ID code for the CCC representative who documented the call
Rep Name	Name of the CCC associate who took the call
Sup Name	Supervisor of the CCC associate who took the call
Mbr ID	The Calviva Health ID number of the member
SPD	Marked "yes" if the member is part of the "Seniors & Persons with Disabilities" population
Date of Birth	Date of birth of the member
Mbr Name	Name of the member
Reason	The case was categorized as a Calviva Exempt Grievance, hence the reason it's on the report
Preventable	Used if an Exempt Grievance was determined to be preventable
Access to Care	Used if determined Exempt Grievance was related to Access to Care
Issue Main Classification	Case is categorized by type of complaint
Issue Sub Classification	Case is subcategorized by type of complaint
DMHC Complaint Category	Case is categorized based on the DMHC TAR template complaint category
Discrimination?	Marked "yes" if case involved perceived discrimination by the member, otherwise marked "no"
Resolution	The resolution to the exempt grievance is notated here
Date Reviewed	The date the case was reviewed by CCC exempt grievance personnel
Provider Involved	The provider involved in the exempt grievance is notated here
Provider Category	The type of provider that is involved
County	The county the member resides in is notated here
PPG	Whether the member is assigned to a PPG is notated here
Health Plan ID	The Internal HN Plan ID for the Provider Involved in the exempt grievance.
PPG Service Area	Internal HN Code for the PPG to whom the member belongs.
Yes	
Classification Definitions	
Authorization	Used when it's an Authorization/Referral issue related exempt grievance
Avail of Appt w/ Other Providers	The case is related to appointment availability of ancillary providers
Avail of Appt w/ PCP	The case is related to appointment availability of the PCP
Avail of Appt w/ Specialist	The case is related to appointment availability of a Specialist
Claims Complaint	The case is related to a claims issue/dispute
Eligibility Issue	The case is related to the members eligibilty or lackthereof.
Health Care Benefits	When it's an exempt grievance related to a specific benefit, eg transportation
ID Card - Not Received	The case is related to the member having not received their ID card
Information Discrepancy	When the exempt grievance is related to being given wrong or misleading information
Interpersonal - Behavior of Clinic/Staff - Health Plan Staff	The case is related to the interpersonal behavoir of a health plan staff member
Interpersonal - Behavior of Clinic/Staff - Provider	The case is related to the interpersonal behavoir of a provider
Interpersonal - Behavior of Clinic/Staff - Vendor	The case is related to the interpersonal behavoir of a vendor
Other	For miscellaneous exempt grievances
PCP Assignment/Transfer	
PCP Assignment/Transfer-Health Plan Assignment- Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member, whether it be through the auto-assignment logic process or any other health plan assignments reasons.
PCP Assignment/Transfer-HCO Assignment - Change Request	Use this when the member is upset/dissatisfied with the health plan's PCP assignment for the member.This category will represent PCP assignments in which the assignment was made as a result of the 834 file HCO Input. "Electronic Assignment- HCO Input"
Pharmacy	The case is related to a pharmacy issue
Wait Time - In Office for Scheduled Appt	When the Access to Care complaint is in regards to wait time at a providers office
Wait Time - Too Long on Telephone	When the Access to Care complaint is in regards to being placed on hold or unable to get through by telephone
The Outlier Tab	This tab is used by the Reporting Team, CalViva, and A&G. The Reporting Team will use this tab to call out any outliers to the A&G team that were identified during the report creation such as trends or increase in volume of appeals and/or grievances. The Reporting team will send the outliers to the business when the Dashboard is sent for approval. CalViva will use this tab to call out any outliers to the A&G team that were identified during the report creation. The A&G Team will use this tab to document the reasons for the call out, trending, or unusual high numbers of complaints from the Reporting Team or CalViva on the outliers that were identified during the report creation or review of cases.
Month	This is used to track the month effected by the change that was made
Date	This is used to track the date the change was made
Outlier	This is the section that describes a brief explanation of the outlier such as increase number of PCP wait time complaints, trends, etc.
Explanation	This is the section that explains the outlier.
Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Item #7

Attachment 7.E

Key Indicator Report

Healthcare Solutions Reporting

Key Indicator Report

Auth Based PPG Utilization Metrics for CALVIVA California SHP

Report from 6/01/2021 to 6/30/2021

Report created 7/27/2021

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:

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

Contact Information

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

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 6/01/2021 to 6/30/2021
Report created 7/27/2021

ER utilization based on Claims data	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
																Quarterly Averages							Annual Averages		
Expansion Mbr Months	87,395	88,816	90,637	91,812	92,887	94,206	95,081		96,096	96,834	95,782	95,319	94,989	94,637		84,103	85,941	90,422	94,058	96,237	94,982		88,631	95,610	
Family/Adult/Other Mbr Mos	249,198	250,891	252,443	253,747	254,834	255,916	256,634		257,483	257,725	249,442	248,418	247,605	246,854		244,312	247,127	252,360	255,795	254,883	247,626		249,899	251,255	
SPD Mbr Months	34,715	34,742	34,788	34,784	34,816	34,798	34,761		34,701	34,552	34,016	33,822	33,641	33,469		34,616	34,670	34,771	34,792	34,423	33,644		34,712	34,034	
Admits - Count	1,938	2,052	2,246	2,092	2,159	2,028	2,009		2,027	1,827	2,164	2,043	2,059	2,058		2,204	1,782	2,130	2,065	2,006	2,053		2,045	2,251	
Expansion	602	681	680	682	732	635	570		564	536	684	664	656	675		626	559	681	646	595	665		628	700	
Family/Adult/Other	917	945	1,082	995	999	961	999		1,032	850	976	911	913	888		1,045	852	1,007	986	953	904		973	1,024	
SPD	418	421	481	411	424	430	437		423	435	493	460	487	491		531	369	438	430	450	479		442	521	
Admits Acute - Count	1,287	1,341	1,488	1,359	1,410	1,425	1,379		1,384	1,225	1,516	1,479	1,482	1,461		1,512	1,135	1,396	1,405	1,375	1,474		1,362	1,591	
Expansion	459	496	519	495	537	514	476		483	415	535	526	514	517		467	409	503	509	478	519		472	557	
Family/Adult/Other	430	445	514	487	489	500	489		502	415	533	522	504	487		556	379	482	493	483	504		477	550	
SPD	397	398	455	376	384	410	412		399	394	448	430	463	456		489	346	410	402	414	450		412	483	
Readmit 30 Day - Count	236	258	308	272	271	242	172		207	199	237	212	216	221		291	224	279	228	214	216		256	222	
Expansion	72	84	95	93	101	92	60		68	76	85	71	58	73		82	68	91	84	76	67		81	74	
Family/Adult/Other	71	72	96	84	71	65	38		53	40	52	39	41	48		79	66	84	58	48	43		72	47	
SPD	93	101	117	95	99	85	74		86	83	100	102	117	100		129	89	104	86	90	106		102	100	
**ER Visits - Count	10,788	12,309	11,342	10,668	10,977	10,488	9,790		9,363	9,242	10,895	11,692	12,288	7,488		16,640	9,261	11,440	10,418	9,833	10,489		11,940	10,161	
Expansion	3,394	3,857	3,636	3,367	3,435	3,233	3,187		2,958	2,856	3,097	3,233	3,117	1,906		3,771	2,919	3,620	3,285	2,970	2,752		3,399	2,861	
Family/Adult/Other	6,043	6,759	6,298	5,929	6,175	5,950	5,419		5,251	5,246	6,010	6,557	7,146	4,382		11,007	5,062	6,329	5,848	5,502	6,028		7,061	5,765	
SPD	1,324	1,410	1,389	1,330	1,344	1,264	1,173		1,137	1,082	1,305	1,279	1,301	681		1,840	1,264	1,376	1,260	1,175	1,087		1,435	1,131	
Admits Acute - PTMPY	41.6	42.9	47.2	42.9	44.2	44.4	42.8		42.7	37.7	46.6	45.4	45.5	44.9		50.0	37.0	44.3	43.8	42.4	45.3		43.8	48.9	
Expansion	63.0	67.0	68.7	64.7	69.4	65.5	60.1		60.3	51.4	67.0	66.2	64.9	65.6		66.7	57.1	66.8	64.9	59.6	65.6		63.9	69.9	
Family/Adult/Other	20.7	21.3	24.4	23.0	23.0	23.4	22.9		23.4	19.3	25.6	25.2	24.4	23.7		27.3	18.4	22.9	23.1	22.8	24.4		22.9	26.3	
SPD	137.2	137.5	157.0	129.7	132.4	141.4	142.2		138.0	136.8	158.0	152.6	165.2	163.5		169.4	119.8	141.4	138.7	144.2	160.4		142.3	170.3	
Bed Days Acute - PTMPY	233.0	269.3	264.3	236.1	248.0	266.2	310.2		288.7	218.5	235.5	227.5	234.7	220.8		246.0	202.3	256.5	274.9	247.5	227.7		245.3	259.5	
Expansion	344.2	423.7	385.7	358.9	371.4	390.2	486.3		443.7	320.1	370.5	349.5	337.7	332.3		350.6	313.4	389.1	416.4	377.9	339.9		368.8	393.2	
Family/Adult/Other	98.0	120.4	124.7	97.8	108.8	120.6	134.8		129.5	100.9	106.2	107.8	97.8	95.5		99.0	83.0	114.3	121.5	112.2	100.4		104.6	115.9	
SPD	922.9	949.9	963.1	921.8	939.2	1,001.4	1,122.3		1,042.6	812.3	879.8	850.8	1,054.1	932.9		1,030.0	777.9	944.9	1,020.9	911.9	945.8		943.5	1,013.9	
ALOS Acute	5.6	6.3	5.6	5.5	5.6	6.0	7.2		6.8	5.8	5.1	5.0	5.2	4.9		4.9	5.5	5.8	6.3	5.8	5.0		5.6	5.3	
Expansion	5.5	6.3	5.6	5.5	5.4	6.0	8.1		7.4	6.2	5.5	5.3	5.2	5.1		5.3	5.5	5.8	6.4	6.3	5.2		5.8	5.6	
Family/Adult/Other	4.7	5.7	5.1	4.2	4.7	5.1	5.9		5.5	5.2	4.1	4.3	4.0	4.0		3.6	4.5	5.0	5.3	4.9	4.1		4.6	4.4	
SPD	6.7	6.9	6.1	7.1	7.1	7.1	7.9		7.6	5.9	5.6	5.6	6.4	5.7		6.1	6.5	6.7	7.4	6.3	5.9		6.6	6.0	
Readmit % 30 Day	12.2%	12.6%	13.7%	13.0%	12.6%	11.9%	8.6%		10.2%	10.9%	11.0%	10.4%	10.5%	10.7%		13.2%	12.5%	13.1%	11.1%	10.7%	10.5%		12.5%	9.8%	
Expansion	12.0%	12.3%	14.0%	13.6%	13.8%	14.5%	10.5%		12.1%	14.2%	12.4%	10.7%	8.8%	10.8%		13.2%	12.1%	13.3%	13.1%	12.8%	10.1%		12.9%	10.6%	
Family/Adult/Other	7.7%	7.6%	8.9%	8.4%	7.1%	6.8%	3.8%		5.1%	4.7%	5.3%	4.3%	4.5%	5.4%		7.6%	7.8%	8.3%	5.9%	5.1%	4.7%		7.4%	4.6%	
SPD	22.2%	24.0%	24.3%	23.1%	23.3%	19.8%	16.9%		20.3%	19.1%	20.3%	22.2%	24.0%	20.4%		24.3%	24.2%	23.8%	20.0%	19.9%	22.2%		23.1%	19.3%	
**ER Visits - PTMPY	348.4	394.2	360.0	336.4	344.1	326.8	303.8		289.2	284.8	335.0	359.0	377.1	230.0		549.8	302.0	363.4	324.8	303.0	322.0		383.7	312.6	
Expansion	466.0	521.1	481.4	440.1	443.8	411.8	402.2		369.4	353.9	388.0	407.0	393.8	241.7		538.0	407.6	480.4	419.1	370.4	347.7		460.2	359.1	
Family/Adult/Other	291.0	323.3	299.4	280.4	290.8	279.0	253.4		244.7	244.3	289.1	316.7	346.3	213.0		540.6	245.8	300.9	274.3	259.1	292.1		339.1	275.4	
SPD	457.7	487.0	479.1	458.8	463.2	435.9	404.9		393.2	375.8	460.4	453.8	464.1	244.2		637.7	437.4	475.0	434.7	409.5	387.7		496.1	398.7	
Services	TAT Compliance Goal: 100%								TAT Compliance Goal: 100%							TAT Compliance Goal: 100%							TAT Compliance Goal: 100%		
Preservice Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	98.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	99.3%	100.0%				
Preservice Urgent	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%		96.0%	100.0%	98.0%	98.0%	100.0%	100.0%		98.7%	99.3%	100.0%	99.3%	98.0%	99.3%				
Postservice	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		98.0%	100.0%	98.0%	100.0%	100.0%	100.0%		100.0%	98.7%	100.0%	100.0%	98.7%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	95.4%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.5%	100.0%				
Deferrals - Urgent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	Null	100.0%	null	50.0%	100.0%		100.0%	99.0%	100.0%	100.0%	100.0%	83.3%				
Deferrals - Post Service	NA	NA	NA	NA	NA	NA	NA		null	null	null	null	null	null		null	null	null	null	null	null				
	CCS ID RATE								CCS ID RATE							CCS ID RATE							CCS ID RATE		
CCS %	8.30%	8.18%	8.16%	8.31%	8.29%	8.27%	8.25%		8.17%	8.29%	8.25%	8.21%	8.17%	8.33%		8.34%	8.23%	8.22%	8.27%	8.24%	8.24%		8.27%	8.22%	
	Perinatal Case Management								Perinatal Case Management							Perinatal Case Management							Perinatal Case Management		
Total Number Of Referrals	178	232	166	161	164	127	113		136	154	265	173	130	96		783	561	559	404	555	399		2,307	955	
Pending	0	0	0	0	1	2	2		0	1	9	0	2	7		1	0	0	5	10	9		6	10	
Ineligible	15	8	12	11	2	4	2		7	8	22	23	6	5		26	30	31	8	37	34		95	70	
Total Outreached	163	224	154	150	161	121	109		129	145	234	150	122	84		756	531	528	391	508	356		2,206	875	
Engaged	70	73	42	42	45	41	26		32	40	47	36	34	29		222	202	157	112	119	99		693	220	
Engagement Rate	43%	33%	27%	28%	28%	34%	24%		25%	28%	20%	24%	28%	35%		29%	38%	30%	29%	23%	28%		31%	25%	
New Cases Opened	70	73	42	42	45	41	26		32	40	47	36	34	29		222	202	157	112	119	99		693	220	
Total Cases Managed	406	416	391	390	365	299	271		257	251	281	286	274	267		465	472	485	413	344	354		943	449	
Total Cases Closed	61	74	57	62	84	54	51		46	17	32	46	36	31		151	169	193	189	95	113		702	213	
Cases Remained Open	319	267	311	267	205	205	205		212	215	225	217	158	115		291	319	267	205	225	115		205	115	

Key Indicator Report
Auth Based PPG Utilization Metrics for CALVIVA California SHP
Report from 6/01/2021 to 6/30/2021
Report created 7/27/2021

ER utilization based on Claims data	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2020-Trend	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-Trend	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Qtr Trend	CY- 2020	YTD-2021	YTD-Trend
	Integrated Case Management								Integrated Case Management							Integrated Case Management							Integrated Case Management		
Total Number Of Referrals	144	214	188	159	178	160	150		123	119	118	92	82	134		373	439	561	488	360	308		1,861	669	
Pending	1	0	0	0	4	2	14		0	2	9	1	2	8		1	1	0	20	11	11		22	11	
Ineligible	12	12	26	13	32	33	32		19	10	9	7	6	4		23	28	51	97	38	17		199	60	
Total Outreached	131	202	162	146	142	125	104		104	107	100	84	74	122		349	410	510	371	311	280		1,640	598	
Engaged	70	108	94	88	78	77	69		74	76	72	55	51	83		172	193	290	224	222	189		879	412	
Engagement Rate	53%	53%	58%	60%	55%	62%	66%		71%	71%	72%	65%	69%	68%		49%	47%	57%	60%	71%	68%		54%	69%	
Total Screened and Refused/Decline	21	34	22	16	23	16	10		8	9	10	8	9	17		55	65	72	49	27	34		241	62	
Unable to Reach	40	60	46	42	41	32	25		22	22	18	21	14	22		122	152	148	98	62	57		520	124	
New Cases Opened	70	108	94	88	78	77	69		74	76	72	55	51	83		172	193	290	224	222	189		879	412	
Total Cases Closed	50	51	65	80	92	85	63		60	60	52	48	51	85		105	142	196	240	172	184		683	356	
Cases Remained Open	289	359	397	314	292	292	292		310	322	330	327	253	166		184	289	314	292	330	166		292	166	
Total Cases Managed	276	339	381	417	407	373	357		378	394	406	408	409	441		279	367	533	541	526	537		990	712	
Critical-Complex Acuity	55	59	64	64	57	55	55		60	58	60	58	50	55		42	65	77	73	74	64		130	87	
High/Moderate/Low Acuity	221	280	317	353	350	318	302		318	336	346	350	359	386		237	302	456	468	452	473		860	625	
	Transitional Case Management								Transitional Case Management							Transitional Case Management							Transitional Case Management		
Total Number Of Referrals	179	268	227	245	251	233	204		143	201	238	252	214	205		421	479	740	688	582	671		2,328	1,253	
Pending	0	0	0	0	0	0	25		0	0	22	0	0	9		0	0	0	25	22	9		25	9	
Ineligible	14	20	27	27	22	25	22		23	21	25	42	24	21		27	33	74	69	69	87		203	160	
Total Outreached	165	248	200	218	229	208	157		120	180	191	210	190	175		394	446	666	594	491	575		2,100	1,084	
Engaged	77	122	105	116	125	99	79		57	102	116	128	133	150		214	218	343	303	275	411		1,078	689	
Engagement Rate	47%	49%	53%	53%	55%	48%	50%		48%	57%	61%	61%	70%	86%		54%	49%	52%	51%	56%	71%		51%	64%	
Total Screened and Refused/Decline	27	38	32	25	26	28	19		13	24	13	10	10	6		65	75	95	73	50	26		308	79	
Unable to Reach	61	88	63	77	78	81	59		50	54	62	72	47	19		115	153	228	218	166	138		714	316	
New Cases Opened	77	122	105	116	125	99	79		57	102	116	128	133	150		214	218	343	303	275	411		1,078	689	
Total Cases Closed	65	82	103	118	105	124	113		89	49	110	120	122	147		199	226	303	342	248	389		1,070	637	
Cases Remained Open	56	81	93	106	42	42	42		76	61	92	103	92	60		63	56	106	42	92	60		42	60	
Total Cases Managed	135	193	217	228	236	230	185		148	161	228	251	263	299		280	296	398	394	366	487		1136	796	
High/Moderate/Low Acuity	135	193	217	228	236	230	185		146	159	226	251	263	299		280	296	398	394	364	487		1136	796	
	Palliative Care								Palliative Care							Palliative Care							Palliative Care		
Total Number Of Referrals	35	15	10	8	10	20	10		15	12	18	16	11	17		69	81	33	40	45	44		223	86	
Pending	0	0	0	0	2	5	0		2	0	6	0	1	4		0	1	0	7	8	5		4	5	
Ineligible	14	4	4	3	3	5	6		6	4	4	7	4	4		24	34	11	14	14	15		83	26	
Total Outreached	21	11	6	5	5	10	4		7	8	8	9	6	9		45	46	22	19	23	24		132	55	
Engaged	17	6	5	5	3	8	3		5	8	6	4	5	8		34	35	16	14	19	17		99	39	
Engagement Rate	81%	55%	83%	100%	60%	80%	75%		71%	100%	75%	44%	83%	89%		76%	76%	73%	74%	83%	71%		75%	71%	
Total Screened and Refused/Decline	4	3	1	0	2	2	0		2	0	2	2	1	1		8	9	4	4	4	4		25	11	
Unable to Reach	0	2	0	0	0	0	1		0	0	0	3	0	0		3	2	2	1	0	3		8	5	
New Cases Opened	16	6	5	5	3	8	3		5	8	6	4	5	8		36	33	16	14	19	17		99	39	
Total Cases Closed	3	5	7	10	5	12	11		5	2	8	2	8	8		23	25	22	28	15	18		98	34	
Cases Remained Open	96	97	101	91	90	92	87		92	91	91	94	68	46		88	96	91	87	91	46		87	46	
Total Cases Managed	103	108	109	106	101	109	105		102	103	107	104	108	107		107	122	126	122	114	116		262	133	
	Behavioral Health Case Management								Behavioral Health Case Management							Behavioral Health Case Management							Behavioral Health Case Management		
Total Number Of Referrals	122	112	132	120	111	84	96		74	94	86	89	95	83		120	325	364	291	254	266		1,100	521	
Pending	0	0	0	0	0	0	6		0	0	2	1	0	4		0	0	0	6	2	5		6	5	
Ineligible	6	2	7	7	5	6	5		7	4	3	2	3	3		4	15	16	16	14	8		51	23	
Total Outreached	116	110	125	113	106	78	85		67	90	81	85	92	76		116	310	348	269	238	253		1,043	493	
Engaged	45	45	57	54	47	33	34		29	48	39	40	43	41		51	119	156	114	116	124		440	239	
Engagement Rate	39%	41%	46%	48%	44%	42%	40%		43.0%	53.0%	48.0%	46.0%	47.0%	54%		44%	38%	45%	42%	49%	49%		42%	48%	
Total Screened and Refused/Decline	3	3	2	11	1	4	3		0	2	2	0	1	0		0	6	16	8	4	1		30	6	
Unable to Reach	68	62	66	48	58	41	48		38	40	40	46	48	35		65	184	176	147	118	129		572	248	
New Cases Opened	45	45	57	54	47	33	34		29	48	39	40	43	41		51	119	156	114	116	124		440	239	
Total Cases Closed	24	25	42	58	53	36	51		52	28	25	33	34	40		52	65	125	140	105	107		382	212	
Cases Remained Open	73	81	66	94	78	78	78		75	92	101	104	80	60		28	73	94	78	101	60		78	60	
Total Cases Managed	119	141	177	203	192	151	149		133	129	140	154	161	168		81	164	295	279	220	236		496	340	
Critical-Complex Acuity	14	16	15	15	7	8	7		7	6	6	9	9	10		9	17	22	13	11	15		26	17	
High/Moderate/Low Acuity	105	125	162	188	185	143	142		126	123	134	145	152	158		72	147	273	266	209	221		470	323	
	Record Processing								Record Processing							Record Processing							Record Processing		
Total Records	7,558	7,566	7,570	6,699	6,785	4,586	4,594		1,972	1,769	2,110	1,981	1,998	2,024		23,580	20,523	21,835	22,827	5,851	6,003		81,903	11,854	
Total Admissions	2,069	2,066	2,060	2,001	2,055	1,617	1,610		1,821	1,650	1,975	1,854	1,851	1,872		6,537	5,736	6,127	6,342	5,446	5,577		23,682	11,023	

Item #7

Attachment 7.F

Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: September 16th, 2021

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 3 2021

Purpose of Activity:

This report is to provide the QI/UM Committee and RHA Commission with a summary of the 3rd Quarter 2021 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on July 15th, 2021. At the July 15th meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the first quarter for 2021 were reviewed for delegated entities and the second quarter 2021 for Health Net. A summary of the first quarter data is included in the table below.

III. Table 1. First Quarter 2021 Credentialing/Recredentialing

	Sante	ChildNet	MHN	Health Net	La Salle	ASH	Envolve Vision	IMG	CVMP	Adventist	**Totals**
Initial credentialing	38	4	29	16	107	0	1	8	49	32	**284**
Recredentialing	82	30	24	22	192	1	0	18	38	0	**407**
Suspensions	0	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	**0**
Totals	**120**	**34**	**53**	**38**	**299**	**1**	**1**	**26**	**87**	**32**	**691**

IV. The Credentialing/Recredentialing Oversight Audit of HN was in progress during Quarter 3 and is expected to close by the end of September. Generally good compliance is noted and any issues of non-compliance will be addressed with a corrective action plan.

V. There was no case activity to report for the Quarter 2 2021 Credentialing Report from Health Net.

Item #7

Attachment 7.G

Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	September 16th, 2021
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 3 2021

Purpose of Activity:

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

I. The Peer Review Sub-Committee met on July 15th, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 2 2021 were reviewed for approval. There were no significant cases to report.

II. The Quarter 2 2021 Peer Count Report was presented at the meeting with a total of 3 cases reviewed. The outcomes for these cases are as follows:
   - All three (3) cases were closed and cleared. There were no (0) cases pending closure for Corrective Action Plan compliance. There were no cases (0) with outstanding CAPs. There were no (0) cases pended for further information.

III. Follow up will be completed to close out cases and ongoing monitoring and reporting will continue.

Item #7

Attachment 7.H

Executive Dashboard

	2020	2020	2020	2020	2020	2020	2021	2021	2021	2021	2021	2021	2021
Month	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**
CVH Members													
Fresno	291,870	294,617	298,003	300,085	302,118	303,493	304,759	305,990	307,463	308,852	310,191	311,420	312,453
Kings	30,624	30,827	31,085	31,230	31,450	31,570	31,802	31,984	32,109	32,332	32,512	32,645	32,699
Madera	38,713	39,035	39,329	39,530	39,733	39,919	40,209	40,381	40,607	40,868	41,173	41,402	41,662
Total	361,207	364,479	368,417	370,845	373,301	374,982	376,770	378,355	380,179	382,052	383,876	385,467	386,814
SPD	33,456	33,556	33,578	33,704	33,785	33,844	33,854	33,850	33,872	33,913	33,987	33,964	33,946
CVH Mrkt Share	70.68%	70.52%	70.40%	70.32%	70.21%	70.10%	70.02%	69.92%	69.84%	69.74%	69.64%	69.56%	69.51%
ABC Members													
Fresno	109,576	111,590	113,570	114,867	116,308	117,408	118,389	119,495	120,612	121,802	123,048	123,939	124,688
Kings	19,591	19,758	20,020	20,139	20,380	20,546	20,697	20,865	20,994	21,100	21,271	21,446	21,498
Madera	20,673	21,036	21,340	21,494	21,735	21,992	22,253	22,415	22,609	22,831	23,055	23,316	23,490
Total	149,840	152,384	154,930	156,500	158,423	159,946	161,339	162,775	164,215	165,733	167,374	168,701	169,676
Default													
Fresno	1,052	1,067	655	747	824	518	616	597	534	583	734	530	501
Kings	178	153	123	143	164	105	150	145	93	115	122	105	95
Madera	123	126	79	89	117	173	97	83	69	96	97	93	93
County Share of Choice as %													
Fresno	61.80%	58.70%	61.60%	60.20%	59.40%	57.80%	59.10%	56.10%	59.20%	56.20%	56.80%	60.50%	58.90%
Kings	48.80%	53.40%	42.90%	47.20%	51.10%	45.40%	48.40%	53.10%	54.40%	54.30%	50.90%	49.10%	53.10%
Madera	55.70%	57.90%	58.90%	61.60%	60.40%	52.70%	57.90%	58.00%	61.00%	62.70%	64.20%	54.90%	58.90%
Voluntary Disenrollment's													
Fresno	352	370	388	359	342	363	421	334	387	444	479	446	643
Kings	31	63	39	42	31	27	36	29	37	51	42	42	46
Madera	54	57	77	70	51	54	59	51	61	75	85	82	56

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 CEO	At present time, there are no significant issues, concerns, or items to note as it pertains to the Plan's IT Communications and Systems.		

Member Call Center CalViva Health Website		**Year**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**
		Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	(Main) Member Call Center	**# of Calls Received**	**29,707**	**20,544**	**23,684**	**23,685**	**26,346**	**26,971**
		# of Calls Answered	**29,564**	**20,407**	**23,488**	**23,520**	**26,119**	**26,664**
		Abandonment Level (Goal < 5%)	**0.50%**	**0.70%**	**0.80%**	**0.70%**	**0.90%**	**1.10%**
		Service Level (Goal 80%)	**96%**	**98%**	**93%**	**95%**	**93%**	**85%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,228**	**1,028**	**1,798**	**936**	**1,196**	**1,232**
		# of Calls Answered	**1,218**	**1,022**	**1,752**	**927**	**1,189**	**1,220**
		Abandonment Level (Goal < 5%)	**0.80%**	**0.60%**	**2.60%**	**1.00%**	**0.60%**	**1.00%**
		Service Level (Goal 80%)	**93%**	**94%**	**78%**	**89%**	**94%**	**89%**
	Transportation Call Center	**# of Calls Received**	**17,872**	**11,717**	**10,011**	**9,867**	**7,364**	**7,768**
		# of Calls Answered	**17,765**	**11,506**	**9,801**	**9,808**	**7,209**	**7,628**
		Abandonment Level (Goal < 5%)	**0.60%**	**1.80%**	**2.10%**	**0.60%**	**1.60%**	**1.30%**
		Service Level (Goal 80%)	**83%**	**76%**	**44%**	**76%**	**61%**	**61%**
	CalViva Health Website	**# of Users**	**21,000**	**16,000**	**22,000**	**25,000**	**33,000**	**26,000**
		Top Page	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (60%)**	**Mobile (56%)**	**Mobile (63%)**	**Mobile (61%)**	**Mobile (57%)**	**Mobile (62%)**
		Session Duration	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 2 minutes**	**~ 1 minutes**	**~ 1 minutes**
Message from the CEO	Q2 2021 numbers are available. Management continues to monitor an improvement plan to improve the Transportation Call Center Service Level Goal.							

Provider Network Activities & Provider Relations	**Year**	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**
	Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**144**	**142**	**143**	**144**	**143**	**144**	**144**
	PCP	**389**	**390**	**388**	**385**	**372**	**371**	**360**
	PCP Extender	**229**	**234**	**235**	**241**	**253**	**258**	**256**
	Specialist	**1455**	**1453**	**1445**	**1441**	**1436**	**1431**	**1422**
	Ancillary	**196**	**201**	**210**	**210**	**210**	**210**	**211**
	Year	**2019**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Pharmacy	**152**	**151**	**153**	**152**	**154**	**155**	**156**
	Behavioral Health	**368**	**356**	**357**	**354**	**359**	**376**	**412**
	Vision	**41**	**42**	**45**	**47**	**46**	**47**	**44**
	Urgent Care	**12**	**12**	**11**	**12**	**11**	**12**	**12**
	Acupuncture	**5**	**4**	**5**	**7**	**7**	**7**	**8**
	Year	**2019**	**2019**	**2020**	**2020**	**2020**	**2020**	**2021**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	% of PCPs Accepting New Patients - Goal (85%)	**90%**	**93%**	**93%**	**93%**	**94%**	**94%**	**95%**
	% Of Specialists Accepting New Patients - Goal (85%)	**95%**	**95%**	**94%**	**97%**	**96%**	**96%**	**96%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**72%**	**78%**	**82%**	**95%**	**96%**	**98%**	**97%**
	Year	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**	**2021**
	Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**
	Providers Touched by Provider Relations	**75**	**271**	**216**	**273**	**181**	**180**	**125**
	Provider Trainings by Provider Relations	**54**	**79**	**228**	**37**	**53**	**477**	**241**
	Year	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
	Total Providers Touched	**2,003**	**2,604**	**2,786**	**2,552**	**1,932**	**3,354**	**1,321**
	Total Trainings Conducted	**550**	**530**	**762**	**808**	**1,353**	**257**	**1,169**
Message From the CEO	On August 2, 2021, DHCS provided approval of the Plan's network stating the network is in compliance with State and federal network adequacy standards. There have been no updates received to date from DMHC on the Plan's network adequacy filing.							

Claims Processing	**Year**	**2019**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	97% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A
	Pharmacy Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	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	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	95% / 97% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	95% / 99% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	93% / 100% NO	96% / 100% NO	85% / 100% NO	95% / 100% NO	95% / 100% NO	91% / 98% NO	91% / 100% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	100% / 100% NO	93% / 100% NO	92% / 100% NO	98% / 99% NO	89% / 99% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	88% / 98% YES	96% / 99% NO	82%/100% YES	100% / 100% YES	99% / 100% YES	99% / 100% YES	98% / 100% YES
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% YES	100% / 100% NO	87% / 100% YES	98% / 98% YES	99% / 100% YES	93% / 98% NO	100% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 98% YES	98% / 100% NO	73% / 100% YES	99% / 100% YES	90% / 92% YES	100% / 100% NO	100% / 100% YES
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	99% / 100% NO	92% / 100% NO	100% / 100% NO	99% / 100% NO	100% / 100% NO	99% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	98% / 100% NO	96% / 100% NO	93% / 100% NO
Message from the CEO	Quarter 2 numbers are available. PPG 3 did not meet the 30-day Claims Timeliness Goal. All other areas met goal as it relates to claims timeliness. Management is monitoring a improvement plan submitted by PPG 4 and PPG 6 as it pertains to their Deficiency Disclosures and their timeline to achieve compliance.							

Provider Disputes	**Year**	**2019**	**2020**	**2020**	**2020**	**2020**	**2021**	**2021**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	95%	97%	99%	99%	99%	99%	99%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	90%	99%	100%	100%	100%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	100%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	64%	92%	100%	91%	88%	95%	99%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	97%	100%	100%	100%	100%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	87%	91%	97%	66%	35%	66%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	99%	100%	100%	100%	100%	100%	100%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	97%	99%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	98%	99%	99%	98%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	100%	100%	100%	100%
Message from the CEO	Quarter 2 numbers are available. PPG 3 did not meet the 45-day Timeliness Goal. All other areas met goal as it relates to provider dispute timeliness. Management is monitoring a corrective action plan submitted by PPG 3 and their timeline to achieve compliance.							