FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

***Fresno County***

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

***Kings County***

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

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

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

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

DATE: March 11, 2022

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

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

**Thursday, March 17, 2022**
**1:30 pm to 3:30 pm**

**Where to attend:**

**1)** CalViva Health
7625 N. Palm Ave., #109
Fresno, CA 93727Fresno, CA 93711

**2)** Family HealthCare Network
305 E. Center Ave.
Visalia, CA 93291

Meeting materials have been emailed to you.

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

Thank you

# AGENDA

**Fresno-Kings-Madera Regional Health Authority**
**Commission Meeting**
March 17, 2022
1:30pm - 3:30pm

**Meeting Locations:**

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

Family HealthCare Network
305 E. Center Ave.
Visalia, CA 93291

| Item | Attachment # | Topic of Discussion | Presenter |
|---|---|---|---|
| **1** | | **Call to Order** | D. Hodge, MD, Chair |
| **2** | | **Roll Call** | C. Hurley, Clerk |
| **3 Action** | | **Consent Agenda:** | D. Hodge, MD, Chair |
| | Attachment 3.A | • Commission Minutes dated 2/17/2022 | |
| | Attachment 3.B | • Finance Committee Minutes dated 10/21/2021 | |
| | Attachment 3.C | • QI/UM Committee Minutes dated 11/18/2021 | |
| | Attachment 3.D | • Public Policy Committee Minutes dated 12/1/2021 | |
| | | *Action: Approve Consent Agenda* | |
| | *Handouts will be available at meeting* | *PowerPoint Presentations will be used for items 4 & 5* ***One vote will be taken for combined items 4 & 5*** | |
| **4 Action** | | **2022 Quality Improvement** | P. Marabella, MD, CMO |
| | Attachment 4.A | • 2022 Program Description | |
| | Attachment 4.B | • 2022 Work Plan | |
| **5 Action** | | **2022 Utilization Management & Case Management** | P. Marabella, MD, CMO |
| | Attachment 5.A | • 2022 Case Management Program Description | |
| | Attachment 5.B | • 2022 UMCM Work Plan | |
| | | *Action: Approve 2022 Quality Improvement Program Description, 2022 Quality Improvement Work Plan, 2022 Case Management Program Description, and the 2021 Utilization Management Case Management Work Plan.* | |
| **6. Action** | | **Standing Reports** | |
| | | **Finance Report** | |
| | Attachment 6.A | • Financials as of January 31, 2022 | D. Maychen, CFO |
| | | **Compliance** | |
| | Attachment 6.B | • Compliance Report | M.L. Leone, CCO |

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|---|---|---|
| | **Medical Management** | |
| Attachment 6.C<br>Attachment 6.D<br>Attachment 6.E<br>Attachment 6.F | • Appeals and Grievances Report<br>• Key Indicator Report<br>• Credentialing Sub-Committee Quarterly Report<br>• Peer Review Sub-Committee Quarterly | P. Marabella, MD, CMO |
| | **Executive Report** | |
| Attachment 6.G | • Executive Dashboard | J. Nkansah, CEO |
| | *Action: Accept Standing Reports* | |
| **7.** | **Final Comments from Commission Members and Staff** | |
| **8.** | **Announcements** | |
| **9.** | **Public Comment**<br>*Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.* | |
| **10.** | **Adjourn** | D. Hodge, MD, Chair |

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

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

Next Meeting scheduled for May 19, 2022 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 2/17/2022

Fresno-Kings-Madera
Regional Health Authority

# CalViva Health
# Commission
## Meeting Minutes
February 17, 2022

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

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|---|---|---|---|
| | **Commission Members** | | |
| | **Sara Bosse**, Director, Madera Co. Dept. of Public Health | ✓ | **David Luchini**, 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 | ✓ | **Rose Mary Rahn**, Director, Kings County Dept. of Public Health |
| ✓ | **David Hodge**, M.D., Chair, Fresno County At-large Appointee | | **David Rogers**, Madera County Board of Supervisors |
| | **Kerry Hydash**, Commission At-large Appointee, Kings County | ✓ | **Brian Smullin**, Valley Children's Hospital Appointee |
| | | ✓ | **Paulo Soares**, Commission At-large Appointee, Madera County |
| | **Commission Staff** | | |
| ✓ | **Jeff Nkansah**, Chief Executive Officer (CEO) | ✓ | **Mary Lourdes Leone**, Chief Compliance Officer |
| ✓ | **Daniel Maychen**, Chief Financial Officer (CFO) | ✓ | **Amy Schneider**, R.N., Director of Medical Management |
| ✓ | **Patrick Marabella, M.D.,** Chief Medical Officer (CMO) | ✓ | **Cheryl Hurley**, Commission Clerk |
| | **General Counsel and Consultants** | | |
| ✓ | **Jason Epperson**, General Counsel | | |
| ✓= Commissioners, Staff, General Counsel Present | | | |
| * = Commissioners arrived late/or left early | | | |
| ● = Attended via Teleconference | | | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **#1 Call to Order** | The meeting was called to order at 1:30 pm. A quorum was present | |
| **#2 Roll Call**<br>Cheryl Hurley, Clerk to the Commission | A roll call was taken for the current Commission Members. | *A roll call was taken* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| **#3 Introduction of Director, Kings County Public Health Department**<br><br>Information<br>D. Hodge, MD, Chair | Rose Mary Rahn was introduced as the Director for the Kings County Department of Public Health and Commissioner on the FKM RHA Commission. | |
| **#4 Reappointed Board of Supervisors Commissioners**<br><br>Action<br>D. Hodge, MD, Chair | Fresno County has re-appointed Supervisor Sal Quintero as Commissioner, and Supervisor Brian Pacheco as alternate. Kings County has re-appointed Supervisor Joe Neves as Commissioner and Supervisor Doug Verboon as alternate. Madera County has re-appointed Supervisor David Rogers as Commissioner and Supervisor Brett Frazier as alternate. | ***See item #6 for motion*** |
| **#5 Valley Children's Hospital Reappointment**<br><br>Action<br>D. Hodge, MD, Chair | Brian Smullin was reappointed as Commission representative for Valley Children's Hospital for an additional three-year term, ending in January 2025. | ***See item #6 for motion*** |
| **#6 Fresno County At-Large Seat Nomination**<br><br>Action<br>D. Hodge, MD, Chair | John Frye was reappointed as the Fresno County At-Large representative for a three-year term, ending in January 2025. | ***Motion**: Ratify reappointment of County BOS Commissioners; Ratify reappointment of VCH representative; and Approve Fresno County At-Large Reappointment*<br><br>*12 – 0 – 0 – 5* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | | *( Neves / Naz )*<br><br>*A roll call was taken* |
| **#7 Closed Session**<br>**1) Government Code section 54956.9(a) – Conference with Legal Counsel-Existing Litigation**<br>Name of case: Case # 21CV381776<br><br>**2) Government Code section 54954.5 – Conference Report Involving Trade Secret – Discussion of service, program, or facility**<br>Estimated Date of Public Disclosure: May 2022 | Jason Epperson, General Counsel, reported out of Closed Session. The Commission went into closed session to discuss item agendized for closed session specifically conference with legal counsel; existing litigation, case #21CV381776 pursuant to Government Code section 54956.9(a); and conference report involving trade secrets pursuant to Government Code section 54954.5.<br><br>Closed Session concluded at 1:50 pm. | ***No reportable action taken*** |
| **#8 Consent Agenda**<br>a) Commission Minutes dated 10/21/2021<br>b) Finance Committee Minutes dated 9/16/2021<br>c) QI/UM Committee Minutes dated 9/16/2021 | All consent items were presented and accepted as read. | ***Motion****: Approve Consent Agenda*<br>*12 – 0 – 0 – 5*<br><br>*( Soares / Neves )*<br><br>*A roll call was taken* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| *d)* QI/UM Committee Minutes dated 10/21/2021<br>*e)* Public Policy Committee Minutes dated 9/1/2021<br>f) Compliance Report<br><br>Action<br>D. Hodge, MD, Chair | | |
| **#9 Annual Administration**<br><br>Information<br>D. Hodge, MD, Chair | Dr. Hodge reminded the Commission the Form 700 is due on an annual basis, due this year on 4/1/22. Commissioners will receive notification from the Commission Clerk via email. Anyone due for an updated Ethics Certification will be notified. | ***No Motion*** |
| **#10 Community Support Program Ad-Hoc Committee Selection**<br><br>Action<br>D. Hodge, MD, Chair | A new ad-hoc committee is needed for the Community Support Program. Dr. Hodge polled Commissioners for volunteers to sit on the Committee. Members that volunteered are: Brian Smullin, Paulo Soares, Joyce Fields-Keene, and Dr. Hodge. | ***No Motion - Committee members selected*** |
| **#11 2021 Annual Quality Improvement Workplan Evaluation**<br>• Executive Summary | Dr. Marabella presented the 2021 Annual Quality Improvement Workplan Evaluation. | **See #12 for Motion** |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| • Year End Evaluation<br><br>Action<br>P. Marabella, MD, CMO | The planned activities and Quality Improvement focus for 2021 included the following:<br>• Access, Availability and Service:<br>o Improve Access to Care:<br>▪ Provider Appointment Availability Survey is the assessment tool. MY20 results reported.<br>▪ Urgent Care scores declined compared to MY19. Non-urgent Care scores improved slightly for PCPs and Specialist care improved in all three counties.<br>▪ Corrective Action Plan (CAP) process with targeted PPG approach.<br>▪ CAP required for non-compliance on one (1) or more metrics.<br>▪ Provider After-Hours Access Survey (PAHAS) is the assessment tool used. A new vendor used therefore will need to re-evaluate results later this year. CAPs were issued for non-compliant PPGs and Direct Network.<br>▪ Provider Office Wait Times continue to meet overall goal of 30 minutes or less with an average wait time of 11 minutes for all three counties combined in Q4 2021.<br><br>• Quality and Safety of Care: The five Default measures are:<br>o Childhood Immunization Combo 10 (Madera County exceeded DHCS MPL; Kings and Fresno counties fell below)<br>o Prenatal Care (all three counties exceeded DHCS MPL)<br>o HbA1c Poor Control <9% Testing (Kings County exceeded DHCS MPL; Fresno and Madera counties fell below)<br>o Controlling High Blood Pressure (Kings and Madera counties exceeded DHCS MPL; Fresno County fell below)<br>o Cervical Cancer Screening (Kings & Madera counties exceeded DHCS MPL; Fresno County fell below) | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | • Performance Improvement Projects (PIPs): The two PIPs were:<br>o Childhood Immunizations (CIS-10). Initiated Text Messaging Campaign in September 2021. The CIS-10 rate continues to decline at the targeted clinic and in Fresno County. Text messaging has limitations, considering a second intervention to boost scores.<br>o Breast Cancer Screening Disparity Project is focused on Hmong women 50-74 years. Hmong Sisters Event was the first intervention and was held on 09/24/21. Attempt to convince women to attend Imaging Center for mammogram. BCS rates continue to decline. Initiating a second intervention of mobile mammography with education at the targeted FQHC. Will continue with Events starting in April.<br>o Two PDSA Projects are also underway for Cervical Cancer Screening and Diabetes Care. | |
| **#12 2021 Annual Utilization Management Case Management Work Plan Evaluation**<br>• Executive Summary<br>• Year End Evaluation<br>**2022 Utilization Management Program Description**<br><br>Action<br>P. Marabella, MD, CMO | Dr. Marabella presented the Annual Utilization Management Case Management Work Plan Evaluation.<br><br>Utilization Management & Case Management focused on the following areas for 2021:<br><br>• Compliance with Regulatory & Accreditation Requirements:<br>o All Accreditation and Regulatory requirements met standard.<br>• Monitoring the UM Process:<br>o Monitoring of the utilization management process activities met objectives in 2021 with the exception of work plan element 2.2 Timeliness of processing the authorization requests.<br>o In the second half of 2021 the preservice TAT goal of 95% was not met in July and August. Improvement noted in quarter 4. | ***Motion**: Approve 2021 Annual Quality Improvement Workplan Evaluation Executive Summary and Year End Evaluation; 2021 Annual Utilization Management Case Management Workplan Evaluation Executive Summary and Year End Evaluation; and the 2022 Utilization Management Program Description.*<br><br>*12 – 0 – 0 – 5*<br>*(Naz / Nikoghosian)* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | ○ Appeal rates were consistent with prior years. Turn-around time at 99.8%.<br>• Monitoring Utilization Metrics:<br>○ Monitoring of the utilization metrics met objectives in 2021 with the exception of work plan element 3.1<br>○ 2021 goals included a 10% reduction in admissions and length of stay compared to 2019. COVID 19 continued to impact admission rates and length of stay. Unable to execute on-site strategy.<br>○ Care management initiatives for all members continued in 2021<br>• Monitoring Coordination with Other Programs and Vendor Oversight:<br>○ All metrics met goal.<br>• Monitoring Activities for Special Populations:<br>○ CCS, SPD, CBAS, and Mental Health tracking and monitoring is ongoing.<br>○ All monitoring activities met goals.<br>• Utilization Management Program Description Changes include:<br>○ Updated HN Mission.<br>○ Vision and Mission changed to Purpose.<br>○ Added "chronic condition management" to statements referencing disease management throughout the document.<br>○ Revised Pharmacy section to only apply to medical benefit medications due to Medi-Cal Rx<br>○ Re-wrote Evaluation of Medical Technologies<br>○ Updated Titles for certain positions<br>○ Updated Reporting review from bi-annual to quarterly | *A roll call was taken* |
| **#13-17**<br>• 13. 2021 Annual Compliance Evaluation<br>• **14**. 2022 Compliance Program Description | M.L. Leone reported on the Annual Compliance Evaluation, the Compliance Program Description, Code of Conduct, the Anti-Fraud Plan, and Privacy and Security Plan.<br><br>**<u>2021 Annual Compliance Evaluation</u>** | ***Motion**: Approve 2021 Annual Compliance Evaluation; 2022 compliance Program Description; 2022 Code of Conduct; 2022 Anti-* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| • **15**. 2022 Code of Conduct<br>• **16**. 2022 Anti-Fraud Plan<br>• **17**. 2022 Privacy and Security Plan<br><br>Action<br>M.L. Leone, CCO | In 2021, the Compliance Program was implemented by all Plan Departments: Compliance, Medical Management, Finance and Operations (as of 8/1/2021, the Operations department was consolidated into the Compliance department).<br><br>Administrative and Operational Regulatory Reporting:<br>• Over 250 regulatory filings were made to DMHC and DHCS<br><br>Summary of State Audits, Corrective Actions, and Medi-Cal Contract Amendments:<br>• Department of Health Care Services (DHCS):<br>○ 2020 DHCS Audit - On 8/27/2021, the Plan submitted its final CAP Update to DHCS indicating all corrective actions have been implemented. The Plan has not yet received DHCS' acceptance of the Plan's CAP response.<br>○ 2021 DHCS Annual Audit – In consideration of the impact of the COVID-19 PHE, this audit was deferred until 2022 at the request of the Plan.<br>○ DHCS -2019-2020 Performance Evaluation – The final report issued in July 2021 identified three external quality review (EQR) improvement recommendations: one related to the 2020 DHCS Medical Survey finding, one related to HEDIS® data validation, one related to quality performance improvement projects. The Plan successfully implemented interventions addressing these areas.<br>○ DHCS 2020 - 2021 Encounter Data Validation (EDV) Study –The annual EDV study was postponed in 2021 due to the COVID-19 PHE.<br>○ 2020 DHCS Annual Network Certification (ANC) – The Plan submitted the ANC in April of 2020. The DHCS issued a CAP on November 25, 2020. On March 11, 2021 DHCS informed the Plan that all ANC deficiencies were resolved and the CAP was closed.<br>○ 2021 DHCS Annual Network Certification (ANC) - The Plan submitted the ANC in April of 2021. On August 2, 2021, DHCS informed the Plan that it passed the 2021 ANC. | *Fraud Plan; and 2022 Privacy and Security Plan*<br><br>*11 – 0 – 0 – 6*<br>*( Naz / Smullin )*<br><br>*A roll call was taken* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | ○ DHCS MOT Corrective Action Plan (CAP) – On December 10, 2021, the Plan received written notice of deficiencies related to the failure to meet CalAIM's Major Organ Transplants (MOT) network certification requirements. DHCS issued CAPs to all Managed Care plans as the issue resulted from the DHCS' delay in establishing reimbursements rates for the COEs.<br>○ DHCS Contract Amendments - Several Medi-Cal contract amendments were executed between DHCS and CalViva Health in 2021.<br>○ Contract 10-8750 A15 – This amendment revises language for the Final Rule and Behavioral Health Treatment (BHT).<br>○ Contract 10-8750 A16 ("The Bridge Amendment") – This amendment incorporates new Bridge language.<br>○ Contract 10-8750 A22 – This amendment incorporates new Enhanced Care Management (ECM) risk mitigation language.<br>• Department of Managed Health Care (DMHC):<br>○ Measurement Year (MY) 2019 Timely Access Report (TAR): The Plan submitted its annual MY2019 TAR filing in May of 2020. The DMHC issued its findings on February 26, 2021 and the Plan submitted its response on May 27, 2021. An alternative access filing was subsequently filed. The filing remains open.<br>○ Measurement Year (MY) 2020 Timely Access Report (TAR): The Plan submitted its annual MY2020 TAR filing in March of 2021 and is awaiting DMHC's final report.<br>○ March 2021 DMHC 18-Month Follow-Up Audit – The DMHC issued its Final Report on November 2, 2021. The reported stated one of the two deficiencies had been corrected. The second deficiency remains uncorrected and under DMHC review and will be assessed at the next triennial DMHC Audit scheduled for September 2022. | |

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| | ○ March 2022 DMHC Routine Financial Exam – CalViva received written notice from DMHC of their intent to conduct the biennial financial audit on March 15, 2022.<br><br>DHCS Fraud, Waste and Abuse Required Reporting:<br>• 4 Suspected FWA cases total:<br>○ 1-Pharmacy provider<br>○ 1-Non-contracted DME provider.<br>○ 2-Other Contracted providers<br>• Privacy and Security Oversight:<br>• Regulatory and Contractual Obligations<br>• On-going breach assessments/notifications and staff training and internal monitoring<br>• Reports of Possible Privacy and Security Incidents/Breaches<br>• 32 privacy/security cases total:<br>○ High-risk -1<br>○ Moderate-risk – 3<br>○ Low-risk- 20<br>○ No-Risk - 8<br><br>DHCS New Benefits, Waivers and Other Programs:<br>• CalAim (Effective 1/1/2022):<br>○ Enhanced Care Management (ECM) and Community Supports (CS)<br>○ Major Organ Transplants (MOT)<br>○ CalAIM Incentive Program (CalAIM IP)<br>○ Medi-Cal RX – Effective 1/1/2022<br>○ COVID-19 Vaccine Response Plan and Incentive Program<br>○ Behavioral Health Integration (BHI) Incentive Program | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | **Compliance Program Activities**<br>• Oversight and Monitoring of Delegated Activities:<br>  ○ Delegation Audits and CAPS of Health Net in 2021: Access & Availability, Claims, FWA, Pharmacy, Provider Disputes, Emergency Services, Call Center, and Utilization Management.<br><br>**Periodic Monitoring of Health Net**<br>• Monthly Management Oversight (MOM) meetings<br>• Review monthly/quarterly performance metrics & key indicator data<br>• Joint Workgroups - Access & Availability, Encounter Data Integrity, Grievances & Appeals, QI/UM/Credentialing<br>• On-going oversight of PPGs, specialty plans and vendors<br><br>**2021 CalViva Internal Audit:**<br>• Internal audit of Employee, Commission and Committee Member files. All files were found compliant and no CAP was issued.<br>• **CalViva Health Staff Trainings:**<br>  ○ Four new employees successfully completed training<br>  ○ All staff members successfully competed annual training<br>• **Member Communications:**<br>  ○ 43 member communications were reviewed<br>• **Provider Communications:**<br>  ○ 229 Provider Updates<br>  ○ 27 Informational Letters<br>  ○ 9 Forms<br>• **Provider Relations:**<br>  ○ 1,952 “touches”<br>  ○ 3,376 trainings | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | **2022 Activities**<br>• Expect the California and Federal declarations of the COVID-19 PHE will continue to be renewed and have ongoing impacts on some Plan activities.<br>• CalAim initiatives:<br>  ○ Plan will continue its efforts to implement ECM/CS in Fresno and Madera counties by 7/1/2022;<br>  ○ Begin planning activities for the January 1, 2023 carve-in of Long-Term Care<br>• Non-CalAim Initiatives:<br>  ○ May 1, 2022, transition of full-scope Medi-Cal eligibility will be expanded to individuals 50 years of age and older, and who do not have satisfactory immigration status or are unable to establish immigration status.<br>• DHCS 2022 Audit scheduled for April 18, 2022, and DMHC 2022 Audit is scheduled for September 19, 2022.<br>• Increased regulatory oversight and monitoring of health plan activities, in the following areas:<br>  ○ Provider network adequacy and certification requirements for direct and delegated networks<br>  ○ Timely Access<br>  ○ Encounter data quality and timeliness<br>  ○ Clinical Quality Improvement (MCAS measures)<br>  ○ Member Grievances/Appeals<br><br>**Annual Review and Approval of Compliance Program Documents**<br>• **2022 Compliance Program Description**:<br>  ○ Updated CCO and CEO to Mary Lourdes Leone and Jeff Nkansah, respectively; added "Privacy Officer to the CCO's role; added FWA audit to Table 3.<br>• **2022 Code of Conduct:** | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | ○ Updated CCO and CEO to Mary Lourdes Leone and Jeff Nkansah, respectively.<br>• **2022 Anti-Fraud Plan:**<br>○ Updated CCO and CEO to Mary Lourdes Leone and Jeff Nkansah, respectively; updated the Reference section to specify "CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation"<br>• **2022 Privacy & Security Plan:**<br>○ Updated CCO and CEO to Mary Lourdes Leone and Jeff Nkansah, respectively. | |
| **#18 Standing Reports**<br><br>• **Finance Reports**<br>Daniel Maychen, CFO | **Finance**<br><br>Financials as of December 31, 2021:<br><br>Total current assets recorded were approximately $372.3M; total current liabilities were approximately $259.8M. Current ratio is approximately 1.43. Total net equity as of the end of December 2021 was approximately $122.3M which is approximately 724% above the minimum DMHC required TNE amount.<br><br>Interest Income actual recorded was approximately $133K which is approximately $85K more than budgeted due to a new accounting standard called GASB 87 which relates to leases. From a lessor perspective, GASB 87 requires a portion of rental payments to be booked to Interest Income which is due to the foundational principal of GASB 87 which views leases as essentially financing arrangements which allow for the use of another entities' assets. The increase in Interest Income as a result of GASB 87 was not accounted for in the FY 2022 budget due to a timing difference, noting that when the FY 2022 budget was finalized, CalViva was still in the process of working through the GASB 87 implementation with Moss Adams. The increase in Interest Income will be accounted for in the FY 2023 budget. | ***Motion**: Standing Reports Approved*<br><br>*11 – 0 – 0 – 6*<br>*( Nikoghosian / Griffin )*<br><br>*A roll call was taken* |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| • **Medical Management**<br>P. Marabella, MD, CMO | Premium capitation income actual recorded was approximately $694.6M which is approximately $11.9M more than budgeted primarily due to enrollment and rates being higher than projected. In addition, in the FY 2022 budget, the Plan projected an MCO tax loss of approximately $2.2M; however, due to higher-than-expected enrollment the MCO tax loss only amounted to approximately $384K.<br><br>Total Cost of Medical Care Expense actual recorded is approximately $577M which is approximately $9.6M more than budgeted due to the same reasons as stated above. Admin Service Agreement Fees Expense actual recorded was approximately $25.7M, which is approximately $565k more than projected due to higher-than-expected enrollment. Other Income actual recorded was approximately $163K which is approximately $96.6K less than budgeted due to the GASB 87 implementation.<br><br>Net income for the first six (6) months of FY 2022 recorded was approximately $3.2M which is approximately $2.3M more than budgeted primarily due to the MCO tax loss the Plan projected for FY 2022 being less than projected; and higher enrollment and rates than projected.<br><br>**Medical Management**<br><br>Appeals and Grievances Dashboard<br><br>Dr. Marabella presented the Appeals & Grievances Dashboard through December 2021.<br><br>• The total number of grievances for 2021 increased in comparison to calendar year 2020. The majority of grievances were Quality-of-Service related. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | • Quality of Care Grievances also increased in 2021 when compared to calendar year 2020.<br>• Exempt Grievances had a notable increase in 2021 compared to calendar year 2020.<br>• Appeals for calendar year 2021 decreased from 2020 with the majority of cases being related to Advanced Imaging, Durable Medical Equipment (DME), and Pharmacy.<br><br>Key Indicator Report<br><br>Dr. Marabella presented the Key Indicator Report (KIR) for 2021.<br><br>Acute Care Admission decreased slightly from Q3 to Q4 2021; with an increase in Average Length of Stay (ALOS).<br><br>Utilization for all risk types increased in 2021.<br><br>Turn Around Time was met in all areas for Q4 2021.<br><br>Case Management results remain strong and demonstrate positive results in all areas consistent with previous months.<br><br>QIUM Quarterly Report – Q4 2021<br><br>Dr. Marabella provided the QI/UM Qtr. 4, 2021 update. Two QI/UM meetings were held in Quarter 4; one in October and one in November.<br><br>The following program documents were approved at these meetings:<br>• 2021 Culture & Linguistics Work Plan Mid-Year Evaluation & Executive Summary | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | • 2021 Health Education Work Plan Mid-Year Evaluation & Executive Summary<br>• Culture & Linguistics Language Assistance Program Mid-Year Report<br>• Culture & Linguistics Geo Access Report<br>• Preventive Health Guidelines<br><br>In addition, the following general documents were approved:<br><br>• Pharmacy Formulary & Provider Updates<br>• Medical Policies Update Q3<br>• UMCM Policies & Procedures<br><br>The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard, Potential Quality Issues (PQI) Report, MHN Performance Indicator Report for Behavioral Health, Initial Health Assessment Quarterly Audit Report, and Access Related Reporting. Additional Quality Improvement Reports including SPD Health Risk Assessment and Provider Office Wait Time.<br><br>The Utilization Management & Case Management reports reviewed were the Key Indicator Report, and Utilization Management Concurrent Review Report. Additional UMCM Reports include UM PA Member Letter Monitoring Report, and the Case Management & CCM Report.<br><br>Pharmacy reports reviewed included Pharmacy Call Report, Operation Metrics, Top 30 Medication Prior Authorizations, and the Inter-rater Reliability Report.<br><br>HEDIS® Activity:<br><br>In Q4, HEDIS® related activities focused on analyzing the results for RY2021 under the Managed Care Accountability Set (MCAS) measures and the minimum | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | performance level (MPL) of 50th percentile and initiating activities to address opportunities for improvement.<br><br>Two new PDSA projects were initiated to include:<br>• Diabetes: A1c> 9% with Clinica Sierra Vista, Fresno County.<br>• Cervical Cancer Screening with Clinica Sierra Vista, Fresno County.<br><br>Continuing Performance Improvement Projects (PIP) include:<br>• Childhood Immunizations with Family HealthCare Network, Fresno County.<br>• Breast Cancer Screening with Greater Fresno Health Organization, Fresno County.<br><br>The continuing Quality Improvement Projects (QIP) relating to COVID-19 includes:<br>• Antidepressant Outreach<br>• HTN & Diabetes outreach<br>• Well-Child & Chlamydia screening<br><br>No significant compliance issues have been identified. Oversight and monitoring processes will continue.<br><br>**Credentialing Sub-Committee Quarterly Report**<br><br>The Credentialing Sub-Committee met on October 21, 2021. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q2 2021 were reviewed for delegated entities, and Q3 2021 for Health Net. There was no case activity to report for the Q3 2021 Credentialing Report from Health Net.<br><br>**Peer Review Sub-Committee Quarterly Report** | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| • **Executive Report**<br>J. Nkansah, CEO | The Peer Review Sub-Committee met on October 21, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Q3 2021 were reviewed for approval. There were no significant cases to report.<br><br>The Q3 2021 Peer Count Report was presented with a total of five (5) cases reviewed. All five (5) cases were closed and cleared. There were no cases pending closure for Corrective Action Plan compliance. There were no cases with outstanding CAPs. There were no cases pended for further information.<br><br>Ongoing monitoring and reporting will continue.<br><br>**Executive Report**<br><br>The enrollment through December 31, 2021 is approximately 393,125 members. The preliminary enrollment numbers for January 2022 have increased to approximately 398,000. The new membership is a result of transition activities by DHCS and the CalAIM initiative. Enrollment is likely to continue to increase through mid-2022 until the Public Health Emergency is ended.<br><br>There are no significant issues, concerns, or items to note as it pertains to the Plan's IT Communications and Systems.<br><br>There are no significant issues, concerns, or items to note as it pertains to the Member Call Center with the exception to note the Transportation Call Center reached the service level goal of 80% at the end of Q4 2021. | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | No new items to identify as it pertains to Provider Network Activities and Provider Relations. The Executive Dashboard will not include a count of Pharmacy Providers moving forward because Pharmacy transitioned to Medi-Cal RX effective 1/1/2022.<br><br>With reference to Claims Processing activities, PPG 3 did not meet the 30-day claims processing timeliness. Management continues to work with PPG 4, 5, and 6 with regard to their deficiency disclosures.<br><br>With regard to Provider Disputes, PPG 3 did not meet Provider Dispute Processing Timeliness goal; all other areas met goal.<br><br>A hard copy of the Plan's Annual Report was provided to all Commissioners. The Annual Report is also posted on the Plan's Website and Social Media forums.<br><br>J. Nkansah advised the Commission that the DHCS released the proposal for Medi-Cal procurement on February 9, 2022. The proposal is for commercial partners to bid for the Medi-Cal business. With the Plan being the local initiative, the Plan does not need to participate in the bidding process. However, the contract that is awarded will ultimately be applicable to the Plan as the local initiative effective January 1, 2024. As part of that proposal, the State has proposed entering into a statewide contractual agreement with Kaiser which would be effective January 1, 2024. Legislature and Federal approval is needed for the proposal to contract with Kaiser statewide.<br><br>Jason Epperson, General Counsel, provided insight on AB 361 and how the Bill affects public entities and the Brown Act. Given the structure of the Plan, AB 361 will not affect how the Plan's Commission meetings are run, and all of the Plan's public meetings have resumed to pre-COVID policy and must follow the Brown Act | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | with regard to remote participation. Any Commissioner requesting to participate remotely will be required to follow Policy CO-101 Telephonic Participation. | |
| **#19 Final Comments from Commission Members and Staff** | None. | |
| **#20 Announcements** | None. | |
| **#21 Public Comment** | None. | |
| **#22 Adjourn** | The meeting was adjourned at 3:13 pm.<br>The next Commission meeting is scheduled for March 17, 2022 in Fresno County. | |

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

# Item #3

## Attachment 3.B

Finance Committee Minutes
Dated 10/21/2021

# CalViva Health
# Finance
# Committee Meeting Minutes

October 21, 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 |
| ✓ | Jeff Nkansah, 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 |
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| #1 Call to Order<br>D. Maychen, Chair | The meeting was called to order at 11:30 am.<br>A quorum was present via conference call in lieu of gathering in public per executive order signed by the Governor of California on Monday, 3/16/2020, allowing Public Health Plans subject to the Brown Act to hold public meetings via teleconferencing due to COVID-19. A quorum remains a requirement to take actions, but can be achieved with any combination of Commissioners' physical attendance at the public location or by teleconferencing. | A roll call was taken. |
| #2 Finance Committee Minutes dated July 15, 2021 | The minutes from the September 16, 2021 Finance meeting were approved as read. | Motion: *Minutes were approved 6 – 0 – 0 – 1* |

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| Attachment 2.A<br>Action<br>D. Maychen, Chair | | *(Rogers / Nikoghosian)*<br><br>A roll call was taken. |
| #3 Presentation of Fiscal Year 2021 Audit Results<br><br>Action<br>D. Maychen, Chair | Rianne Suico and Eleanor Garibaldi, representatives with Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an unmodified opinion on the financial statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances were discussed.<br><br>The required communications and the organization's accounting policies are in compliance with GAAP. After completing the work, it was found that the financial statements do not need to be adjusted and no issues were encountered when completing the work. | Motion*: Approve Fiscal Year 2021 Audit Results*<br>*6 – 0 – 0 – 1*<br><br>*(Nikoghosian / Soares)*<br><br>A roll call was taken. |
| #4 Financial Statements as of August 31, 2021<br><br>Action<br>D. Maychen, Chair | Total current assets recorded were approximately $340.3M; total current liabilities were approximately $231M. Current ratio is approximately 1.47. Total net equity as of August 2021 was approximately $119.3M which is approximately 737% above the minimum DMHC required TNE amount.<br><br>Premium capitation income actual recorded was approximately $226.7M which is approximately $393K less than budgeted due to the retroactive rate adjustment that DHCS made in August 2021 which related to DHCS updating the pharmacy component of the rate for the entire 2021 calendar year which reduced the Plan's rates and revenues. Total cost of medical care expense actual recorded is approximately $187.8M which is approximately $896K less than budgeted due to the same reason as stated above. The revenue difference is smaller than the medical cost difference because the MCO tax loss was not as great as what was budgeted. Admin service agreement fees expense actual | Motion*: Financials as of August 31, 2021 were approved*<br><br>*5 – 0 – 0 – 2*<br><br>*(Neves / Soares)*<br><br>A roll call was taken. |

| | | |
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| | recorded was approximately $8.5M, which is approximately $154k more than budgeted due to higher than expected enrollment. All other line-item expense items are in line with what was budgeted. For the first two months of FY 2022 net income was approximately $206k primarily due to front loading grants made to various entities and CBOs which is approximately $542K more than budgeted primarily due to the MCO tax loss not being as high as projected due to enrollment being higher than anticipated.<br><br>*Harold Nikoghosian not present for roll call and not included in vote.* | |
| #5 Announcements | | |
| #6 Adjourn | Meeting was adjourned at 11:52 am | |

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

Dated: 2-17-2022

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 2/17/2022

# Item #3

## Attachment 3.C

QIUM Committee Minutes
dated 11/18/2021

Fresno-Kings-Madera
Regional Health Authority

# CalViva Health
# QI/UM Committee
# Meeting Minutes

November 18th, 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 | ✓ | **Amy Schneider, RN,** Director of Medical Management Services |
| ✓• | **Fenglaly Lee, M.D.,** Central California Faculty Medical Group | ✓ | **Ashelee Alvarado,** Medical Management Specialist |
| ✓• | **Brandon Foster, PhD.** Family Health Care Network | ✓ | **Iris Poveda**, Medical Management Administrative Coordinator |
| | **David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers | ✓ | **Tommi Romagnoli,** Medical Management Nurse Analyst |
| | **Raul Ayala, MD, Adventist Health**, Kings County | ✓ | **Mary Lourdes Leone,** Chief Compliance Officer (CCO) |
| ✓• | **Joel Ramirez, M.D.,** Camarena Health Madera County | ✓ | **Maria Sanchez**, Compliance Manager |
| | **Rajeev Verma, M.D.,** UCSF Fresno Medical Center | | **Lori Norman,** Senior Compliance Analyst |
| | **David Hodge, M.D.**, Fresno County At-large Appointee, Chair of RHA **(Alternate)** | | |
| | **Guests/Speakers** | | |
| | | | |

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

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #1 **Call to Order**<br>Patrick Marabella, M.D Chair | The meeting was called to order at 10:36 am. A quorum was present. | |
| #2 **Approve Consent Agenda**<br>Committee Minutes: October21, 2021<br>- Standing Referrals Report (Q3)<br>- Preventative Health Guidelines<br>- Appeals & Grievances Inter-Rater Reliability Report (Q3)<br>- Appeals & Grievances Classification Audit Report (Q3)<br>- Customer Contact Center DMHC | The October 21st, 2021 QIUM 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.<br><br>The full November Formulary (PDL) was available for review. | Motion: *Approve* Consent Agenda (Foster/Ramirez)<br>4-0-0-2 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| Expedited Grievance Report (Q3)<br>- California Children's Service Report (Q3)<br>- Concurrent Review Inter-Rater Reliability Audit Report (Q3)<br>- Facility Site & Medical Record & PARS Review Report<br>- MHN Performance Indicator Report for Behavioral Health Services (Q3)<br>- County Relations Quarterly Report (Q3)<br>- NIA/Magellan (Q3)<br>- Medical Policies Update (Q3)<br>- Pharmacy Prior Authorization Update<br>- Pharmacy Provider Updates (Q4)<br>(Attachments A-O)<br><br>**Action**<br>Patrick Marabella, M.D Chair | | |
| #3 **QI Business**<br>- Appeals & Grievances Dashboard and TAT Report (September)<br>- Appeals & Grievances Executive Summary (Q3)<br>- Appeals & Grievances Quarterly Member Report (Q3)<br>- Quarterly A&G Member Letter Monitoring Report (Q3)<br>(Attachments P-S) | Dr. Marabella presented the **Appeals & Grievances Dashboard** through September 2021.<br>➢ The total number of grievances received in August decreased compared to recent months, however the number resolved remained consistent.<br>➢ An increase was noted in the number of *Quality-of-Care* grievances resolved in August, mainly attributable to ancillary services and specialist care as members obtain services postponed due to the pandemic.<br>➢ One (1) grievance Ack Letter and one (1) Expedited Appeal were noted to be out of compliance. Follow up completed.<br>➢ Exempt Grievances had a slight increase from previous months.<br>➢ Appeals continue to demonstrate variation with the majority of cases related to | Motion: *Approve*<br>- Appeals & Grievances Dashboard and TAT Report (September)<br>- Appeals & Grievances Executive Summary (Q3)<br>- Appeals & |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| **Action**<br>Patrick Marabella, M.D Chair | Advanced Imaging and Pharmacy consistent with last month.<br>➢ The Q3 Appeals and Grievances Letter Monitoring report presented provides a summary of the results of the daily audits of Appeal and Grievance acknowledgment and resolution letters and any related corrective actions taken. In review of the 2021 Q3 letter monitoring report, the ongoing primary issue appears to be grammatical in nature. All errors were corrected prior to mailing. Follow up occurs with staff and physicians as indicated based upon the source of the errors. | Grievances Quarterly Member Report (Q3)<br>- Quarterly A&G Member Letter Monitoring Report (Q3)<br>(Lee/Ramirez)<br>4-0-0-2 |
| #3 **QI Business**<br>- Potential Quality Issues Report (Q3)<br>- Provider Preventable Conditions (Q3)<br>(Attachments T-U)<br><br>**Action**<br>Patrick Marabella, M.D Chair | **Potential Quality Issues (PQI) Report** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data for Q3 was reviewed for all case types including the follow up actions taken when indicated.<br>➢ Of the six (6) cases closed, zero were documented as being generated from provider preventable conditions (PPCs)<br>➢ Member generated PQI's slightly increased based on previous quarters with a total of 87 cases.<br>The number of peer review cases varies from quarter-to-quarter independent of the other case types. Follow up has been initiated when appropriate.<br><br>**Provider Preventable Conditions** are identified via four mechanisms: Provider/Facility, Monthly Claims Data review, Monthly Encounter Data review and Confidential Potential Quality Issue submission of identified/suspected quality cases.<br>➢ The eight (8) potential PPC Cases reviewed in Quarter 3 do not represent reportable events that occurred in Quarter 3, but rather cases ready for review in Q3 after records have been received and initial review completed.<br>➢ Five (5) cases were found to meet PPC criteria for reporting to DHCS via the secure online portal. The five (5) cases were reported accordingly. | Motion: *Approve*<br>- Potential Quality Issues Report (Q3)<br>- Provider Preventable Conditions (Q3)<br>(Foster/Ramirez)<br>4-0-0-2 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #3 **QI Business**<br>- Initial Health Assessment Quarterly Audit Report (Q2)<br>(Attachment V)<br><br>**Action**<br>Patrick Marabella, M.D Chair | The Department of Health Care Services (DHCS) requires that newly enrolled Medi-Cal members have an **Initial Health Assessment** (IHA) and Individual Health Education Behavioral Assessment (IHEBA) completed within the first 120 days of enrollment. CalViva Health is required to facilitate and support members and providers through this process. The current approach to monitoring has three components:<br>➢ Medical Record Review (MRR) via onsite (or virtual) provider audits.<br>➢ Monitoring of claims and encounters data.<br>➢ Member outreach utilizing a three-step methodology.<br>The Q2 2021 IHA Quarterly Report demonstrates CalViva Health's performance on IHA/IHEBA compliance monitoring from July 2020 – June 2021.<br>➢ The Report also describes CalViva's efforts to improve its IHA/IHEBA completion rates during Q1-Q3, 2021 in partnership with a provider organization. In Q1-Q2 2021, an IHA workgroup designed and implemented a successful process for completing member outreach and visit completion and documentation within the pilot provider's offices. In Q3 CalViva spread the resulting best practices throughout its provider network.<br>➢ Results of this initiative will be monitored and reported on in future IHA Quarterly Audit Reports.<br>➢ | Motion: *Approve*<br>- Initial Health Assessment Quarterly Audit Report (Q2)<br>(Lee/Ramirez)<br>4-0-0-2 |
| #4 **Access Business**<br>- Specialty Referrals Report – HN (Q2)<br>- Specialty Referrals Report – HN (Q3)<br>(Attachments W-X)<br><br>**Action**<br>Patrick Marabella, M.D Chair | **Specialty Referral Report Q2 & Q3 2021.** This report provides a summary of Specialty Referral services that required prior authorization in the three-county area (Fresno, Kings, and Madera) for the second and third quarters of 2021. This report captures three utilization case types:<br>➢ Key services that while within the service area and within the network require clinical review<br>➢ Services recognized as out of the tri-county area, but within the provider network<br>➢ Out of network requests<br>These reports provide evidence of a system-wide process for tracking and following up on member referrals requiring prior authorization, and includes a breakdown of SPD and non-SPD member specialty referral requests. At this time, due to changes in system capabilities the plan is unable to capture the data for this report consistent with prior years. The Data Analytics team continues to investigate options and the plan will amend Q1-3 of this report if appropriate. In the meantime, monitoring will continue with the data available. | Motion: *Approve*<br>- Specialty Referrals Report – HN (Q2)<br>- Specialty Referrals Report – HN (Q3)<br>(Foster/Ramirez)<br>4-0-0-2 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| #5 **UM/CM Business**<br>- Key Indicator Report and TAT Report (September)<br>- Utilization Management Concurrent Review Report (Q3)<br>(Attachments Y-Z)<br><br>**Action**<br>Patrick Marabella, M.D Chair | Dr. Marabella presented the **Key Indicator Report and TAT Report** through September 2021.<br>➢ Acute Care Admission rates for SPDs remain low, however they appear to be increasing for the Family/Adult and Expansion populations.<br>➢ Length of Stay remains higher than prior years for Family/Adult and Expansion populations.<br>➢ Turn-around Times for Prior Authorizations were noted to have some opportunities for improvement this month. An increase in the number of requests submitted as "urgent" was noted along with some COVID-related staffing issues.<br>➢ The volume of Deferrals is low and therefore the rate is highly sensitive to variations.<br>➢ Adjustments are in progress, anticipate improvement next month.<br><br>The **Utilization Management Concurrent Review Report** presents inpatient data and clinical concurrent review activities such as authorization for inpatient admissions, discharge planning and medical appropriateness during Quarter 3 2021.<br>➢ TANF and MCE populations experienced an increase in Admits in Q3. TANF bed days/1000 also increased in Q3.<br>➢ The SPD population experienced a decrease in readmissions during Q3 compared to prior months.<br>➢ Overall increases in bed days are attributable to increases in acuity for COVID-19patients with a high percentage of these members requiring specialty care such as ICU upon admission. | Motion: *Approve*<br>- Key Indicator Report and TAT Report (September)<br>- Utilization Management Concurrent Review Report (Q3)<br>(Foster/Lee)<br>4-0-0-2 |
| #5 **UM/CM Business**<br>- PA Member Letter Monitoring Report (Q3)<br>(Attachment AA)<br><br>**Action**<br>Patrick Marabella, M.D Chair | **PA Member Letter Monitoring Report** Quarter 3 was presented and reviewed. This report monitors Notice of Action (NOA) letters including Prior Authorizations (PAs), Concurrent, and Post Service denials. Findings are discussed with UM Management Directors on a monthly basis. All metrics are expected to meet standard of 100% compliance. All categories had audit scores were above 95% except for one. Improved scores have been noted in recent months for several metrics and Medical Management has implemented several Actions to sustain these, including:<br>➢ Weekly audit meetings for any identified failures<br>➢ Weekly progressive coaching of staff with any opportunities identified during internal audits.<br>➢ Physician Coaching during individual and team meetings. The Senior Medical Director has met with several of the Medical Director to review determinations. They review the NCQA | Motion: *Approve*<br>- PA Member Letter Monitoring Report (Q3)<br>(Foster/Lee)<br>4-0-0-2 |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| | requirements, focusing on clear and concise determinations. | |
| #5 **UM/CM Business**<br>- Case Management and CCM Report (Q3)<br>(Attachment BB)<br><br>**Action**<br>Patrick Marabella, M.D Chair | The **Case Management and CCM Report** Q3 2021 report summarizes the Integrated Case Management, Transitional Care management, Behavioral Health Case Management, Perinatal Case Management, MemberConnections, Palliative Care, and Emergency Department (ED) diversion activities for 2021 through the third quarter and utilization related outcomes through second quarter 2021.<br>Barriers/Issues identified included:<br>➢ Decreased referrals to some programs<br>o Fewer CCR referrals due to COVID related complications for Members (members in ICU, discharging to SNF or Rehabs, expiring)<br>➢ Limited successful telephonic outreach to members referred to some CM programs due to incorrect phone numbers<br>➢ Changes in TCM staffing and work process<br>➢ Staffing constraints<br><br>Actions Taken/Next Steps<br>➢ Partner with Quality staff on provider education regarding CM referral process<br>➢ Reassignment of staff as needed and referral volume assessment to determine if additional resources are needed<br>Re-educated staff on various sources and systems to obtain current member contact information. | Motion: *Approve*<br>- Case Management and CCM Report (Q3) (Foster/Ramirez)<br>4-0-0-2 |
| #6 **Pharmacy Business**<br>- Pharmacy Executive Summary (Q3)<br>- Pharmacy Operations Metrics (Q3)<br>- Pharmacy Top 30 Prior Authorizations (Q3)<br>- CalViva Health Pharmacy Call Report (Q3)<br>- Pharmacy Inter-Rater Reliability Results (IRR) (Q3)<br>(Attachment CC-GG) | The **Pharmacy Reports** for Q3 2021 are presented in order to assess for emerging patterns in authorization requests, evaluate compliance for prior authorizations, and to evaluate the consistency of decision making in order to formulate potential process improvement recommendations.<br>➢ Pharmacy Prior Authorizations (PA) metrics were within 5% of standard for the 3rd Quarter of 2021.<br>➢ Overall TAT for Q3 was 97.2%<br>➢ The TAT recovered in September of 2021 to 99.5%<br>➢ 3rd Quarter 2021 top medication PA requests were similar to 2nd Quarter 2021.<br>**Top 30 Prior Authorization** Quarter 3 2021 top 30 medication PA requests were slightly lower compared to 2nd Quarter 2021. | Motion: *Approve*<br>- Pharmacy Executive Summary (Q3)<br>- Pharmacy Operations Metrics (Q3)<br>- Pharmacy Top 30 Prior Authorizations (Q3)<br>- CalViva Health |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
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| **Action**<br>Patrick Marabella, M.D Chair | ➢ Narcotic Pain Medication requests were lower in 3rd Quarter 2021 compared to 2nd Quarter 2021.<br>➢ Diabetes management Prior Auth request continue to be high and slightly ahead of Narcotic Pain Medications in Q3 2021<br>➢ The approval rate of Prior Authorizations was lower than 2nd Quarter 2021.<br>**Pharmacy Call Report** Quarter 3 2021 reviews quarterly operational metrics for the CVS Caremark Call Center. All Call metrics met standard for this quarter. **Inter-Rater Reliability Results** for Q3 2021<br>➢ 90% threshold met. 95% goal not met, overall score was 94.17%<br>➢ Follow up to occur when opportunities for improvement are identified both on an individual and team basis. | Pharmacy Call Report (Q3)<br>- Pharmacy Inter-Rater Reliability Results (IRR) (Q3)<br>(Lee/Ramirez)<br>4-0-0-2 |
| #7 **Policy & Procedure Business**<br>- UMCM Policy Grid and Attachments<br>(Attachment HH)<br><br>**Action**<br>Patrick Marabella, M.D Chair | **The Utilization Management and Case Management Policies** were presented to the committee. The majority of the policies were updated with minor or no changes per the Policy Grid.<br>➢ UM-007 Major Organ Transplant: Developed to cover organ transplants for all major organs. Benefit will no longer be "carved out" as of 01/01/2022.<br>➢ CMP-107 Care Coordination / Case Management Services- significant edits.<br>➢ CMP-500 Enhanced Care Management Program Overview and Requirements: developed to support CalAIM rollout of ECM/Community Supports.<br>➢ CMP-501 Administration of CalAIM In Lieu of Services: developed to support CalAIM rollout of ECM/Community Supports. | Motion: *Approve*<br>- UMCM Policy Grid and Attachments<br>(Lee/Foster)<br>4-0-0-2 |
| #8 **Credentialing & Peer Review Subcommittee Business**<br>- Credentialing Subcommittee Report (Q4)<br>- Peer Review Subcommittee Report (Q4)<br>(Attachment II-JJ)<br><br>**Action**<br>Patrick Marabella, M.D Chair | **Credentialing Sub-Committee Quarterly Report** was presented.<br>In Quarter 4 the Credentialing Sub-Committee met on October 21, 2021. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering the second quarter for 2021 were reviewed for delegated entities and the third quarter 2021 reports were reviewed for Health Net. The Credentialing Sub-Committee 2021 Charter was reviewed and approved without changes.<br>There was no case activity to report for the Quarter 3 2021 Credentialing Report from Health Net.<br>**Peer Review Sub-Committee Quarterly Report** was presented.<br>The Peer Review Sub-Committee met on October 21, 2021. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2021 were reviewed and approved. There were no significant cases to report. The Quarter 3 2021 Peer Count Report was presented at the meeting with a total of 5 cases reviewed. The outcomes for these cases are as follows: All five (5) cases | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | 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.<br>Follow up will be completed to close out cases and ongoing monitoring and reporting will continue. | |
| #9 **Compliance Update**<br>- Compliance Regulatory Report (Attachment KK) | Mary Lourdes Leone presented the **Compliance Report**.<br>**Oversight Audits** The following annual audits are in-progress: Access and Availability, Credentialing, Appeals & Grievances, Continuity of Care, Quality Improvement and Provider Network/ Provider Relations. The following audits have been completed since the last Commission report: Call Center (No CAP), and Provider Disputes (No CAP).<br>**Fraud, Waste, & Abuse Activity** Since the last report, there have not been any MC609 cases filed. There were no cases that needed to be referred to other law enforcement agencies by the Plan.<br>**2021 DMHC 18-Month Follow-Up** Audit On 11/2/21, the Plan received DMHC's "Follow-Up Report of the 2021 Routine Full-Service Survey". Of the two deficiencies cited, the DMHC noted the Plan corrected the one dealing with written responses to grievances not being clear and concise and not containing all required information. However, with regards to the second deficiency related to not deeming requests for post-stabilization care authorized when the Plan fails to timely respond to requests from non-contracting hospitals, the Report indicated the Plan has not yet corrected this. Specifically, the DMHC stated they were not able to assess whether the Plan corrected this deficiency, and at the Plan's next routine survey, the Department will conduct a full evaluation of the Plan's post-stabilization processes.<br>**Department of Health Care Services ("DHCS") 2020 Medical Audit – CAP** 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. We are still awaiting DHCS' response.<br>**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:<br>➢ 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.<br>➢ Major Organ Transplant (MOT) carve-in – Effective 1/1/22 for all CalViva counties and | |

| AGENDA ITEM / PRESENTER | MOTIONS / MAJOR DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | membership.<br>**Behavioral Health Incentive (BHI) Program** the Plan received the Q3 BHI Milestone Report on 11/8/21 and is reviewing it. It must be submitted to DHCS by 11/29/21.<br>**COVID-19 Novel Coronavirus** Our downtown office for walk-ins is still closed. Our administrator Health Net has indicated they will continue to carry-out operations on a semi-remote basis until March 2022.<br>**Public Policy Committee** 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. | |
| #10 **Old Business** | None. | |
| #11 **Announcements** | Next meeting February 17th, 2022 | |
| #12 **Public Comment** | None. | |
| #13 **Adjourn** | Meeting was adjourned at 12:21pm | |

**NEXT MEETING: February 17th, 2022**

Submitted this Day: February 17, 2022

Submitted by: Amy Schneider

Amy Schneider, RN, Director Medical Management

**Acknowledgment of Committee Approval:**

Patrick Marabella, MD Committee Chair

# Item #3

## Attachment 3.D

Public Policy Committee Minutes
dated 12/1/2021

# Public Policy Committee Meeting Minutes December 1, 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, Director Community Relations |
| ✓• | Kristi Hernandez, At-Large Representative | ✓ | Cheryl Hurley, Commission Clerk / Director, HR /Office |
| ✓• | Kevin Dat Vu, Fresno County Representative | ✓ | Jeff Nkansah, CEO |
| ✓ | Norma Mendoza, At-Large Representative | ✓ | Mary Lourdes Leone, Chief Compliance Officer |
| | | ✓ | Steven Si, Senior Compliance & Privacy/Security Specialist |
| | | ✓ | Maria Sanchez, Compliance Manager |
| | | ✓ | Patrick Marabella, M.D., CMO |
| | | ✓ | Amy Schneider, Director, Medical Management |
| | | * | = late arrival |
| | | • | = participation by teleconference |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **#1 Call to Order**<br>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. |
| **#2 Meeting Minutes from** | The September 1, 2021 meeting minutes were reviewed. There was one edit needed and minutes were approved as amended. | **Motion:**<br>Approve |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **September 1, 2021**<br><br>**Action**<br>Joe Neves, Chair | | December 1, 2021 Minutes<br>8-0-0-1<br>(D. Phillips / J. Garner)<br><br>A roll call was taken. |
| **#3 Enrollment Dashboard Information**<br>Maria Sanchez, Compliance Manager | Maria Sanchez presented the enrollment dashboard through September 2021. Membership as of the end of September 2021 was 389,651. CalViva Health maintains a 69.41% market share. | **No Motion** |
| **#4 Health Education**<br>2021 Executive Summary and Work Plan Mid-Year Evaluation<br><br>**Information**<br>Steven Si, Senior Compliance Operations/Privacy Specialist | The 2021 Health Education Work Plan Mid-Year Evaluation documents progress of 17 initiatives with 33 performance objectives. Within each initiative, there are multiple objectives. Of the 17 initiatives, 12 initiatives with 22 objectives are on track to meet the year-end goal. The remaining 5 initiatives with 11 objectives are off track to meet the year-end goal.<br><br>The five (5) key initiatives off track are:<br>• Diabetes Prevention Program<br>• Mental/Behavioral Health<br>• Tobacco Cessation<br>• Women's Health<br>• Geomaps | **No Motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| #5 Cultural and Linguistics<br>• 2021 Executive Summary and Work Plan Mid-Year Evaluation<br>• 2021 Summary and Language Assistance Program Mid-Year Report<br>• 2021 Summary and Geo Access Report<br><br>Information<br>Steven Si, Senior Compliance Operations/Privacy Specialist | For the 2021 Work Plan Mid-Year Evaluation, the Cultural and Linguistics activities completed during the first six months of 2021 consist of:<br><br>• Language Assistance Services<br>o Updated / amended contracts with three vendors. Amendments included contract extensions and adds new rates.<br>o Newsletter informing members on how to access language services completed and disseminated.<br>o Twenty-seven staff completed their bilingual assessment / re-assessment.<br>o Two quarterly LAP and Health Literacy meetings conducted.<br>o Population Needs Assessment completed in collaboration with HE and QI departments.<br>o Completed annual report of the LAP assessment results for the Timely Access Reporting.<br>o LAP training module updated. Total of 4,032 staff have completed the LAP training in Q1 and Q2.<br><br>• Compliance Monitoring<br>o C&L reviewed 39 grievance cases with four interventions identified.<br>o 2020 grievance trending report will be completed in Q3.<br>o Completed, presented and received approval for the 2020 End of Year Language Assistant Program and 2020 End of Year Work Plan reports and the 2021 Program Description and 2021 Work Plan.<br>o The CalViva member SDOH assessment is pending DHCS approval.<br>o All C&L Policy &Procedures reviewed and updated in Archer.<br><br>• Communication, Training and Education<br>o Four call center trainings conducted and training decks updated.<br>o Language identification poster for provider office was remediated and posted in provider library.<br>o Implemented the 2-part implicit bias training series.<br>o Implemented the 2-part-Motivational Interviewing training<br><br>• Health Literacy, Cultural Competency and Health Equity | **No Motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | ○ English material review completed for a total of 59 materials.<br>○ Revised Provider Health Literacy toolkit.<br>○ Conducted two trainings on C&L database and Plain Language.<br>○ Led 6 ICE C&L team meetings.<br>○ Produced two new documents in support of COVID patient care.<br>○ Published Cultural Humility and ACEs articles<br>○ Co-leading internal workgroup meetings with local CBO partner to plan all health disparity and cultural and linguistic components of BCS PIP.<br>○ Supporting work plan development, and updating and extending the Scope of Work for the community partner.<br>○ Leading and/or collaborating on the BCS PIP intervention components inclusive of agendas, slide deck, talking points, event survey, appointment reminder, etc.<br><br>All activities are on target to be completed by the end of the year with some already completed. Will continue to implement, monitor and track C&L related services and activities.<br><br><u>The report out for the 2021 Summary and Language Assistance Program Mid-Year Report is as follows:</u><br><br>• Member Services Department representatives handled a total of 52,783 calls across all languages. Of these, 8,960 (17%) were handled in Spanish and Hmong languages.<br>• A total of 1,706 interpreter requests were fulfilled for CalViva Health members, 1,290 (76%) of these requests were fulfilled utilizing telephonic interpreter services with 368 (22%) for in-person, 48 (3%) for sign language interpretation, and zero requests for video remote interpreting.<br>• MHN Services' Member Services Department representatives handled a total of 192 across all languages (Spanish, Vietnamese, Punjabi, Cantonese and Arabic) with 182 (95%) handled in Spanish.<br>• There were 85 requests for interpreter services that were fulfilled. Of these 85 requests, 70 (82%) were fulfilled for in-person, 11 (13%) for sign language interpretation and four (5%) for telephone interpretation. | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | • One request for Written Translations were received from CalViva Health members during this reporting period. No requests for Oral or Alternate Format translations.<br>• A total of 59 English material reviews completed for CalViva Health documents/materials, including the member newsletter.<br>• A total of 12 grievance cases were received and reviewed by C&L.<br><br>C&L language assistance services utilization and language assistance program updates are mostly consistent with previous reporting periods. Interpreter requests and call volume for CalViva Health decreased slightly compared to the same reporting period in 2020. Additionally, while the total membership increased slightly, the percent of LEP members remained consistent.<br><br>CalViva will continue to track C&L and MHN Services language services utilization and program updates.<br><br><u>The results of the 2021 Cultural and Linguistic Services Geo Access Assessment are as follows:</u><br><br>This information summarizes the identified language needs/gaps by county for Fresno, Kings and Madera. Five of the non-English languages with the most speakers were included in the analysis: Spanish, Hmong, Arabic, Lao and Khmer. If one member did not have a primary care provider and/or a specialist that offered their language, a gap is identified. These gaps help identify areas where language support services are more critical to accessing health care services.<br><br>Gaps were identified for various languages for PCPs and specialists or both except for Spanish. All members identified as Spanish-speaking members residing in Fresno, Kings and Madera counties had their access needs meet. Of the members identified as Hmong speakers, seven members residing in Fresno County were identified as having an access gap to a specialist and one having an access gap to a PCP, according to the parameters. Khmer and Arabic are the two-member language needs with the most gaps. Madera demonstrates to be the county with the least gaps. When comparing data to the 2019 analysis, 2021 analysis demonstrates more gaps in Hmong and less gaps for Khmer. | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | The Cultural and Linguistic Services Department will continue to produce the C&L Geo Access Assessment and report out every other year. Progress updates will be incorporated into the Cultural and Linguistics Services Department's Work Plan reports regarding the strategies discussed, planned, and implemented and their outcome. | |
| **#6 Medical Management**<br>MY 2020 HEDIS® Data Results<br><br>**Information**<br>Patrick Marabella, M.D., CMO | Dr. Marabella presented the Healthcare Effectiveness Data and Information Set (HEDIS®) update for MY 2020.<br><br>Fresno County was below the minimum performance levels (MPL) in the following categories:<br>• Antidepressant Medication Management<br>• Breast Cancer Screening<br>• Cervical Cancer Screening<br>• Chlamydia Screening<br>• Childhood Immunization<br>• HbA1c<br>• Controlling High Blood Pressure<br>• Weight Assessment & Counseling<br>• Well-Child Visits – first 15 months of life<br><br>Kings County was below the minimum performance levels (MPL) in the following categories:<br>• Antidepressant Medication Management<br>• Breast Cancer Screening<br>• Childhood Immunization<br>• Immunizations for Adolescents: Combo 2<br>• Well-Child Visits – first 15 months of life<br><br>Madera County was below the minimum performance levels (MPL) in the following categories:<br>• Antidepressant Medication Management<br>• Chlamydia Screening | **No Motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | • HbA1c<br>• Well-Child Visits – first 15 months of life<br><br>Managed Care Accountability Set updates for December 2021 include:<br>• Performance Improvement Projects (PIPs) will continue through 12/31/2022:<br>  o Childhood Immunizations<br>  o Breast Cancer Screening<br>• DHCS will not impose sanctions or corrective action plans for not meeting the MPL in 2021.<br>• Two PDSA rapid cycle improvement projects required for CalViva Health:<br>  o Cervical Cancer Screening<br>  o Diabetes Care – HbA1c<br>• COVID-19 Quality Improvement Plan (QIP) – Three strategies to address: behavioral health, chronic disease and well child. | |
| **#7 Quarterly Appeals and Grievance Report**<br><br>**Information**<br>Maria Sanchez, Compliance Manager | For Q3 2021 there were 92 Coverage Disputes (Appeals), 122 Disputes Involving Medical Necessity (Appeals), 91 Quality of Care, 151 Access to Care, and 165 Quality of Service, for a total of 621 appeals and grievances. The majority of which are from Fresno County.<br><br>The turn-around time compliance for appeal and grievance cases was as follows:<br>• Standard Grievances: 99.7%<br>• Expedited Grievances: 100%<br>• Standard Appeals: 100%<br>• Expedited Appeals: 95.2%<br><br>There was a total of 1,105 Exempt Grievances received in Q3 2021.<br><br>Of the total grievances and appeals received in Q3, the following were associated with Seniors and Persons with Disabilities (SPD): | **No Motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | • Grievances: 157<br>• Appeals: 54<br>• Exempt: 11<br><br>The majority of appeals and grievances were from members in Fresno County (largest CalViva Health enrollment).<br><br>The majority of quality of service (QOS) grievance cases resolved were categorized as Administrative, Access-Other, and Transpiration Behavior.<br><br>The majority of quality of care (QOC) grievance cases were categorized as PCP Delay, Specialist Care and Other.<br><br>The top categories of appeal cases were related to Advanced Imaging, Pharmacy, and DME. | |
| **#8 Health Education**<br>2021 Population Needs Assessment Report<br><br>**Information**<br>Steven Si, Senior Compliance Operations/Privacy Specialist | Steven Si presented the 2021 Population Needs Assessment.<br><br>• Based on measurement year 2020 (MY2020) data, all CalViva counties demonstrated various HEDIS® measures below the 50th percentile minimum performance level (MPL).<br>• The COVID-19 pandemic impacted heath care access, resulting in lower performance for some HEDIS® measures.<br>• Fresno County had the most measures below the MPL, while Madera had the least.<br>• Under Pediatric Health:<br>  o Madera County performed most favorably, noting three measures under the MPL out of the nine captured for review. Fresno County had eight (89%) of their measures below the MPL.<br>  o Across all counties, three measures were consistently below the MPL: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Well-Child Visits in the First 30 Months of Life – 0 to 15 Months (W30-15), and Child and Adolescent Well-Care Visits (WCV).<br>• Under Women's Health: | **No Motion** |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | ○ Kings and Madera Counties had the best performance across all CalViva counties, with only one measure each, Breast Cancer Screening (BCS) and Chlamydia (CHL) respectively below the MPL.<br>○ Fresno County had at least three of five measures below the MPL. In the majority of CalViva counties, BCS and CHL were consistently below the benchmark.<br>○ All three CalViva counties met the MPL for timeliness of prenatal and postpartum visit HEDIS® measures.<br>• Under Adult and Chronic Health:<br>○ Kings and Madera Counties met the MPL for three of the six measures.<br>○ Fresno County missed the MPL on four measures. Antidepressant Medication Management – Effective Acute Phase Treatment and Effective Continuation Phase Treatment are the most recurring measures in CalViva counties below the 50th percentile.<br><br>The action plan moving forward for 2021-2022 is as follows:<br>• Health Education: continue improving myStrength participation<br>• Quality Improvement: address disparity for breast cancer screening among Southeast Asian speaking females in Fresno County<br>• Cultural & Linguistics: increase Language Assistance Program utilization with new Video Remote Interpreting services. | |
| **#9 2020 DHCS Audit – CAP Update**<br><br>**Information**<br>Mary Lourdes Leone, Chief Compliance Officer | The last update submitted to DHCS was submitted in August 2021 and included a request from the Plan to accept and close out the corrective action plan (CAP). As of December 1, 2021 no formal written response has been received from DHCS. This remains an open issue. | **No Motion** |
| **#10 DMHC 2021 18-Month Audit – Update** | The Plan has recently received the final report from DMHC regarding the 2021 18-month Audit. Initially there were two deficiencies noted; one dealing with appeals and grievances letters not being | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| **Information**<br>Mary Lourdes Leone, Chief Compliance Officer | clear and concise. This issue has since been corrected and resolved. The second deficiency was related to how the Plan processes certain types of requests called post-stabilization requests and the claims associated with those requests. The DMHC indicated they were not able to determine if the Plan was compliant and has asked the Plan for additional information over the next few months. The DMHC will look towards the next audit in September of 2022 to ultimately make a determination as to whether or not the Plan is compliant. | |
| **#11 CalViva Health Recreation Youth Fund**<br><br>**Information**<br>Courtney Shapiro, Director, Community Relations | The CVH Recreation Youth Fund was approved by the Commission during budget approval in May 2021 and is a part of the Community Supports Program. The Plan created the youth fund due to the amount of requests received from youth organizations to cover expenses such as allowing children to participate when they otherwise would not be able to due to the cost, or maybe for the purchase of warmups for teams which would stay with organization for future participants. The application can be obtained on the CVH website. The funding is from $1,000 - $10,000 and does not cover travel sports or competitive sports. | |
| **#12 Enhanced Care Management (ECM) & Community Supports – Update**<br><br>**Information**<br>Mary Lourdes Leone, CCO | The Enhanced Care Management (ECM) and Community Supports program is part of a multi-year CalAIM initiative. As an update, the programs go-live on January 1, 2022. In anticipation of that, the Plan has had to submit large types of submissions. The Plan received notice from DHCS that two of the three major submissions have been approved; with the third being conditional upon receipt of a policy description. | |
| **#13 Final Comments from Committee Members and Staff** | David Phillips from United Health Centers announced the grand opening of their Clovis facility the week of 12/6/21. There is also a Chamber mixer on 12/15/21 at the Milburn location.<br><br>Sylvia Garcia announced Cornerstone distributes boxes of food every Wednesday morning.<br><br>Jeff Garner announced KCAO received additional funding allowing the expansion of subsidized childcare in Kings County for working families. In addition, through a donation from CVH, KCAO was able to work with West Hills College in Lemoore to establish a food pantry on campus. | |

| AGENDA ITEM / PRESENTER | DISCUSSIONS | ACTION TAKEN |
|---|---|---|
| | Roberto Garcia announced Self Help Enterprises has a grand opening of Sugar Pine Village in Madera 12/3/21.<br><br>Tony Gonzalez with CVH Community Engagement introduced two of his team members. Their primary focus is to help CVH implement CalAIM, and the COVID vaccine response plan.<br><br>Courtney Shapiro followed up with additional information on the COVID response plan with a vaccine event being held 12/5/21. Courtney also announced the new CalViva Health Cares Facebook page. Questions posed on Facebook in Spanish will be answered. Posters provided in English and Spanish will both be posted. Whatever the language is on the flyer that is provided is what is posted.<br><br>Jeff Nkansah announced new legislation, AB 361, which will change the way in which the meetings will be held moving forward in 2022. PPC members should plan to participate in person for the March 2022 meeting. In addition, Jeff also announced for anyone that is on Medi-Cal or might be experiencing financial hardship and may have a premium they are unable to pay, the State is looking to connect those members and families with a waiver for their premium. Reach out to Courtney Shapiro and will also be posted on the CVH Facebook page. Jeff expressed thanks to the community partners and provider partners, as well as staff and the HN team, for all the work involved with CalAIM. | |
| **#14 Announcements** | None. | |
| **#15 Public Comment** | None. | |
| **#16 Adjourn** | Meeting adjourned at 12:56 pm. | |

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

Submitted This Day: March 2, 2022

Submitted By: _____
Courtney Shapiro, Director Community Relations

Approval Date: March 2, 2022

Approved By: _____
Joe Neves, Chairman

# Item #4

## Attachment 4.A

2022 Quality Improvement Program Description

# REPORT SUMMARY TO COMMITTEE

**TO:** CalViva Health QI/UM Committee

**FROM:** Amy Wittig Quality Improvement

**COMMITTEE DATE:** March 17, 2022

**SUBJECT:** Quality Improvement Program Description Change Summary

| UM Redline Page # | Section/Paragraph name | Description of change |
|---|---|---|
| Throughout | Multiple | Updated year from 2020 to 2021 |
| Throughout | Multiple | Changed CalViva Health to CalViva after the first reference. |
| 2-3 | Table of Contents | Page numbering and section titles updated |
| 9, 12, 15, 16, 10, 19 23, 26, 41 | Multiple | Changed disease management to chronic conditions Management |
| 12 | Scope of QI Program | Added information on CalViva's PHM strategy. |
| 15 | Health Promotion Programs | Revised Health Promotion Program descriptions for 2022: Weight Management Program, Health Education Classes/Webinars (Health Habits for Health People, and Fit Families for Life), Kick It California tobacco cessation program, and Health Education Resources. |
| 16 | MemberConnections | Revised MemberConnectione responsibilities including addressing SDOH, support on outreach programs/PIPS/PDSAs, scheduling and completing member home visits, and monitoring and following up on high risk member referrals. |
| 18 | Clinical Practice Guidelines (CPGs) | Added that CPGs are reviewed and approved through the Health Net Medical Advisory Council. |
| 19 | Health Management Programs | Under the Nurse Advice Line program, removed "Nurse advice line nurses may access support from a physician when needed as the nurse interacts directly with the member." |
| 29 | Continuity of Care | Revised nurse advice line with specific operation hours. |
| 31, 34, 42 | Multiple | Revised/Removed the pharmacy activities to only include the medical benefit pharmacy information. |
| 32 | Health Plan Performance | Added a section on Population Health Management.<br>Revised member satisfaction to member experience. Added the plan monitors clinical and service quality key performance metrics for Chronic Conditions Management, Customer Service, Population Health Management, and MHNS areas. |
| 33 | Satisfaction | Revised the Member experience description to include CAHPS survey activities and removed the CXCI initiatives. |
| 34, 41, 42 | Access and Availability | Changed Access surveys from quarterly to annual. |
| 36 | Medical Records | Revised the description on how the plan monitors medical record and how the plan evaluates interventions effectiveness (via annual data aggregation and analysis). Removed information on Corrective |

| | | |
|---|---|---|
| | | Action Plan. Revised interventions when issues are identified to include “face to face instructions with Nurse Auditors.” |
| 37, 38 | Health Equity and Cultural and Linguistic Needs | Changed Cultural and Linguistic Department to Health Equity Department. |
| 41, 42 | QI Process | Changed CAHPS as a bi-annual survey administered by DHCS. Added Annual Access Survey. Additional details added regarding the provider update to include QI outcomes and findings. |
| 44 | CalViva Quality Committees | Added NCQA and contractual language changes regarding oversight of policy decision and changes and provider representation in the QI Committee. |
| 48 | Staff Resources and Accountability | Added role description for BH Medical Director. Added DHCS APL 21-011 for FSR/MRR/PARS. |
| 49 | Health Education | Revised Health Education description to include information on collaborations and population health assessments. |
| 49 | Pharmacy Services | Revised Pharmacy to include only the Pharmacy Medical Drug Benefit. |
| 50 | HEDIS® Management and Clinical Reporting | Removed “CAHPS.” |
| 52 | Annual QI Evaluation | Added that CalViva assesses performance for “quality of service and clinical care, and safety of clinical care” |


# CalViva Health

## Quality Improvement (QI) Program Description

2022

# Table of Contents

# I.

# Introduction and Background

# A. *Health Plan Products and Membership*

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

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

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

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

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

# B. *Provider Network*

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

# C. *Information Systems and Analysis*

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

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

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

# II.

# Purpose and Goals

# A. *Mission*

The CalViva mission is:

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

The mission of the CalViva QI Program is:

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

The vision of CalViva QI Program is to:

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

# B. *Purpose*

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

# C. *Goals*

1. Support CalViva's strategic business plan to promote safe, high quality care and services while maintaining full compliance with regulations or standards established state regulatory and accreditation agencies.
2. Objectively and systematically monitor and evaluate services provided to CalViva members to ensure conformity to professionally recognized standards of practice and codes of ethics.
3. Provide an integrative structure that links knowledge and processes together throughout the organization to assess and improve the quality and safety of clinical care with quality service provided to members.
4. Develop and implement an annual quality improvement work plan and continually evaluate the effectiveness of plan activities at improving/maintaining performance of target measures, and takes action, as needed, to improve performance.
5. Support a partnership among members, practitioners, providers, regulators and employers to provide effective health management, health education, disease prevention and management, and facilitate appropriate use of health care resources and services.

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

# III.

# Scope

# A. *Scope of QI Program*

The CalViva QI Program includes the development and implementation of standards for clinical care and service, the measurement of compliance to the standards and implementation of actions to improve performance~~.—~~. The scope of these activities considers the enrolled populations' demographics and health risk characteristics, as well as current national, state and regional public health goals. CalViva's Population Health Management (PHM) strategy provides a unifying framework to support the QI Program in delivering a whole-person approach to caring for members. The framework uses risk stratification data compiled from a variety of data sources to help teams target the right members with the right resources to address member health and social determinants of health (SDoH) needs at all stages of life.

CalViva ensures that there are no financial incentives or gain, including financial gain to providers, vendors, or facilities, to delay or withhold appropriate care. The QI Program provides oversight to ensure that RHA Commission and CalViva providers exert no economic pressure on facilities to grant privileges to providers~~.—~~. Facilities have in place Policies and Procedures for credentialing and re-credentialing~~.—~~. These processes are not subject to CalViva intervention~~.—~~.

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

- Health promotion, wellness and preventive care including the Initial Health Assessment
- Chronic care improvement/ chronic conditions ~~disease~~ management
- Monitoring and evaluating access, availability, satisfaction and service
- Case Management (CM)
- Quality and safety of care
- Monitoring and evaluating care coordination for medical and behavioral conditions, ensuring coordination of care with other county and state programs
- Practitioner satisfaction
- Practitioner site and facility inspection including physical accessibility reviews of PCP and high-volume specialist provider sites.
- Medical record and documentation standards
- Practitioner and provider qualifications and selection through a careful credentialing and peer review process
- Utilization Management
- Credentialing & recredentialing
- Delegation Oversight
- Health Plan Clinical and Service Performance
- Member Rights & Responsibilities
- Communication to meet cultural and linguistic needs of all members
- Ensure SPD members undergo annual risk stratification, Health Risk Assessment (HRA), care plan preparation and distribution to the PCP

CalViva's QI Program has mechanisms to monitor the quality of care provided in an inpatient setting to ensure that providers utilize equipment and facilities appropriate to the care through the concurrent review process~~.—~~. The Plan's Provider Network Management staff ensures hospital and outpatient facilities are

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

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

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

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

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

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

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

# C. *Health Promotion Programs*

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

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

- Weight Management Programs –Members have access to ~~a~~ three program options under ~~comprehensive~~ Fit Families for Life-Be In Charge!$^{SM}$~~:~~ ~~suite of programs.~~
    - The Fit Families for Life-Home Edition is a five~~5~~-week home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. Materials include a program booklet, cookbook, and exercise stretch band. Providers may complete and fax a copy of the Fit Families for Life - *Be In Charge!*$^{SM}$ Program Referral Form to the CalViva Health Education Department to refer members to the Home Edition program.
    - The Healthy Habits for Healthy People weight management educational resource is ~~designed specifically~~ for older adults and seniors~~.~~. Program materials also include a program booklet, cookbook, and exercise stretch band.
    - ~~Other nutrition and weight control education resources are also available upon request. Providers should complete and fax a copy of the~~ Fit Families for Life and Healthy Habits for Healthy People Community Classes/Webinars - classes and/or webinars that teach basic nutrition and physical activity information. The community classes and/or webinars are free to all CalViva members and the community. ~~Be In Charge! Program Referral Form to the Health Education Department to refer members to the Home Edition program.~~

- CalViva Pregnancy Program – The pregnancy program incorporates the concepts of case management, care coordination, chronic conditions~~disease~~ management and health promotion in an effort to teach pregnant members how to have a healthy pregnancy and first year of life for babies~~.~~. The program also aims to reinforce the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for ~~your~~ the baby~~.~~. High~~-~~risk pregnancies receive additional case management services.
- ~~~~Kick It California – Formerly known as the California Smokers' Helpline, Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), a texting program in English or Spanish, a website chat function, and mobile apps on smoking and vaping. Telephonic coaching is available Monday-Friday, 7am-9pm, and Saturday from 9am-5pm by calling 1-800-300-8086. To learn more about available resources and medication options, members may call the toll-free number or visit www.kickitca.org.~~California Smokers' Helpline~~ ~~The California Smokers' Helpline (1-800-NO-~~

~~BUTTS) is a free statewide quit smoking service. The Helpline offers self-help resources, referrals to local programs, and one-on-one telephone counseling to quit smoking. Helpline services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), and specialized services are available to teens, pregnant women, and tobacco chewers. Members are offered a 90-day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.~~

- ~~~~
- Diabetes Prevention Program – Eligible members 18 years old and older at risk of developing type 2 diabetes ~~with prediabetes~~ can participate in a yearlong evidence-based, lifestyle change program that promotes and focuses on emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes. An all-mobile app program is available for Medi-Cal members.
- Healthy Hearts, Healthy Lives – Members have access to a comprehensive heart health ~~prevention~~ toolkit ~~to learn how~~ to maintain a healthy heart.
- Digital Health Education -Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app~~.~~. T2X engages members in discussing health topics that are important to them~~.~~. T2X interventions guide members in learning how to access credible health education information and seek preventive health care services.
- myStrength Program – Members have access to an evidence-based, self-help resource that is available on-line or in a mobile app~~.~~. myStrength offers interactive, personalized modules that empower members to help manage their depression, anxiety, stress, substance use, chronic conditions, pain management and many other conditions.

The following resources are also available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, weight control~~healthy eating~~, diabetes, immunizations, dental care, breastfeeding, breast cancer, cervical cancer, ~~prenatal care,~~ exercise and more. These materials are available in threshold languages. Members may also access more than 4,000 topics relating to health and medication using Krames Online at www.calvivahealth.org.
- ~~Health Education Member Request Form – Members complete this pre-stamped form to request free health education resources in threshold languages available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line. They can also get CalViva Health's print resources at contracted providers offices.~~
- Health Education Programs and Services Flyer — This flyer contains information on all health education interventions offered to members and information on how to access them.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in threshold languages~~.~~. They are mailed to new members and are also available on www.CalvivaHealth.org~~.~~. These are available in English, Spanish and Hmong.
- Member Newsletter – ~~CalViva Health~~CalViva News is mailed to members once a year and covers various health topics and the most up-to-date information on health education interventions.

**MemberConnections® Program**

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

More specifically, MCRs:

- Conduct assessments to better understand members' needs such as the Health Risk Screening.
- Facilitate access to health services by scheduling medical appointments, helping members find doctors and specialists, and checking the status of referral authorizations.
- Assist with removing barriers to health care by arranging transportation and language services through the health plan vendors.
- Connect members to case management and ~~disease~~ chronic conditions management to better manage their chronic and/or complex health conditions.
- Identify and ~~A~~address SDoH ~~social~~ needs by linking members to county and community based organizations. ~~resources~~
- Help reduce health care costs by promoting preventive practices and educating members on how to use their benefits and appropriate utilization of health services.
- Support various outreach programs from the Health Plan. These include multiple Plan, Do, Study, Act and Performance Improvement Projects.
- Schedule and complete home visits for noncompliance members. These visits include benefit information, Emergency Department and Readmission diversion, as well as other high-risk issues.
- Follow-up and monitor the status of high-risk member referrals.

# D. *Clinical Practice Guidelines*

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

~~CalViva Health~~CalViva adopts guidelines from recognized organizations that develop or disseminate evidence-based clinical practice guidelines. These include professional medical associations, voluntary and other health organizations such as the National Institutes of Health (NIH) and the U.S. Preventive Services Task Force (USPSTF). Input from specialists is obtained as necessary and clinical practice guidelines are reviewed and approved by Health Net's Medical Directors, (through the Health Net Medical Advisory Council), network practitioners, and ~~CalViva Health~~CalViva's CMO and the QI/UM Committee. The guidelines are updated and revised at least every two years or more frequently when new scientific evidence or national standards are published.

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

# E. *Health Management Programs*

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

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

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

The PHM operations team is a cross-unit operations team composed of talent from multiple departments and is led by a core team of a Medical Director and a Pharmacist. The team is accountable to the QI/UM Committee.

**Chronic Conditions~~Disease~~ Management**
CalViva's chronic conditions ~~disease~~ management programs increase awareness of self-care strategies and empower participants to better manage their disease. ~~CalViva~~ The program targets high-risk members identified with chronic asthma, diabetes and heart failure conditions and encourages them to participate in the chronic conditions~~disease~~ management program. This program includes a population-based identification process, interventions based on clinical need, patient self-management, disease education, and process and outcome measurement. Multi-disciplinary teams are involved in the development of these efforts. Referrals to chronic conditions ~~disease~~ management programs are multichannel and come through provider, Case Management and member self-referrals.

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

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

orf the ER. ~~Nurse advice line nurses may access support from a physician when needed as the nurse interacts directly with the member.~~

## Adult Weight Management

Members ages 18 and older with a BMI of 25 or greater are eligible for the adult weight management program. Individualized care plans are developed based on the member's current health status, presence of co-morbidities, dietary intake, and physical activity limitations. Registered Dietitians (RDs) and exercise physiologists serve as program coaches. Themes introduced include behavior modification for weight loss and weight maintenance, nutritional counseling to assist weight loss goals, food preparation and portion control, food label reading, lifestyle approaches to physical activity, and tips for eating out. Members are offered unlimited inbound calls to program coaches and appropriate educational resources~~.~~.

### Raising Well - Pediatric Weight Management

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

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

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

### Audio Library

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

# F. Transition Care Management Program

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

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

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

1. Introducing the CTI to the member at the time of hospitalization
2. Use of other tools to transfer skills to patients and family members on how to communicate care needs effectively during direct encounters with their health care team
3. Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation, how to respond to medication discrepancies, and how to utilize a personal health record (PHR).
4. Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond
5. Follow-up calls with the member are conducted within 30 days of post-discharge, which focuses interventions on:

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

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

### Member Impact of TCM

The TCM Program has a positive impact on participating members, including outcomes such as:

- Improved ability to manage member care through coaching interventions. Increasing member engagement reduces the risk of adverse post discharge outcomes and/or readmissions.
- Increased member satisfaction, further strengthening CalViva's brand and market standing.
- Active participation of the member and/or the member's caregiver in the health care continuum. The member becomes more apt to take an assertive role in his/her own care.

- Increased problem-solving skills, proactive thinking and ability to anticipate issues,
- Increased ability to collaborate with clinical staff to address the member's ongoing needs
- Increased ability of clinical staff to understand member's psychosocial barriers and needs
- Improved access to member's contracted network resources, including PCP, specialist physicians, radiology, laboratory services, urgent care
- Improved organizational and time management skills

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

# G. *Case Management (CM) Program*

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

The goals of the CM program are:

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

This program seeks to identify and intervene with members:

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

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

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

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

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

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

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

# H. *Behavioral Health Services*

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

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

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

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

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

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

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

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

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

A. General Eligibility Criteria

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

B. Disease- Specific Eligibility Criteria

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

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

~~A.~~C. Pediatric Palliative Care Eligibility Criteria

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

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

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

Palliative care services shall include the following services:

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

Referrals can come from multiple sources. This may include:

- Internal health plan case managers and concurrent review nurses
- Primary Physician Groups (PPG)
- Member's Primary Care Physicians and Specialists
- Palliative Care Vendors/Providers
- Hospitals
- Internal Claims Data
- California Children's Services (CCS) Program

# J. *Credentialing / Recredentialing*

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

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

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

# K. *Continuity and Coordination of Care*

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

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

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

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

For all members with identified complex health needs, CalViva supports their continuity and coordination of care through an integrated healthcare model that provides the level of care management the member needs based on acuity and includes the care management of behavioral health conditions. Nurse advice line also addresses member triage needs 24 hours a day, seven days a week. ~~Other programs such as disease management and nurse advice line are also available to members and can help those with complex needs manage their conditions.~~ Provider groups also support members through their coordination of care programs.

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

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

# L. Delegation

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

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

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

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

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

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

# M. —*Safety*

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

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

Mechanisms for communication include:

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

# N. ~~–~~*Health Plan Performance*

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

CalViva ~~adopts and~~ maintains a broad range of key performance metrics to monitor clinical and service quality in Medical Management, Appeals & Grievances, ~~Disease Management,~~ Ca~~r~~se Management, Chronic Conditions Management, Customer Service, Population Health Management, Concurrent Review and the Medical Review Unit. CalViva's QI Program also monitors key performance metrics for Pharmacy and MHN Services (MHNS)~~.—~~.

# O. *Satisfaction*

~~CalViva Health~~CalViva continuously monitors member ~~satisfaction~~ experience throughout the year using the ~~CAHPS survey results~~Access Survey results and monitoring member pain points~~,~~ (member appeals and grievances~~).,~~ ~~and CMS complaint tracking modules (CTMs). CAHPS~~Access survey results are integrated into ~~various state and federal performance rating systems and reports including the following:~~

~~Office of the Patient Advocate Report Cards~~
DHCS Medi-Cal Managed Care Quality Improvement Reports. Results from the bi-annual CAHPS survey conducted by DHCS are also reviewed to track member experience improvement and include in the Population Needs Assessment Report.

~~Q~~Improvement activities are focused on educating CAHPS stakeholders and measure owners, partnering with operational areas to implement initiatives and leading quarterly CAHPS Steering Committees. The CAHPS Program Managers meet ~~and implementing improvement activities. Quality Improvement partners~~ with several business areas including Medical Management, Customer Contact Center, Appeals and Grievances, Pharmacy, ~~Claims, Credentialing,~~ Provider Network Management, Provider ~~Engagement Performance Management (PEPM~~ Relations~~)~~, Delegation Oversight, Sales, Marketing, and MHNS. ~~Annually, QI analyzes data and documents and reports to stakeholders the integrated member satisfaction reports required to support an improved member experience.~~

Member materials are assessed to ensure that prospective member and enrollment information includes details on the benefit plan, obtaining primary and specialty care, and how to voice a complaint and submit an appeal. In addition, members receive various communications that highlight general medical information and other focused activities.
~~The Quality Improvement department partners with the Customer Experience team (CXCI) to improve operational and organizational processes. The CXCI team has several initiatives underway including:~~

- ~~Implementation and monitoring of the Net Promoter Score (NPS)~~
- ~~Member Contact Data: Identification of an approach for collecting and storing member contact information and communication preferences.~~
- ~~Member Orchestration: Creation of a holistic approach to the member experience by communicating via their preferred methods. Development of digital member communication journey from enrollment to retention.~~
- ~~Value stream mapping to improve work flow and information processing in Utilization Management, Case Management, and Population Health~~
- ~~Welcome Experience: Launching a redesigned CalViva Welcome Kit and member onboarding materials.~~

# P. *Access and Availability*

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

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

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

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

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

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

# Q. *Member Rights and Responsibilities*

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

Member rights include the right to:

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

Member responsibilities include:

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

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

# R. *Medical Records*

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

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

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

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

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

# S. Health Equity and Cultural and Linguistic Needs

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

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

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

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

- Develops and implements Policies and Procedures (P&Ps) related to the delivery of culturally and linguistically appropriate services
- Utilizes and implement the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health, to address Health Care disparities
- Collects and analyzes C&L information and requirements as identified by DMHC and DHCS and other regulatory or oversight entities
- Collects, analyzes and reports membership language, race and ethnicity data in reports such as the Population Needs Assessment (PNA)
- Informs members of interpreter services via the member newsletter, the Member Handbook/Evidence of Coverage (EOC), and other communication sources at least once annually
- Maintains information links with the community through Public Policy Committee (PPC) meetings, Population Needs Assessment (PNA) and other methods
- Informs contracted providers annually of the C&L services available via Provider Updates, online newsletter articles, the Provider Operations Manual, in-services, trainings, conferences, and other communication sources

- Engage community-based organizations, coalitions, and collaborative in counties where ~~CalViva Health~~CalViva members reside and be a resource for them on C&L issues
- Participate actively and leverage resources from community and government committees including Health Industry Collaboration Effort (HICE) and America's Health Insurance Plans (AHIP)
- Provide health equity and C&L services that support member satisfaction, retention, and growth

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

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

# IV.

# QI Process

# A. *Confidentiality / Conflict of Interest*

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

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

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

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

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

# B. *QI Process*

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

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

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

- HEDIS®, ~~CAHPS®,~~annual Access Survey, ~~and~~ SWBHC~~,~~ rates, and national and regional benchmarks and goals
- Local and state required improvement projects
- Concordance with plan initiatives (~~e.g.~~e.g., ~~disease~~ chronic conditions management programs)
- QI programs identified through community collaborative activities
- Patterns of inappropriate utilization
- Cultural or linguistic makeup of membership causing gaps in care
- Health Outcome disparities
- Appeals and grievance/customer service rates
- Member and provider survey results regarding satisfaction, access and availability, and coordination of care

Selection of topics takes into account:

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

Data collected to support the CalViva QI process include:

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

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

# V.

# Program Structure and Resources

# A. *QI Committees*

## *Governing Body/RHA Commission*

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

RHA Commission functions:

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

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

The CalViva QI/UM Committee meets at least quarterly and monitors the quality and safety of care and services rendered to CalViva members and maintain records of its quality improvement activities. Quality of care and service is defined as medical care and service which is accessible, meets CalViva standards of performance, is provided in the most timely and appropriate setting, and results in a high level of member satisfaction and improved health outcomes. This Committee identifies opportunities for improvement, recommends and oversees policy decisions and changes, evaluates the results of QI activities, institutes needed actions, and ensures follow up as appropriate. The Committee also ensures ~~practitioners~~providers, who are representative of specialties in the network (i.e.; behavioral health, SPD and members with chronic conditions), participate in the planning, design, implementation and review of the CalViva QI Program. This Committee is accountable to and provides reporting to the RHA Commission on a quarterly basis. Membership of the CalViva QI/UM Committees includes practicing practitioners.

CalViva QI/UM Committee has the following subcommittees:

- Credentialing and Peer Review Sub-Committees

## *Credentialing and Peer Review Sub-Committees*

The RHA Commission has final authority for the Credentialing and Peer Review Programs. The CMO receives recommendations regarding policies, processes and standards from the Credentialing and Peer Review Sub-Committees. The Chairperson of the Credentialing and Peer Review Sub-Committees is responsible for the Credentialing and Peer Review Sub-Committees operations, including, but not limited to,

communicating committee decisions to network practitioners and providers, maintaining committee protocol, and signing and enacting credentialing and peer review policies. The CalViva QI/UM Committee, through annual approval of the Credentialing Program and quarterly reports supplied by the Credentialing and Peer Review Sub-Committees, provides program oversight.

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

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

# B. *QI Workgroups*

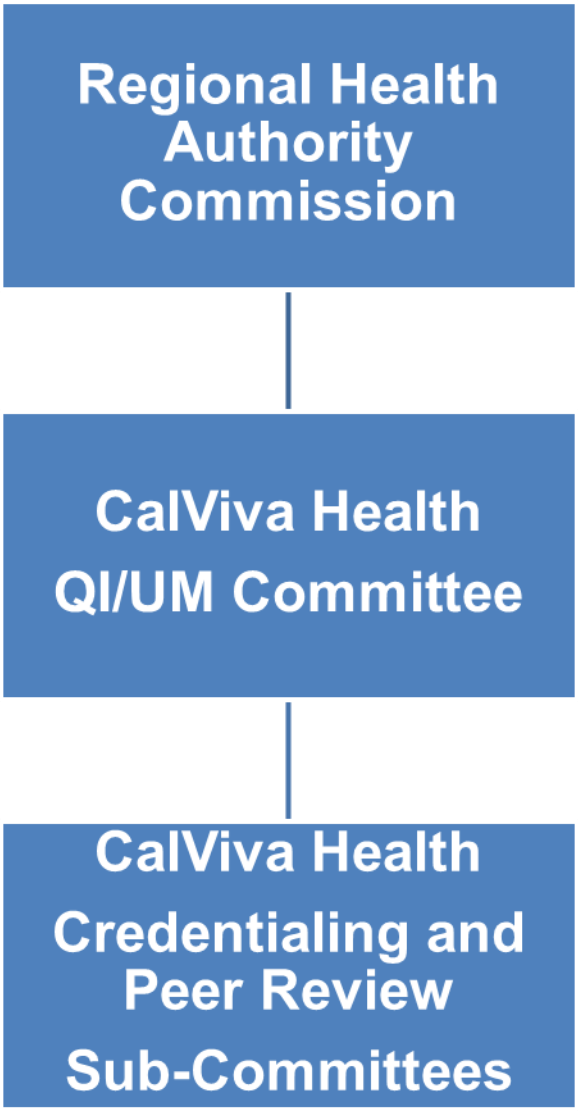
## *QI/UM Operational Workgroup*

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

## *Access Workgroup*

The CalViva Access Workgroup brings together representatives from CalViva and multiple HNCS departments that have access and network adequacy related functions~~.~~ . The function of the workgroup is to review findings from ongoing monitoring of access to Health Plan services, identify gaps, and develop and evaluate implementation of activities in collaboration with HNCS representatives to improve access to care services~~.~~ . The Access Workgroup will report recommendations and findings to the QI/UM Workgroup.

***Committee Organizational Chart***



# C. *Staff Resources and Accountability*

### *CalViva Chief Medical Officer*

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

### *Regional Medical Director*

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

### *Behavioral Health Medical Director*

The Behavioral Health Medical Directors are involved with the delegated behavioral health care aspects of the QI clinical program for CalViva members, including reviewing all potential quality concerns. They are responsible for ensuring delegated behavioral health clinical services for members are administered in a manner consistent with accepted standards of care and provides direction and oversight for clinical quality improvement activities. Results are reported to CVH's QI/UM.

### *Department Resources*

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

### *QI Team*

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

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

CalViva delegates DHCS's required PCP Facility Site and Medical Record Reviews and Physical Accessibility Review Surveys (PARS) to HNCS. Per Medi-Cal Managed Care Division (MMCD) Policy Letters 14-004, 12-006, ~~and~~ APL 15-023 and~~,~~ 21-011, HNCS collaborates with other Medi-Cal Plans to develop and maintain a standardized system-wide process for conducting reviews of Primary Care Physician (PCP) facility sites and medical records~~.~~. PARS are conducted for PCPs and high volume specialists (including behavioral health), ancillary providers, CBAS providers and hospitals. Collaboration with other

Medi-Cal Plans minimizes FSR and PARS duplication and supports consolidation of FSR and PARS surveys. The FSR/PARS process uses evaluation criteria and guidelines in compliance with the DHCS contractual requirements and is applicable to all Health Plans participating in the MMCD process~~.~~.

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

### *Health Education*

CalViva and HNCS staff provide health education programs, materials, and services to CalViva members based on community health, cultural, and linguistic needs in order to encourage members to practice positive health and lifestyle behaviors, and to use appropriate preventive care and primary health care services~~.~~. Health education services include individual, group and community-level education, and support by trained health educators. Under the oversight of CalViva, the Health Education Department (HED), in coordination with Health Equity and Quality Improvement Departments, conduct a population needs assessment annually. Assessment results are used to develop health education, culturally and linguistic, and quality improvement priorities and annual work plans.~~and support community needs assessments and work plans based on the results of the assessments. Based on cultural and linguistic needs of the membership, CalViva, with HNCS's assistance, implements preventive care programs, such as diabetes prevention, weight management, tobacco cessation and prenatal/postpartum education, at varying intervention levels such as individual, group and community level.~~

### *Pharmacy Services*

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

### *Grievances and Appeals*

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

### *Credentialing/Recredentialing*

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

### *Utilization Management/Medical Management*

CalViva's Chief Medical Officer is ultimately responsible for the design, implementation and monitoring of the effectiveness of utilization and medical management programs. A systematic approach is used by

CalViva, with the assistance of HNCS staff, to identify and manage members who are currently accessing inpatient or ambulatory health care services. HNCS Healthcare Services Department and medical management team partner with contracted practitioners and member/family and/or caregivers to monitor, to evaluate and to facilitate continuity and coordination of care among CalViva's members. Utilization/Medical Management staff interfaces with the QI staff in development, management and assessment of programs designed to improve the health of CalViva members. HNCS UM Department prepares and presents reports to the CalViva QI/UM committee at each meeting and presents a semi-annual and annual report on the UM Workplan~~.~~ . HNCS seeks input from the CalViva QI/UM committee and RHA Commission prior to preparing the annual Work Plan~~.~~ .

### *Customer Contact Centers*

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

### *Provider Network Management*

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

### *Delegation Oversight*

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

### *HEDIS® Management and Clinical Reporting*

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

# VI.

# Program Evaluation and Work Plan

# A. *Review and Oversight*

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

# B. *Annual QI Evaluation*

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

# C. *Annual QI Work Plan*

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

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

# VII.

# Approval

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

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

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

Date

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

Date

# Item #4

## Attachment 4.B

2022 Quality Improvement Work Plan


# CalViva Health Quality Improvement Work Plan 2022

03/11/2022

# CalViva Health 2022 Quality Improvement Work Plan

## TABLE OF CONTENTS

# CalViva Health 2022 Quality Improvement Work Plan

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

# CalViva Health 2022 Quality Improvement Work Plan

## I. Purpose

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

## II. CalViva Health Goals

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

## III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2022. The development of this document requires resources of multiple departments.

# CalViva Health 2022 Quality Improvement Work Plan

**Glossary of Abbreviations/Acronyms**

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

# I. ACCESS, AVAILABILITY, & SERVICE

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

| **Rationale and Aim(s) of Initiative** |
|---|
| Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. Assessing practitioner compliance with access standards and surveying members allows the identification of areas for improvement. |
| **Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.** |
| Timely Appointment Access to Primary Care Physicians and Specialists is measured through eight metrics. The specific goal is 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<br>Q1 – Provider Webinar Trainings<br>Q3 – MY 2022 Survey Prep<br>Q3 – MY 2021 Survey Results | CVH/HN |
| Conduct provider training webinars related to timely access standards and surveys. | P | Q1-Q4 | CVH/HN |
| Conduct Telephone Access surveys annually to monitor provider office answer time and member callback times. | P | 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 | Q3-Q4 | CVH/HN |
| Complete a CAP as necessary when CalViva Health 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 | Q2-Q4 | CVH/HN |

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

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), 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)**

| Measure(s) | Performance Goal | Rate (%) MY 2020 | Rate (%) MY 2021 (Populated mid-year) | Baseline Value Source | Baseline Value (%) MY 2019 |
|---|---|---|---|---|---|
| Overall Combined:<br>Urgent Care – PCP & SCP<br>Non-Urgent Care – PCP & SCP | 90% | Urgent = 55.9 (-4.4)<br>Non-Urgent = 81.9 (3.2)<br>Prenatal = 85.3 (-4.8) | Urgent =<br>Non-Urgent =<br>Prenatal = | CVH Performance MY 2019 | Urgent = 60.3<br>Non-Urgent = 78.7<br>Prenatal = 90.1 |

| | | | | | |
|---|---|---|---|---|---|
| First Visit – PCP or SCP Prenatal | | | | | |
| Urgent Care Services that do not require prior authorization (PCP) – Appointment within 48 hours of request | 90% | Overall= 68.9 (-2.0)<br>Fresno= 71.3<br>Kings= 58.9<br>Madera= 67.7 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=70.9<br>Fresno=71.9<br>Kings=67.3<br>Madera=70.3 |
| Urgent Care Services that require prior authorization (SCP) – Appointment within 96 hours of request | 90% | Overall=44.4 (-7.8)<br>Fresno= 47.0<br>Kings= 38.5<br>Madera= 39.0 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=52.2<br>Fresno=53.8<br>Kings=42.3<br>Madera=50.9 |
| Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request | 90% | Overall= 85.9 (1.2)<br>Fresno= 83.7<br>Kings= 91.1<br>Madera= 93.9 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=84.7<br>Fresno=85.5<br>Kings= 84.9<br>Madera= 79.5 |
| Non-Urgent Appointments with Specialist – Appointment within 15 business days of request | 90% | Overall= 78.4 (3.0)<br>Fresno= 78.1<br>Kings= 82.5<br>Madera= 77.5 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=75.4<br>Fresno=77.1<br>Kings=64.3<br>Madera=74.2 |
| First Prenatal Visit (PCP) – Within 2 weeks of request | 90% | Overall= 87.1 (-1.3)<br>Fresno= 86.7<br>Kings= 94.7<br>Madera= 71.4* | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=88.4<br>Fresno=90.0<br>Kings=91.3<br>Madera=70.0 |
| First Prenatal Visit (SCP) – Within 2 weeks of request | 90% | Overall= 80.9 (-10.3)<br>Fresno= 81.8<br>Kings= 57.1*<br>Madera= 100* | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=91.2<br>Fresno=90.3<br>Kings=100*<br>Madera=NR |
| Well-Child Visit with PCP – within 10 business days of request | 90% | Overall= 80.9 (4.0)<br>Fresno= 77.1<br>Kings= 97.1<br>Madera= 87.5 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=76.9<br>Fresno=77.5<br>Kings=79.6<br>Madera=70.3 |
| **Measure(s)** | **Performance Goal** | **Rate (%) MY 2020** | **Rate (%) MY 2021 (Populated mid-year)** | **Baseline Value Source** | **Baseline Value (%) MY 2019** |
| Physical Exams and Wellness Checks – within 30 calendar days of request | 90% | Overall= 89.0 (1.2)<br>Fresno= 86.7<br>Kings= 94.4<br>Madera= 100 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=87.8<br>Fresno=88.1<br>Kings=91.5^<br>Madera=81.6 |
| Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – | 90% | Overall= 100 (6.7)<br>Fresno= 100 | Overall=<br>Fresno= | CVH Performance | Overall=93.3<br>Fresno=90.9 |

| | | | | | |
|---|---|---|---|---|---|
| Appointment within 15 business days of request | | Kings= 100*<br>Madera=100* | Kings=<br>Madera= | MY 2019 | Kings=100*<br>Madera=100* |
| Appropriate After-Hours (AH) emergency instructions | 90% | Overall=96.0 (-1.9)<br>Fresno= 95.0<br>Kings= 99.1<br>Madera= 100 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=97.9<br>Fresno=97.9<br>Kings=99.0<br>Madera=96.1 |
| AH physician callback: Member informed to expect a call-back from a qualified health professional within 30 minutes | 90% | Overall= 84.2(-15.2)<br>Fresno= 85.4<br>Kings= 70.9<br>Madera=95.6 | Overall=<br>Fresno=<br>Kings=<br>Madera= | CVH Performance MY 2019 | Overall=99.4<br>Fresno=99.4<br>Kings=99.0<br>Madera=100 |

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

↑↓ Statistically significant difference between RY 2021 vs RY 202, p<0.05.

NR – No reportable data.

| **Section D. Year-end Evaluation—Overall Effectiveness/Lessons Learned/Barriers Encountered** | |
|---|---|
| **Analysis: Intervention Effectiveness with 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 Health is monitored in two ways:

1. **CalViva Health 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 MY 2019 Result Rates: October 2019 – April 2020
    ii. Look-back Period for MY 2020 Result Rates: October 2020 – April 2021
e. Results: Final results are shared with CalViva Health & 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 MY 2019 Result Rates: August 2018 – May 2019
    ii. Look-back Period for MY 2021 Results Rates: August 2021 – May 2021
e. Results: Results are posted on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfCAHPS.aspx

The CalViva Health 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 Health 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 Health 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 Health 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 Health 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)

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. Resource topics include: Appointment Scheduling Tip Sheet and Quick Reference Guide, Talking with my Doctor Guide, Interpreter Services Guide, Access Standards. | P | Q3 2022 | CVH/HN |
| Update the following articles and distribute in Member newsletter: Access standards, interpreter services, nurse advice line. | M | Q3 2022 | CVH/HN |
| Update (as needed) and conduct scaled-back member survey/Annual CalViva Health Access Survey to assess effectiveness of interventions implemented. Share and review results once they are made available. | M | Q1–Q2 2022 | 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 2022 | 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 |
| Prepare and coordinate all needed requirements for CalViva Health to launch regulatory CAHPS Survey in Q1 2023. | M | Q4 2022 | CVH/HN |
| Launch Provider Training Series Pilot: trainings will cover several topics related to | P | Q1 2022 | CVH/HN |

| | | | |
|---|---|---|---|
| member experience/CAHPS and will be offered in different formats (Lunch & Learn Sessions, On-Demand Videos). | | | |
| CAHPS Tip Sheet: Provider Tip Sheet highlighting the importance of CAHPS, member experience, and best practices of major CAHPS measures. | P | Q2 2022 | CVH/HN |
| On-Demand Provider Training Series: Short video trainings that providers can access anytime, on-demand. 4 topics will include: Motivational Interviewing, Patient Empathy, Cultural Competency, Psychotropic Medications (Behavioral Health focus) | P | Q2 2022 | CVH/HN |

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

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)**
**Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)**
**Section C: Evaluation of Effectiveness of Interventions - Evaluation Period, Analysis (due Q3 2022)**

| **CalViva Health Access Survey Measure(s)** | **Specific Goal** | **MY 2019** | **MY 2020** | **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** | **MY 2018** | **MY 2020** | **Baseline Source** (Source: Quality Compass Percentiles) | **Baseline Value** |
| Getting Needed Care | Meet or Exceed Quality Compass 50th Percentile | 69.10% | 79.9% | MY 2021 50th Percentile | 83.0% |
| Getting Care Quickly | Meet or Exceed Quality Compass 50th Percentile | 73.31% | 76.1% | MY 2021 50th Percentile | 82.3% |

| | | | | | |
|---|---|---|---|---|---|
| How Well Doctors Communicate | Meet or Exceed Quality Compass 50th Percentile | 86.52% | 85.8% | MY 2021 50th Percentile | 93.2% |
| Customer Service | Meet or Exceed Quality Compass 50th Percentile | NA | NA | MY 2021 50th Percentile | 89.3% |
| Rating of All Health Care | Meet or Exceed Quality Compass 50th Percentile | 63.41% | 72.2% | MY 2021 50th Percentile | 76.4% |
| Rating of Personal Doctor | Meet or Exceed Quality Compass 50th Percentile | 75.46% | 77.8% | MY 2021 50th Percentile | 83.5% |
| Rating of Health Plan | Meet or Exceed Quality Compass 50th Percentile | 73.35% | 75.9% | MY 2021 50th Percentile | 78.5% |
| Rating of Specialist | Meet or Exceed Quality Compass 50th Percentile | 74.44% | NA | MY 2021 50th Percentile | 83.9% |

| **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: Cervical Cancer Screening (CCS)** | | | | |
| ☒ **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 increase treatment choices and improve survival rates of CalViva Health members in Fresno County who are diagnosed with cervical cancer through early detection.
**Rationale:** Screening is looking for cancer before a person has any symptoms. This can help find cancer at an early stage. When abnormal tissue or cancer is found early, it may be easier to treat. By the time symptoms appear, cancer may have begun to spread.

Key Points:

- Cervical cancer is a disease in which malignant (cancer) cells form in the cervix.
- Screening for cervical cancer using the Pap test has decreased the number of new cases of cervical cancer and the number of deaths due to cervical cancer since 1950.
- Human papillomavirus (HPV) infection is the major risk factor for cervical cancer.

Cervical dysplasia occurs more often in women who are in their 20s and 30s. Death from cervical cancer is rare in women younger than 30 years and in women of any age who have regular screenings with the Pap test. The Pap test is used to detect cancer and changes that may lead to cancer. The chance of death from cervical cancer increases with age. In recent years, deaths from cervical cancer have been slightly higher in Black women younger than 50 years than in White women younger than 50 years. Deaths from cervical cancer are almost twice as likely in Black women older than 60 years than in White women older than 60 years.

Although most women with cervical cancer have the human papillomavirus (HPV) infection, not all women with HPV infection will develop cervical cancer. Many different types of HPV can affect the cervix and only some of them cause abnormal cells that may become cancer.

Other risk factors for cervical cancer include:

- Giving birth to many children.
- Smoking cigarettes.
- Using oral contraceptives
- Having a weakened immune system.[1]

Cervical cancer can be prevented with detection and treatment of precancerous cell changes caused primarily by high-risk types of human papillomavirus (hrHPV), the causative agents in more than 90% of cervical cancers. Effective screening and treatment for precancerous lesions are associated with low rates of cervical cancer mortality in the United States.[2]

[1] NIH National Cancer Institute (2021). Cervical Cancer Screening (PDQ®)-Patient Version. https://www.cancer.gov/types/cervical/patient/cervical-screening-pdq#_7

[2] U.S. Task Force Preventive Services (2018). Cervical Cancer: Screening https://www.uspreventiveservicestaskforce.org/uspstf/document/evidence-summary/cervical-cancer-screening#bootstrap-panel--3

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

The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21-64 years of age who had cervical cytology performed within the last 3 years.
- Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.

Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) contesting within the last 5 years.
At the targeted high volume, low performance clinic.

**Planned Activities**

| Activities | Target of Intervention: Member (M) / Provider (P) | Timeframe for Completion | Responsible Party(s) |
|---|---|---|---|
| Work with a high volume, low compliance clinic in Fresno County to improve CCS screening rates. | P/M | Q1-Q2 | CVH/HN |
| Conduct regular meetings with Fresno County provider to plan improvements to increase the frequency of CCS screenings in women. | P | Q1-Q2 | CVH/HN |
| Using a call script for outreach and education to members, 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 |

| | | | |
|---|---|---|---|
| Members will be mailed a letter after three unsuccessful phone attempts have been made. | P/M | Q1-Q2 | CVH/HN |
| Work with targeted provider to develop a second intervention to address women we have been unable to reach (voicemail left, initial refusal) and newly eligible to further increase testing rate at the clinic and in Fresno County. | M | Q1-2 | CVH/HN |

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

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

| Measure(s) | Specific Goal | Rate MY 2020 | Rate MY 2021 | Baseline Source | Baseline Value |
|---|---|---|---|---|---|
| HEDIS CCS Screening in Women (CCS) – County Goal | Meet or Exceed DHCS 50th Percentile 61.31% | Fresno: 60.42% | | MY 2021 HEDIS Data | 61.31% |
| HEDIS CCS Screening – Provider Goal | By 2/15/2022 increase rate to 55.35%<br>By 06/15/2022 increase rate by an additional 10% | Fresno: 46.50% | | MY 2021 Provider Results | 44.1% |

| **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** |

| **Section A: Description of Intervention (due Q1)** |
|---|
| **2-2: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC) PDSA** |
| ☒ **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<br>Health Net Health Education Department |

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

**Overall Aim:** The overall aim is to assist CalViva Health diabetic members to control and maintain their blood glucose levels within a healthy range, thereby minimizing the long-term risks and complications associated with this highly prevalent chronic disease. This can be accomplished through basic diabetes education, routine testing, lifestyle changes, healthy behaviors and optimal medication management.

**Rationale:** Our review of literature, internal and external data, and discussions (brainstorming sessions) with our new CalViva Health Diabetes- H9 Improvement Team indicates that many of the same issues remain, they have just been escalated by the Public Health Emergency. A high volume of CalViva Health members in Fresno County are noted to have blood glucose levels out of range (greater than 9%) or have not had any testing administered for HbA1c levels, with the COVID-19 pandemic likely to be a major contributing factor.

CalViva Health is committed to improving the quality of care for our diabetic population in Fresno County by increasing the frequency of HbA1c testing and screening for members who have difficulty with maintaining their glycated hemoglobin levels below 9%. For this PDSA cycle, we are targeting Fresno County because it was the poorest performer in MY 2020 with the highest rate increase (CDC-H9 is an inverse measure, so a rate increase indicates poorer performance) of 7.43% from the previous year (MY 2019), as seen in Table 1.

**Table 1: CalViva Health CDC-H9 County Rates for MY 2019 and MY 2020**

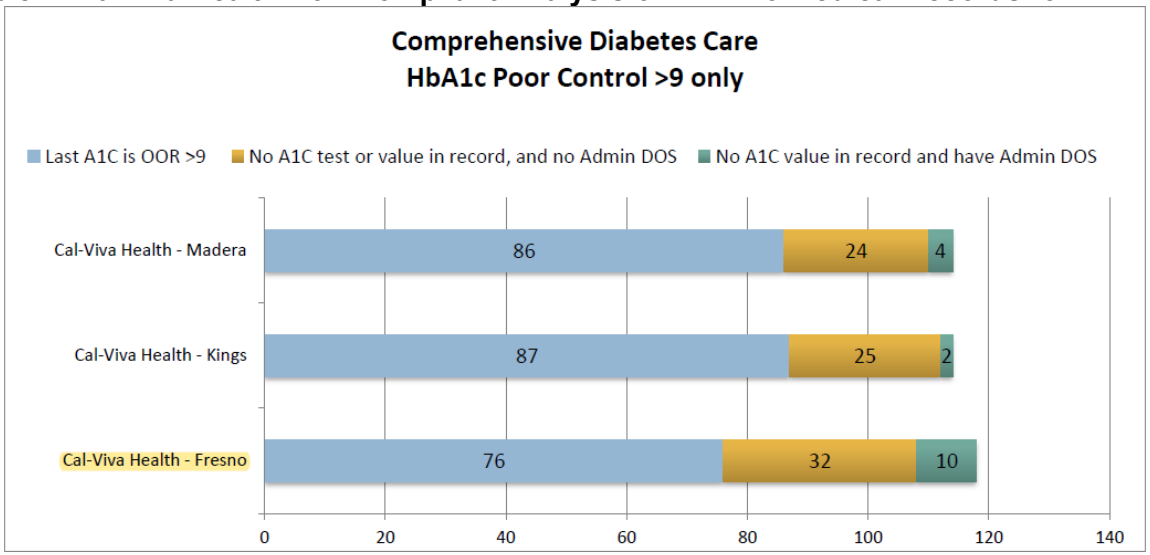
**Comprehensive Diabetes Care (CDC) HbA1C Poor Control >9**

| Population | MY 2019 Rate | MY 2020 Rate | Rate Change From Prior Year | Goal 50th Percentile | Records to Hit Goal |
|---|---|---|---|---|---|
| Cal-Viva - Fresno | 34.06 % | 41.49 % | 7.43 | 37.47 % | 16 |
| Cal-Viva - Kings | 35.77 % | 35.00 % | - 0.77 | 37.47 % | 9 |
| Cal-Viva - Madera | 36.25 % | 40.63 % | 4.38 | 37.47 % | 13 |

** Per NCQA: A lower rate indicates better performance (i.e. low rates...indicate better care).*

Fresno County also had the highest proportion of noncompliant members who were not screened or tested for HbA1c in MY 2021 as seen in Table 2 below. Twenty-seven percent of non-compliant members in Fresno County did not have a HbA1c test in MY 2020, compared to 22% of members in Kings County and 21% in Madera County. These issues were likely a result of the various COVID-19 challenges affecting provider offices (decreased staff capacity, office closures, etc.) and hesitancy from members who feared they would contract the virus despite all preventative measures in place at provider offices.

**Table 2: CalViva Health Non-Compliant Analysis of CDC-H9 Medical Records for MY 2020**




CalViva Health Primary Reasons for CDC-H9 Noncompliance in MY 2020:

- The most common reason was the member's last A1c for the measure year was out of range ( > 9.0%)
- Secondly, members did not have an A1c test performed during the measurement year

We chose Clinica Sierra Vista as the target clinic for our Planned Care Visit intervention because Clinica Sierra Vista is one of the largest providers in Fresno County and they demonstrated the lowest compliance rate among FQHCs for this measure. Within the FQHC, we selected the West Fresno location because they had the second lowest compliance rate of 61.5% in MY 2020, which subsequently continued to decrease going into MY 2021, as reflected in Tables 3 and 4 below.

**Table 3: Clinica Sierra Vista Fresno County CDC-H9 Compliance Rates for MY 2020 – MY 2021**

| | MY 2020 MPL = 37.47%* | MY 2021 YTD (9/2021) MPL = 37.47%* | | |
|---|---|---|---|---|
| Clinica Sierra Vista Locations – Fresno County | Final Rate | YTD Rate | Denominator | Gaps to 50th |
| CSV - ELM COMMUNITY HEALTH CENTER FC | 55.9% | 63.3% | 708 | 183 |
| CSV - REGIONAL MED. COMMUNITY HLTH C | 59.2% | 64.6% | 362 | 99 |
| CSV – ORANGE AND BUTLER COMMUNITY HEALTH CT | 54.7% | 56.7% | 156 | 53 |
| CSV - SHAW COMMUNITY HEALTH CENTER F | 65.9% | 72.2% | 91 | 44 |
| CSV – WEST FRESNO COMMUNITY HEALTH C | 61.5% | 72.6% | 82 | 40 |

**Table 4: Clinica Sierra Vista CDC-H9 Patients by HbA1c Levels**
**West Fresno Community Health Center MY 2021 (7/21)**

| HbA1c Level | | Raw Numbers |
|---|---|---|
| Latest A1c Uncontrolled >9 | | 19 |
| Latest A1c Uncontrolled >10 | | 4 |
| Latest A1c Uncontrolled >12 | | 5 |
| Latest A1c Result Not Available | | 55 |

Note: Table 3 and table 4 do not reconcile exactly due to different report run dates. However, both tables indicate a need for HbA1c testing and improved results.

| |
|---|
| **Description of Outcome Measures Used to Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.** |
| Utilize the Planned Care Visit Workflow intervention to reduce the number of diabetic members with Poor control (HbA1c >9%) assigned to provider partner clinic, in Fresno County by first obtaining current HbA1c testing for at least 60% of this target population from a baseline testing rate of 34%.<br><br>Reduce the number of members with HbA1c Poor Control (>9.0%) in the targeted population. |

**Planned Activities**

| Activities | Target of Intervention: Member (M) / Provider (P) | Timeframe for Completion | Responsible Party(s) |
|---|---|---|---|
| Collaborate with a high volume, low compliance clinic in Fresno County to improve HbA1c testing rates among noncompliant diabetic members (HbA1c > 9%) | P/M | Q1-Q2 | CVH/HN |
| Conduct regular meetings with the Fresno County provider and staff, to discuss improvement plans for increasing the frequency of HbA1c testing for members | P | Q1-Q2 | CVH/HN |
| Using a call script for member outreach and education, and to facilitate completion of member HbA1c testing, via 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 HbA1c testing. The Profile will facilitate documentation of each member outreach attempt and test completion. | P/M | Q1-Q2 | CVH/HN |

| | | | |
|---|---|---|---|
| Shifting our PDSA focus in Cycle 2 from obtaining HbA1c tests, to changing lifestyle behaviors and drawing meaningful insight from our target population. New intervention will prioritize more emphasis on lowering A1c levels for members with values greater than 9%. CalViva Health will be collaborating with a clinic provider at CSV-West Fresno, who has a panel of diabetic members eligible to receive case management and registered dietician support. | M | Q1-Q2 | CVH/HN |

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

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

| Measure(s) | Specific Goal | Rate MY 2020 | Rate MY 2021 | Goal 50th Percentile | Baseline Source |
|---|---|---|---|---|---|
| HEDIS Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC H9) – County Goal | Meet or Exceed DHCS 50th Percentile 37.47% | Fresno: 43.88% | | 37.47% | MY 2021 HEDIS Data |
| HEDIS Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) – Provider Goal | Obtain current HbA1c testing for at least 60% of this target population from a baseline testing rate of 34%. | Fresno: 61.50% | | 37.47% | MY 2021 Provider Results |

**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 |
|---|---|---|---|

# 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 Health members in Fresno County who are diagnosed with breast cancer through early detection.

**Rationale**: Finding breast cancer early and getting state-of-the-art cancer treatment are the most important strategies to prevent deaths from breast cancer. Breast cancer that is found early, when it is small and has not spread, is easier to treat successfully. Getting regular screening test is the most reliable way to find breast cancer early. Breast cancers found during screening exams are more likely to be smaller and still confined to the breast. The size of a breast cancer and how far it has spread are some of the most important factors in predicting the prognosis of a woman with this disease (American Cancer Society, 2021). The COVID-19 pandemic has resulted in many elective procedures being put on hold, and this has led to a substantial decline in cancer screening. Health care facilities are providing cancer screening during the pandemic with many safety precautions in place (American Cancer Society, 2021).[1]

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 reported barriers were perceived pain from the screening and embarrassment. Lack of physician recommendation was the most identified social barrier (Miller et al., 2019).[2]

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 (Kue et al., 2014).[3]

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[1]American Cancer Society (2021). American Cancer Society Recommendations for the Early Detection of Breast Cancer. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations

[2] 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
[3] 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 2021 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 28.46% to a goal rate of 47.8%.

**Planned Activities**

| Activities | Target of Intervention: Member (M) / Provider (P) | Timeframe for Completion | Responsible Party(s) |
|---|---|---|---|
| Continue to work with a high volume, low compliance 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 Southeast Asian BCS non-compliant CalViva Health members. The educational event will be held at the cultural center, which will include a video in the Hmong language to address health literacy barriers among the Hmong population, testimonials of breast cancer survivors, transportation presentation, and raffle items. CVH will continue to implement a Member Friendly Approach by having providing a warm welcoming atmosphere at the event that addresses cultural and language issues, and other potential barriers. | M | Q1-Q4 | CVH/HN |
| Update Key Driver Diagram with potential interventions (Module 4). | P/M | Q1-Q4 | CVH/HN |
| Implement and test interventions with the clinic which includes PDSA cycles (Complete Module 3) | P | Q2-Q4 | CVH/HN |
| Health Education to distribute educational materials on the importance of breast cancer screening to members | M | Q2-Q4 | CVH/HN |

| | | | |
|---|---|---|---|
| at the educational sessions, cultural center, and women's imaging center. | | | |
| Implement provider incentives to support gap closure and improve HEDIS rates for BCS. | P | Q1-Q4 | CVH/HN |
| Implement member incentive for breast cancer screening to support mammogram completion. | 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: mobile mammography with on-site interpreters, and transportation services (Member Friendly Approach) at clinic sites. | M | Q1-Q4 | CVH/HN |

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

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)**
**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 2022)**

| Measure(s) | Specific Goal | Rate MY 2020 | Rate MY 2021 | Baseline Source | Baseline Value |
|---|---|---|---|---|---|
| HEDIS Breast Cancer Screening – County Goal | Meet or Exceed the MPL (50th Percentile) 58.82% | Fresno: 52.64% | | MY 2021 HEDIS Data | 55.26% |
| HEDIS Breast Cancer Screening – Provider Goal | Meet or Exceed SMART Aim Goal of 47.8% | Fresno: 44.25% | | MY 2021 Provider Results | 28.46% |

**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** |

| 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**: Childhood vaccines or immunizations can seem overwhelming when you are a new parent. Vaccine schedules recommended by agencies and organizations, such as the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians cover about 14 different diseases. Vaccinations not only protect your child from deadly diseases, such as polio, tetanus, and diphtheria, but they also keep other children safe by eliminating or greatly decreasing dangerous diseases that used to spread from child to child (Stanford Children's Hospital, 2021).

According to the U.S. Health and Human Services, there are 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, 2021).[2]

Centers for Disease Control and Prevention, (CDC), report released in May 2020 found a troubling drop in routine childhood vaccination because of families staying at home. CDC and the American Academy of Pediatrics (AAP) recommend that children stay on track with their well-child appointments and routine vaccinations even during the pandemic. As in-person learning, and play become more common, on-time vaccinations is even more urgent to help provide immunity against 14 serious diseases (CDC, 2021).[3]

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] Standford Children's Hospital. (2021). Why Childhood Immunizations Are Important
https://www.stanfordchildrens.org/en/topic/default?id=why-childhood-immunizations-are-important-1-4510

[2] United States Department of Health and Human Services. (2021). Five Important Reasons to Vaccinate Your Child.
https://www.hhs.gov/immunization/get-vaccinated/for-parents/five-reasons/index.html

[3] Centers for Disease Control and Prevention. (2021). NIIW (National Infant Immunization Week)
https://www.cdc.gov/vaccines/events/niiw/index.html

[4] 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.
This outcome measure will be monitored and reported for the targeted provider site and Fresno County using hybrid data.

**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 CIS -10 interventions and monitor effectiveness. | P | Q1-Q4 | CVH/HN |

| | | | |
|---|---|---|---|
| Update Key Driver Diagram with potential interventions (Module 4). | P | Q1-Q4 | 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 to support completion of childhood immunization 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 |
| Work with targeted provider to develop a second intervention: a Special Immunization Recurring Event. It will be convenient and culturally competent to support members in accessing childhood immunizations for children 0-2 years in Fresno County. | P/M | Q1-Q4 | CVH/HN |

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

**Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)**
**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 2022)**

| Measure(s) | Specific Goal | Rate MY 2020 | Rate MY 2021 | Baseline Source | Baseline Value |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Childhood Immunization Combo 10 – County Goal | Meet or Exceed the MPL (50th Percentile) 37.47% | Fresno: 32.36% | | MY 2021 HEDIS Results | 33.82% |
| Childhood Immunization Combo 10 – Provider Goal | Meet or Exceed SMART Aim Goal of 34.82% | Fresno: 19.76% | | MY 2021 Provider Results | 27.58% |

| **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** |

# IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

| Activity | Activity Leader | Mid-Year Update | Year End (YE) | | |
|---|---|---|---|---|---|
| | | | Complete? | Date | YE Update or Explanation *(if not complete)* |
| **WELLNESS/ PREVENTIVE HEALTH** | | | | | |
| 1. Distribute Preventive Screening Guidelines (PSG) to Members. | Health Education | | ☐ | | |
| 2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG). | CVH/HN | | ☐ | | |
| 3. Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management. | Care Management | | ☐ | | |
| 4. Promote Kick It California (formerly known as CA Smokers' Helpline) to smokers. | Health Education | | ☐ | | |
| 5. Promote Diabetes Prevention Program to members at risk of developing type 2 diabetes. | Health Education | | ☐ | | |
| 6. Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016. | Quality Improvement | | ☐ | | |
| **DISEASE/CHRONIC CONDITIONS MANAGEMENT** | | | | | |
| 1. Monitor Chronic Conditions Management Program for appropriate member outreach. | Chronic Conditions Management | | ☐ | | |
| **ACCESS, AVAILABILITY, SATISFACTION AND SERVICE** | | | | | |
| 1. C&L Report: Analyze and report on Cultural and Linguistics. | Health Equity | | ☐ | | |
| 2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s). | Access & Availability | | ☐ | | |
| 3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date. | Access & Availability | | ☐ | | |

| Activity | Activity Leader | Mid-Year Update | Year End (YE) | | |
|---|---|---|---|---|---|
| | | | Complete? | Date | YE Update or Explanation *(if not complete)* |
| 4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers. | Access & Availability | | ☐ | | |
| 5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars. | Access & Availability | | ☐ | | |
| 6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers. | Access & Availability | | ☐ | | |
| 7. DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY: Conduct quarterly education outreach to noncompliant providers identified by this survey. | Access & Availability | | ☐ | | |
| 8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review. | A&G | | ☐ | | |
| 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. | Health Education | | ☐ | | |
| 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. | Health Equity | | ☐ | | |
| 11. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report. | Quality Improvement | | ☐ | | |

| Activity | Activity Leader | Mid-Year Update | Year End (YE) | | |
|---|---|---|---|---|---|
| | | | Complete? | Date | YE Update or Explanation *(if not complete)* |
| 12. Engage with CVH provider offices to complete MY 2022 MCAS training focused on best practices for closing care gaps. | Quality Improvement | | ☐ | | |
| 13. In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to complete interventions addressing systemic barriers to HEDIS performance. | Quality Improvement/ Provider Engagement | | ☐ | | |
| **QUALITY AND SAFETY OF CARE** | | | | | |
| 1. Integrated Care Management (ICM)<br>• Implement ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM.<br>• Evaluate the ICM Program based on the following measures:<br>o Readmission rates<br>o ED utilization<br>o Overall health care costs<br>o Member Satisfaction | Care Management | | ☐ | | |
| **CREDENTIALING / RECREDENTIALING** | | | | | |
| 1. Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score. | Credentialing | | ☐ | | |
| **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 | | ☐ | | |
| 2. MHN live calls to adult members (in Kings and Madera counties) that were newly prescribed an antidepressant medication, diagnosed with major depression, and | Quality Improvement/ MHN | | ☐ | | |

| Activity | Activity Leader | Mid-Year Update | Year End (YE) | | |
|---|---|---|---|---|---|
| | | | Complete? | Date | YE Update or Explanation *(if not complete)* |
| demonstrating refill gaps between 15-50 days (supports COVID-19 QIP for BH) | | | | | |
| **QUALITY IMPROVEMENT** | | | | | |
| 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 | | ☐ | | |
| 2. Evaluation of the QI program: Complete QI Work Plan evaluation annually. | Quality Improvement | | ☐ | | |

# Item #5

## Attachment 5.A

2022 Case Management Program Description

# REPORT SUMMARY TO COMMITTEE

**TO:** CalViva Health QI/UM Committee

**FROM:** Carrie-Lee Patnaude, Manager Care Management

**COMMITTEE DATE:** March 17th, 2022

**SUBJECT:** Case Management Program Description Change Summary

| CM Redline Page # | Section/Paragraph name | Description of change |
|---|---|---|
| 1 | Header & Definitions | Updated Department to Care Management; updated template moves Definitions to first page. |
| 2 | Title page | Updated year from 2021 to 2022. |
| 7 | Complex Case Management Criteria | Modified filter criteria to identify members who will be referred to CM and managed as complex cases automatically. Previously filtering did not yield enough results. |
| 8 | Case Management Criteria | Added members who reach a designated score based on responses to the Screening HRA and or who requested an ICP or individualized care team may be referred to Case Management. |
| 10 | Care Team (CT) Staffing Model | Changed average active case load from 70 to 73 cases to align with Centene goal of 73 cases/CM. |
| 22 | Condition Specific CM and DM Programs | Added Palliative Care to programs that Plan Case Management may include |
| 23-24 | Special Programs | Added CalAIM, including ECM and Community Supports. Edits made to what the TCM program includes to clarify: 1st bullet- outreach timeframes; 3rd bullet- adding use of personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care; 5th bullet – clarified timeframe for PCP follow up after discharge if not listed on the members discharge instructions. |
| | | |
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# Health Net Community Solutions and CalViva Health Case Management Program Description 2022

## Table of Contents

## PURPOSE

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

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

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

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

## SCOPE

### *Definition of Case Management*

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

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

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

### *Levels of case management include:*

- **Non-complex Case Management**

- **Care Coordination** – appropriate for members with primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources of assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of case management is used for continuity of care transitions and supplemental support for members managed by the county.
- **Case Management** – appropriate for members needing a higher level of service, with clinical needs. Members in case management may have a complex condition or multiple co-morbidities that are generally well managed. Members in case management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services included at this level of case management include the level of coordination along with identification of member agreed upon goals and progress towards meeting those goals.

- **Complex Case Management** – a high level of case management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. Complex case management is performed by Health Net for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services at this level of complex case management include all coordination and case management services from above, along with a more frequent outreach to the member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence.

## Goals and Objectives

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

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

***The Goals of the Case Management Program are:***

| Measure | Goal | Frequency |
|---|---|---|
| Member experience survey – each question and overall | > 90% | Annual |
| Member complaints/grievances | < 1/10,000 | Annual |
| Reduce Non-Emergent ER Visits | > 3% | Annual |
| Reduce Readmissions | > 3% | Annual |
| Members managed in high risk OB program have greater % of members completing the 1st pre-natal visit with in the 1st trimester or 42 days of enrollment than pregnant members not managed. | > 5% difference | Pregnancy |
| Members managed in high risk OB program have greater % of members completing the post-natal visit between 7-84 days post-delivery than pregnant members not managed. | > 5% difference | Pregnancy |
| Members managed in high risk OB program have a lower rate of pre-term delivery than high risk members not managed. | >2% lower rate | Pregnancy |

## Case Management Functions:

### *Case Management functions include:*

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

## Program Segments

The Plan has defined a set of case management population criteria for use with all Medi-Cal members (children, adults and seniors, children with special needs (CSHCN), developmentally disabled (DD), seniors and persons with disabilities (SPD) etc.). This creates efficiencies and a consistent measurement process of case management program effectiveness across the Medi-Cal membership. The criteria below is not all inclusive; clinical judgment should be used to determine a member's appropriateness for each level of case management, considering such factors as stability of the condition(s), available support system, current place of residence, etc.

**Complex Case Management Criteria**

The Plan uses the Population Health Management (PHM) report to identify members for Complex Case Management. The PHM report combines data from multiple sources to use in its population and program eligibility process. Data elements from multiple sources are stored in corporate-wide data warehouses. Data from the warehouse is extracted into a predictive modeling tool, Impact Pro. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information. Members are stratified into one of ten Population Health Categories in Impact Pro: Level 01: Healthy to Level 10: End of Life. In addition to Impact Pro, a web-based customizable report generating system, Micro Strategies, is used to produce adjunctive analytical reports for related PHM programs including Complex Case Management.

Members stratified as described below are identified as complex and are referred to case management.

Members stratified into one of the PHM report categories below:
08b High Priority Homeless/SUD
07b High Priority PH CM
07a high Priority BH CM
05d Chronic Highly Complex
05c Chronic High Risk - With Care Gap (under Clinical Analytics Population Grouping)
~~AND are in one of the following Primary Risk categories:~~

- ~~Acute and chronic renal failure~~
- ~~Anxiety disorders/ phobias~~
- ~~Atrial fibrillation/flutter~~
- ~~Childhood-onset psychiatric disorders~~
- ~~COPD, including asthma~~
- ~~CVA~~
- ~~Diabetes~~

| Case Management Criteria |
|---|
| Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well managed in the individual. Diagnoses include, but are not limited to:<br>• HIV/AIDS<br>• Cancer<br>• Asthma, with associated inpatient admission<br>• Sickle cell<br>• Diabetes<br>• Congestive Heart Failure<br>• Children with special health care needs<br>• Other State-mandated criteria such as members under 21 years of age receiving private duty nursing services<br>• Members otherwise meeting criteria for Complex Case Management but do not have an additional parameter such as 30% inpatient probability score<br>• Members who reach a designated score based on responses to the Screening HRA and or who requested an ICP or individualized care team may be referred to Case Management. |
| **Care Coordination Criteria** |
| • Primarily social determinants of health such as housing, financial, etc. with need for referrals to community resources<br>• Need for assistance with accessing health care services related to continuity of care<br>• Participation in county program requiring supplemental Plan support |

## INFRASTRUCTURE AND TOOLS

### *Organizational Structure*

**Vice President Medical Affairs**

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

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

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations.
- Monitors compliance with the Case Management Program.
- Provides clinical support to the case management staff in the performance of their case management responsibilities.
- Provides a point of contact for practitioners with questions about the case management process.
- Communicates with practitioners as necessary to discuss case management issues.

- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed.
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees.

**Behavioral Health Practitioner**

A behavioral health practitioner is involved in implementing, monitoring, and directing the behavioral health care aspects of the Plan's Case Management Program. A behavioral health practitioner may participate in case management rounds to assist in identifying behavioral health care needs and integrating behavioral and physical care. The behavioral health practitioner may be a clinical director, a Plan network practitioner, or behavioral health delegate. A physician, appropriate behavioral health practitioner (i.e. doctoral-level clinical psychologist or certified addiction medicine specialist) or pharmacist, as appropriate, may be consulted on cases involving behavioral health issues.

**Sr. Vice President of Medical Management (VPMM)**

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

**Vice President of Medical Management (VPMM)**

The VPMM is a registered nurse with experience in case management activities. The VPMM is responsible for overseeing the operational activities of the Plan's Case Management Program. The VPMM reports to the Sr. Vice President of Medical Management and assists with the development and oversight of the strategy, policy, and operational planning and execution of work processes for the Case Management program.

**Case Management Director/ Manager**

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

**Supervisor, Program Coordinator (PC)**

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

Coordinators to promote quality and continuity of services delivered to members and providers. The Supervisor PC reports to the Director of CM.

### *Care Team (CT) Staffing Model*

Care Coordination/Case Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions~~,~~ and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers work closely with the concurrent review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Care Manager's average active case load may be up to 73~~0~~ cases. The Integrated Care Team roles and responsibilities ~~include:~~include care managers, social workers, other licensed clinical staff, program specialists, program coordinators, care coordinators, and Connection Representatives.

**Medical Director**

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

**Care Manager (CM)**

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

**Social Workers/Program Specialists (SW/PS)**

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

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

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

**Program Coordinator (PC) I**

- Non-clinical staff person working under the direction and oversight of a PC II or CM.
- Provides administrative support to CC/CM team.
- Collects data for Health Risk Screening.
- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of Care Manager.

**Member Connections Representative (MCR)**

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

Integrated Care Team meetings are held at least monthly. The participants are comprised of plan behavioral health and physical health care managers, social workers, non-clinical associates, medical directors, and a pharmacy coordinator. Other participants may ~~include:~~include PCPs or specialists, behavioral health providers and/or County Mental Health Plan staff and/or CR depending on the case. These meetings are augmented by CM huddles held at least weekly and facilitated by a Plan Medical Director.

## Information System

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

The clinical documentation system contains additional clinical information, e.g., inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's case to a list which

allows the information to be readily available without having to review authorization and referral data. These features permit the care team to easily access all clinical information associated with a member's case in one central location.

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

## MEMBER IDENTIFICATION AND ACCESS TO CASE MANAGEMENT

A key objective of Plan's Case Management Program is early identification of members who have the greatest need for care coordination and case management services. This includes, but is not limited to, those classified as children or adults with special health care needs; with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are frail, elderly, disabled, or at the end of life.

### *Data Sources*

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

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

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

### *Referral Sources*

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

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Case Management Program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.
- Envolve PeopleCare Nurse Advice Line staff –has policies and procedures in place for referring members to the Health Plan for case management screening. This may be accomplished via a "triage summary report" that is sent to the Plan electronically on

the next business day after member contact has occurred, or by direct communication with the designated contact person at the Plan.

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

The specific means which a member was identified as a potential candidate for case management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to case management. Multiple referral avenues help to minimize the time between need for and initiation of case management services.

Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

## SCREENING AND ASSESSMENT

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 7calendar days of identification as potential candidates for case management. Care team staff obtain consent to complete the case management screening and/or initial assessment once member contact is made. Case Management staff also explains the care manager role and function and benefits of the Case Management Program to the member and/or their authorized representative or guardian.

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

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Case Management Program~~,~~ and are informed they are entitled to decline participation in, or disenroll from case management at any time, if allowed per state regulations.

The member/guardian is notified of the potential need for the care team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always obtained prior to any contact. Documentation of verbal member consent to participate in the Case Management Program is included in the general assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented.

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

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly ~~stable~~stable, and the member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are assigned to a care team who confirms the findings of the screening assessment and may complete a more thorough assessment with the member. Outreach to members is initiated within 7 calendar days and completed within 21~~14~~ calendar days of identification/referral.

A Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history. Stratification as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions, and assignment to Care Coordination, Case Management, or Complex Case Management may be revised at this ~~time, or~~time or following further assessment.

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

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

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

The care team reviews the gathered information and begins to build a plan of care. The initial assessment and plan of care are completed no later than 60 days after the identification/referral of the member to Case Management, but in most cases is completed earlier. A member is considered eligible for case management services upon their consent to participate unless

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

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

### *Behavioral Health Services*

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

### *Continuity and Coordination of Care between Medical and Behavioral Health Care*

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

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

- Contacts the medical provider to ask about a behavioral health consult.

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

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

### *Coordination with External Programs*

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

## ONGOING MANAGEMENT

### *Plan of Care Development*

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

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

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

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

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

### *Monitoring and Evaluation*

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

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

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

- Member or caretaker agreement to participate in the Case Management Program (agreement may be oral or written; if oral, the Care Manager documents the discussion with the member/caretaker).
- Notes, including a summary of team conferences and all communications with the member/family, health care providers and any other parties pertaining to the member's case.

- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available.
- The case management care plan, including:
    - Prioritized goals, barriers to meeting the goals and/or adhering to the care plan and interventions for meeting the member's goals and overcoming barriers.
    - Schedule for follow-up and communication with the member, member's family, providers, etc.
    - The member's self-management plan.
    - Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below.

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

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

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

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

### *Discharge from Case Management*

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

- Member terminates with the Health Plan.

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

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

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

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

## PROGRAM ASSESSMENT AND IMPACT MEASUREMENT

### *Population Health Assessment*

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

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

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

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

### *Member Experience with Case Management*

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

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

### *Outcomes*

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

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

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

- Readmission rates.

- ED utilization.
- Rate of pregnant members with an appropriate prenatal visit.
- Rate of pregnant members with an appropriate post-partum discharge visit.
- Rate of ~~high risk~~high-risk pregnant members who have a pre-term delivery.

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

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

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

### *Condition Specific CM and Chronic Condition Management ~~DM~~ Programs*

Members in condition specific Case/~~Disease~~ Chronic Condition Management Programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The case management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from case management when not specifically addressed in the program. ~~Disease~~ Chronic Condition Management has been delegated to Envolve PeopleCare and the Plan Care Manager coordinates care and member interaction to prevent duplication of contacts and services.

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

- Children and Adults with Special Health Care Needs
- Sickle Cell
- Transitional Care Management (post hospitalization follow-up)
- High Risk Pregnancy
- Palliative Care

Plan ~~Disease Management~~Chronic Condition Managment Programs may include, but are not limited to:

- Asthma
- Diabetes
- Heart Failure

## SPECIAL PROGRAMS

### CalAIM

Is a multi-year 5+ framework program developed by the Department of Health Care services (DHCS) encompassing a broad-based delivery system, program, and payment reform across Medi-Cal. The focus is to address the complex challenges facing the plan's most vulnerable members. It also provides for non-clinical interventions focused on the whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities. Enhanced Care Management (ECM) and Community Support (formally ILOS) in Lieu of Services are the first two programs to launch

- **Enhanced Care Management (ECM)** is a plan benefit that provides a whole-person approach to care coordination that addresses the clinical and non-clinical circumstances of high-need members, building on the current Whole-Person Care pilots and Health Homes Programs
- **Community Supports (formally ILOS)** are designed to be used to provide health related services as an alternative to covered Medi-Cal benefits. It will integrate care management for members at high levels of risk and intended to address SDoH. Support services that may be available in the phase 1 counties will be housing transition and navigation services, housing tenancy and sustaining services, recuperative care otherwise known as medical respite, sobering centers, meals, including medically tailored, and asthma remediation.

The program began on January 01, 2022, in the CalViva county of Kings which had an WPC pilot prior to the CalAIM implementation with tentative plans by DHCS to include San Joaquin County along with the CalViva counties of Fresno and Madera on July 01, 2022. DHCS initial population of focus for both implementation dates will be those members that are:

- Experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless, with complex health and/or behavioral health conditions
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
- Adults with high utilization and/or with severe mental illness (SMI) or substance abuse disorders (SUD).

Members inquiring about or are active in the plan's current case management program can self-refer to (ECM) and assigned CM staff will then make outreach to determine if they fall within the population of focus and then will forward an authorization to the assigned (ECM) provider to make outreach to determine eligibility for their program. Per DHCS policy members accepted into (ECM) cannot be in the plan's complex case management program due to duplication of services but can still be referred to Community Support services, Condition Specific CM/ DM Programs, Palliative Care and Transitional Care Management.

### *Transitional Care Management Program*

The purpose of the Transitional Care Management Program (TCM) is to provide a comprehensive, integrated transition process that supports members during movement between levels of care. Care Transition Interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post discharge period -to ensure timely, safe and

appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post discharge stay is essential in navigating ~~T~~the health care continuum and addressing barriers to post discharge success for the member.

The TCM Program strives to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a patient centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, patient/participant engagement and enhance post-acute care follow-up.

The program includes:

- Conducting ~~a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation, use of a personal health record~~ an initial outreach call within 3 to 10 calendar days from discharge to review post hospital instructions and conduct medication reconciliation with the member
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond
- Preparation for discussions with other health care professionals and use of a personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care
- Supporting the patient's self-management role
- Educating the member to follow up with the PCP/and or specialist within 7-10 days of discharge if not listed on the post discharge instructions

During the post discharge period, staff evaluates the member to provide the best support to the member in managing their continued needs.

### *Palliative Care Program*

Health Net offers the Palliative Care Program to its members with the goal of providing an extra layer of support by providing disease education, pain management, symptom control, and additional resources and guidance to enhance the member's quality of life. Through a partnership of vendors throughout California, Palliative Care is able to provide nurses, medical directors, and social workers in a home setting to members. Palliative Care empowers the member and family through a collaborative effort of communications, coordination of care, and advance planning, while allowing the goals of both the member and family to be the guiding principle.

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

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Individualized Plan of Care including Pain and Symptom Management
- Care Coordination
- Mental Health and Medical Social Services
- Chaplain Services
- 24/7 Telephonic Palliative Care Support

- Additional medically necessary or reasonable services as provisioned in regulatory requirements

# Item #5

## Attachment 5.B

2022 UMCM Work Plan

# CalViva Health
# 2022
## Utilization Management (UM)/ Case Management (CM)
# Annual Work Plan



Last updated: March 9, 2022

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## Fresno-Kings-Madera Regional Health Authority Approval

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

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

Date

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

Date

# 1. Compliance with Regulatory & Accreditation Requirements

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions. | ☒ Medi-Cal | Qualified licensed and trained professionals make UM decisions. | Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions.<br><br>Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software).<br><br>Credentialing maintains records of physicians' credentialing.<br><br>100% compliance with maintaining records of professional licenses and credentialing for health professionals. | Provide minimum 6 clinical continuing education opportunities to staff.<br><br>Conduct Medical Management Staff new hire orientation training.<br><br>Review and revise staff orientation materials, manuals and processes.<br><br>Verification of licensure/certification, participation in InterQual training and IRR testing.<br><br>Conduct training for nurses. | Ongoing<br><br>As needed<br><br>Ongoing<br><br>Ongoing<br><br>Ongoing |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements. | ☒ Medi-Cal | Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations.<br><br>This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance. | Review and report on legislation signed into law and regulations with potential impact on medical management.<br><br>Appropriate and timely changes are made to Medical Management processes to accommodate new legislation as appropriate.<br><br>100% compliance of UMCM staff and processes with all legislation and regulations. | Review new legislation and regulations, either through e-mail or department presentation.<br><br>Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner.<br><br>Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards. | Ongoing |

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| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.3 Separation of Medical Decisions from Fiscal Considerations | ☒ Medi-Cal | DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence. | Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates.<br><br>100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees. | All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and reminded annually thereafter.<br><br>Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care. | Ongoing |

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|---|---|---|---|---|
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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.4 Periodic audits for Compliance with regulatory standards | ☒ Medi-Cal | Ensure compliance with regulatory standards. | Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision. | Conduct File Reviews for compliance with regulatory standards.<br><br>Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process.<br><br>File Audits completed the month following each quarter. | Ongoing<br><br>Ongoing<br><br>April 2022,<br>July 2022,<br>October 2022,<br>January 2022 |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
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| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS) | ☒ Medi-Cal | Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS:<br><br>▪ MMCD Medical Directors Meetings<br>▪ MMCD workgroups<br>▪ Quality Improvement workgroup<br><br>There are benefits to HN MD participation:<br><br>▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program.<br>▪ Provides HN with in-depth information regarding contractual programs.<br>▪ Provides HN with the opportunity to participate in policy determination by DHCS. | HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, and meetings.<br><br>Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD.<br><br>HN and CalViva remain a strong voice in this body with participation on key workgroups. | The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2022.<br><br>Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities. | Ongoing |

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| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 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 2022 UM and CM Program Descriptions.<br><br>Write and receive CalViva approval of 2021 UMCM Work Plan Year-End Evaluation.<br><br>Write and receive CalViva approval of 2022 UMCM Work Plan.<br><br>Write and receive CalViva approval of 2022 UMCM Work Plan Mid-Year Evaluation.<br><br>Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership.<br><br>Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements. | Q 1 2022<br><br>Q 1 2022<br><br>Q 1 2022<br><br>Q 3 2022<br><br>Ongoing<br><br>Ongoing |

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# 2. Monitoring the UM Process

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

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.2 Timeliness of processing the authorization request<br><br>(Turnaround Time =TAT) | ☒ Medi-Cal | TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications).<br><br>Provide oversight, tracking, and monitoring of turnaround times for authorization requests. | Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report. | Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs.<br><br>Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies.<br><br>Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements.<br><br>Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining. | Ongoing<br><br>UM TAT summaries due monthly |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making | ☒ Medi-Cal | Consistency with which criteria are applied in UM decision-making is evaluated annually.<br><br>Opportunities to improve consistency are acted upon. | Health Net administers Change Healthcare InterQual® IRR Tool to physician and non-physician UM reviewers annually<br><br>Physician and non-physician UM reviewers achieving ≥ 90% passing score on InterQual® IRR Tool | <u>Physician IRR</u><br>Administer Physician IRR test using case review method and Change Healthcare InterQual® IRR tool in Q3-4 2022.<br><br><u>Non-Physician IRR</u><br>Administer annual non-physician IRR test using Change Healthcare InterQual® IRR tool in Q3-4 2022. | Q3-4 2022<br><br>Q3-4 2022 |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals. | ☒ Medi-Cal | Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate. | Measure UM Appeals volume as a percentage of the total authorization requests.<br><br>Measure the number upheld and overturned, as well as Turnaround Times. | Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting.<br><br>On a monthly basis appeal trends are reported via a monthly dashboard. Additionally, appeals will be analyzed for trends. This analysis and recommendations will be reported to CalViva Health QI/UM Committee.<br><br>Pharmacy benefit appeals will be handled through Magellan and no longer processed by the plan which will decrease the overall Appeal count for dates of service beginning January 1, 2022.<br><br>Ensure appeals are processed by specialty matched physicians, when appropriate 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.<br><br>The data from appeals and grievances is shared with the Provider Network Management, Adverse Action Team, and Utilization Management/ Quality Improvement (UMQI) committees and is aggregated and reviewed for additional actions and recommendations. | Ongoing |

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|---|---|---|---|---|
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# 3. Monitoring Utilization Metrics

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 3.1 Improve Medi-Cal shared risk and FFS UM acute in-patient performance | ☒ Medi-Cal | Health Net Central Medical Directors and Medical Management manage the non-delegated shared risk PPGs and a sizable FFS membership. | Health Net manages shared risk non-delegated PPGs and FFS inpatient UM.<br>Data reported quarterly at State Health Programs UM/QI Committee meeting<br>▪▪▪▪▪▪▪▪▪▪▪▪▪▪<br>Key Metrics<br>(SPD, Non-SPD, MCE)<br>Bed days/k<br>ALOS<br>Admit /K<br>All cause readmits within 30 days<br><br>2022 Goals:<br>• 5% reduction in admissions over 2019<br>• 5% 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.<br><br>Use data to identify high cost/high utilizing members to target for care management.<br><br>The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings.<br><br>The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. | Ongoing |

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|---|---|---|---|---|
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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 3.2 Over/under utilization | ☒ Medi-Cal | Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members.<br><br>Fraud, Waste and Abuse of medical services is monitored and reported.<br><br>PPG Reports are used internally and externally with medical groups to develop member and population level interventions.<br><br>Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000. | The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members.<br><br>Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include:<br>1. Admissions/K<br>2. Bed days/K<br>3. Acute care average length of stay<br>4. ER admits/K<br>5. All case readmits<br>In addition, PPG metrics will include:<br>6. Specialty referrals for target specialties<br><br>PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. | Continue to enhance provider profile.<br><br>Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports)<br><br>Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department<br><br>Thresholds for 2022 are under evaluation.<br><br><u>Referral Rates: Specialist</u><br>PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation.<br><br>Reevaluate appropriate metrics to be included in the PPG dashboard.<br><br>Specialties and PPG's identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated.<br><br>The Quality Improvement Plans, if applicable are reviewed at the regional joint operations meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard. | Ongoing |

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| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 3.3 PPG Profile | ☒ Medi-Cal | PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM. | Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY.<br><br>The following metrics are tracked by Delegation oversight:<br>1. Prior authorization volume & timeliness<br>2. Specialty referral volume for in network/out of network<br>3. Specialty referral access timeliness<br><br>The PPG Profile 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.<br><br>CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management.<br><br>Variance rate is calculated from previous quarter and all Variances >+- 15% are researched<br><br>Compliance rate is calculated as identified by DHCS for:<br>• Prior authorization timeliness<br><br>CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals.<br><br>CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN. | Ongoing |

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# 4. Monitoring Coordination with Other Programs and Vendor Oversight

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.1 Case Management (CM) Program | ☒ Medi-Cal | Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life.<br><br>Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.<br><br>Reviewing Member self-referrals to ECM and Community supports and creating an authorization for the ECM provider as appropriate. Members not meeting criteria will be referred to case management. | Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes.<br><br>Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly<br><br>Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs<br><br>Measure program effectiveness based on the following measures:<br>o Readmission rates<br>o ED utilization<br>o Overall health care costs<br>o Member Satisfaction | Dedicated staff of RNs, LCSWs, Program Specialists, Program Coordinators to perform physical health and integrated CM activities.<br><br>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.<br><br>Review outcome measures quarterly. | Ongoing |

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|---|---|---|---|---|
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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.2 Referrals to Perinatal Case Management | ☒ Medi-Cal | Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes. | Notify PCP's or PPG's of patients identified for program.<br><br>Measure program effectiveness based on the following measures:<br>o Member compliance with completing<br>• 1st prenatal visit within the 1st trimester and<br>• post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program<br>• 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.<br><br>Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities.<br><br>Use of NOP reports to identify members with moderate and high risk pregnancy for referral to the pregnancy program.<br><br>Review outcome measures quarterly. | Ongoing<br><br>Ongoing<br><br>Ongoing<br><br>Quarterly |

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| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.3 Behavioral Health (BH) Case Management Program | ☒ Medi-Cal | Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life.<br><br>Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. | Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes.<br><br>Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly<br><br>Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs<br><br>Measure program effectiveness based on the following measures:<br>o Readmission rates<br>o ED utilization<br>o Overall health care costs<br>o Member Satisfaction | Dedicated staff of LCSWs, LMFT, and Program Specialist to perform BH CM activities.<br><br>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.<br><br>Review outcome measures quarterly. | Ongoing |

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|---|---|---|---|---|
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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.4 Disease/ Chronic Condition Management | ☒ Medi-Cal<br><br>**Diabetes Age Groups**<br>0-21 CCS Referral (100%)<br><br>>21 Enrolled in program | The Managed Care Plan is responsible for initiating and maintaining a Chronic Condition 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.<br><br>Plan Chronic Condition Management Programs may include, but are not limited to:<br>○ Asthma<br>○ Diabetes<br>○ Heart Failure | Ongoing program monitoring.<br><br>Review prevalence data to affirm selection of Chronic Condition Management program offerings. | Ongoing<br><br>12/31/2022 |

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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.5 MD interactions with Pharmacy | ☒ Medi-Cal | State Health Program (SHP) MDs and the CalViva Health Chief Medical Officer work with Pharmacy to refine the injectable guidelines for medical benefit drugs to facilitate member and provider efficiencies; to ensure adequate and current medications are included, and to ensure appropriate utilization.<br><br>SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists.<br><br>SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data. | Monthly report of PA requests. | Continued active engagement with pharmacy.<br><br>Revised UMQI reporting based on Medical Benefit drug review.<br><br>Revised DUR reporting based on Medi-Cal RX data.<br><br>Continued A&G tracking of pharmacy cases related to medical benefit drug review. | Ongoing |

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| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 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.<br><br>Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that MHN provides. | Ongoing |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 4.7 Behavioral Health Performance Measures | ☒ Medi-Cal | CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members. | Performance Measures to be monitored:<br><br>Appointment Accessibility by Risk Rating<br><br>Authorization Decision Timelines<br><br>Potential Quality Issues<br><br>Provider Disputes<br><br>Network Availability<br><br>Network Adequacy: Member Ratios<br><br>Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder. | Participate in cross functional team to improve quality of behavioral health care. | Ongoing |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

# 5. Monitoring Activities for Special Populations

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objective(s) | 2022 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.<br><br>Based on the standardized formula, monthly report indicates CCS %.<br>Goal: Health Net identifies 5% of total population for likely CCS eligibility. | CCS identification and reporting continues to be a major area of focus.<br><br>Continue current CCS policies and procedures.<br><br>Continue to refine CCS member identification and referral through concurrent review, prior authorization, case management, pharmacy, claims review and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool).<br><br>Continue to improve and refine coordination with CCS between specialists and primary care services. | Ongoing |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

| Activity/ Study/Project | Product Line(s)/ Population | Rationale | Methodology<br>Measurable Objectives | 2022 Planned Interventions | Target Completion Date |
|---|---|---|---|---|---|
| 5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements | ☒ Medi-Cal | California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management. | All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program.<br><br>Monitor HRA outreach | Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Case Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program.<br><br>Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management and Care Coordination. | Ongoing |

| Report Timeframe | Status Report/Results | Barriers | Revised/New Interventions | Target Completion Date |
|---|---|---|---|---|
| **Mid-Year Report**<br><br>☐ **ACTIVITY ON TARGET**<br><br>☐ **TOO SOON TO TELL** | | | | |
| **Annual Evaluation**<br><br>☐ **MET OBJECTIVES**<br><br>☐ **CONTINUE ACTIVITY IN 2023** | | | | |

# Item #6

## Attachment 6.A

Financials as of January 31, 2022

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

## Balance Sheet

## As of January 31, 2022

| | | Total |
|---|---|---|
| 1 | ASSETS | |
| 2 | Current Assets | |
| 3 | Bank Accounts | |
| 4 | Cash & Cash Equivalents | 207,530,558.94 |
| 5 | Total Bank Accounts | $ 207,530,558.94 |
| 6 | Accounts Receivable | |
| 7 | Accounts Receivable | 110,556,257.44 |
| 8 | Total Accounts Receivable | $ 110,556,257.44 |
| 9 | Other Current Assets | |
| 10 | Interest Receivable | 2,770.38 |
| 11 | Investments - CDs | 0.00 |
| 12 | Prepaid Expenses | 573,434.72 |
| 13 | Security Deposit | 0.00 |
| 14 | Total Other Current Assets | $ 576,205.10 |
| 15 | Total Current Assets | $ 318,663,021.48 |
| 16 | Fixed Assets | |
| 17 | Buildings | 6,293,212.74 |
| 18 | Computers & Software | 0.00 |
| 19 | Land | 3,161,419.10 |
| 20 | Office Furniture & Equipment | 85,287.17 |
| 21 | Total Fixed Assets | $ 9,539,919.01 |
| 22 | Other Assets | |
| 23 | Investment -Restricted | 301,627.37 |
| 24 | Lease Receivable | 4,310,607.40 |
| 25 | Total Other Assets | $ 4,612,234.77 |
| 26 | TOTAL ASSETS | $ 332,815,175.26 |
| 27 | LIABILITIES AND EQUITY | |
| 28 | Liabilities | |
| 29 | Current Liabilities | |
| 30 | Accounts Payable | |
| 31 | Accounts Payable | 157,187.79 |
| 32 | Accrued Admin Service Fee | 4,383,742.00 |
| 33 | Capitation Payable | 174,586,612.10 |
| 34 | Claims Payable | 20,261.19 |
| 35 | Directed Payment Payable | 3,455,426.56 |
| 36 | Total Accounts Payable | $ 182,603,229.64 |
| 37 | Other Current Liabilities | |
| 38 | Accrued Expenses | 1,114,923.20 |
| 39 | Accrued Payroll | 65,129.39 |
| 40 | Accrued Vacation Pay | 370,762.59 |
| 41 | Amt Due to DHCS | 0.00 |
| 42 | IBNR | 49,890.52 |
| 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 | $ 21,507,223.07 |
| 48 | Total Current Liabilities | $ 204,110,452.71 |
| 49 | Long-Term Liabilities | |
| 50 | Renters' Security Deposit | 25,906.79 |
| 51 | Subordinated Loan Payable | 0.00 |
| 52 | Total Long-Term Liabilities | $ 25,906.79 |
| 53 | Total Liabilities | $ 204,136,359.50 |
| 54 | Deferred Inflows of Resources | $ 4,362,941.85 |
| 55 | Equity | |
| 56 | Retained Earnings | 119,072,374.53 |
| 57 | Net Income | 5,243,499.38 |
| 58 | Total Equity | $ 124,315,873.91 |
| 59 | TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND EQUITY | $ 332,815,175.26 |

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

## Budget vs. Actuals: Income Statement

## July 2021 - January 2022

| | | Total | | |
|---|---|---|---|---|
| | | Actual | Budget | Over/(Under) Budget |
| 1 | Income | | | |
| 2 | Interest Income | 159,726.61 | 56,000.00 | 103,726.61 |
| 3 | Premium/Capitation Income | 802,335,573.06 | 778,173,732.00 | 24,161,841.06 |
| 4 | **Total Income** | **802,495,299.67** | **778,229,732.00** | **24,265,567.67** |
| 5 | Cost of Medical Care | | | |
| 6 | Capitation - Medical Costs | 662,927,418.55 | 642,919,578.00 | 20,007,840.55 |
| 7 | Medical Claim Costs | 591,522.76 | 630,000.00 | (38,477.24) |
| 8 | **Total Cost of Medical Care** | **663,518,941.31** | **643,549,578.00** | **19,969,363.31** |
| 9 | **Gross Margin** | **138,976,358.36** | **134,680,154.00** | **4,296,204.36** |
| 10 | Expenses | | | |
| 11 | Admin Service Agreement Fees | 30,109,046.00 | 29,352,400.00 | 756,646.00 |
| 12 | Bank Charges | 8.22 | 4,200.00 | (4,191.78) |
| 13 | Computer/IT Services | 101,507.66 | 110,831.00 | (9,323.34) |
| 14 | Consulting Fees | 0.00 | 175,000.00 | (175,000.00) |
| 15 | Depreciation Expense | 167,038.56 | 178,500.00 | (11,461.44) |
| 16 | Dues & Subscriptions | 98,215.15 | 105,112.00 | (6,896.85) |
| 17 | Grants | 2,568,181.84 | 2,568,181.84 | 0.00 |
| 18 | Insurance | 106,515.75 | 106,142.00 | 373.75 |
| 19 | Labor | 2,319,130.09 | 2,484,659.00 | (165,528.91) |
| 20 | Legal & Professional Fees | 46,228.69 | 111,300.00 | (65,071.31) |
| 21 | License Expense | 464,960.51 | 499,135.00 | (34,174.49) |
| 22 | Marketing | 820,997.59 | 980,000.00 | (159,002.41) |
| 23 | Meals and Entertainment | 14,860.81 | 16,500.00 | (1,639.19) |
| 24 | Office Expenses | 34,189.01 | 49,000.00 | (14,810.99) |
| 25 | Parking | 262.95 | 875.00 | (612.05) |
| 26 | Postage & Delivery | 2,054.00 | 1,960.00 | 94.00 |
| 27 | Printing & Reproduction | 2,024.32 | 2,800.00 | (775.68) |
| 28 | Recruitment Expense | 1,698.65 | 21,000.00 | (19,301.35) |
| 29 | Rent | 0.00 | 7,000.00 | (7,000.00) |
| 30 | Seminars and Training | 9,448.88 | 15,000.00 | (5,551.12) |
| 31 | Supplies | 5,736.13 | 6,300.00 | (563.87) |
| 32 | Taxes | 96,979,166.67 | 96,979,169.00 | (2.33) |
| 33 | Telephone | 20,187.62 | 20,930.00 | (742.38) |
| 34 | Travel | 9,285.64 | 13,000.00 | (3,714.36) |
| 35 | **Total Expenses** | **133,880,744.74** | **133,808,994.84** | **71,749.90** |
| 36 | **Net Operating Income/ (Loss)** | **5,095,613.62** | **871,159.16** | **4,224,454.46** |
| 37 | Other Income | | | |
| 38 | Other Income | 147,885.76 | 303,331.00 | (155,445.24) |
| 39 | **Total Other Income** | **147,885.76** | **303,331.00** | **(155,445.24)** |
| 40 | **Net Other Income** | **147,885.76** | **303,331.00** | **(155,445.24)** |
| 41 | **Net Income/ (Loss)** | **5,243,499.38** | **1,174,490.16** | **4,069,009.22** |

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

## Income Statement: Current Year vs Prior Year

## FY 2022 vs FY 2021

| | | Total | |
|---|---|---|---|
| | | July 2021 - January 2022 (FY 2022) | July 2020 - January 2021 (FY 2021) |
| 1 | **Income** | | |
| 2 | **Interest Income** | 159,726.61 | 81,425.57 |
| 3 | **Premium/Capitation Income** | 802,335,573.06 | 739,626,316.65 |
| 4 | **Total Income** | **802,495,299.67** | **739,707,742.22** |
| 5 | **Cost of Medical Care** | | |
| 6 | **Capitation - Medical Costs** | 662,927,418.55 | 617,222,962.61 |
| 7 | **Medical Claim Costs** | 591,522.76 | 427,496.54 |
| 8 | **Total Cost of Medical Care** | **663,518,941.31** | **617,650,459.15** |
| 9 | **Gross Margin** | **138,976,358.36** | **122,057,283.07** |
| 10 | **Expenses** | | |
| 11 | **Admin Service Agreement Fees** | 30,109,046.00 | 28,575,745.00 |
| 12 | **Bank Charges** | 8.22 | 998.77 |
| 13 | **Computer/IT Services** | 101,507.66 | 101,847.32 |
| 14 | **Depreciation Expense** | 167,038.56 | 166,996.96 |
| 15 | **Dues & Subscriptions** | 98,215.15 | 95,530.75 |
| 16 | **Grants** | 2,568,181.84 | 2,762,500.00 |
| 17 | **Insurance** | 106,515.75 | 102,669.99 |
| 18 | **Labor** | 2,319,130.09 | 2,113,572.99 |
| 19 | **Legal & Professional Fees** | 46,228.69 | 69,850.00 |
| 20 | **License Expense** | 464,960.51 | 440,901.26 |
| 21 | **Marketing** | 820,997.59 | 832,546.31 |
| 22 | **Meals and Entertainment** | 14,860.81 | 11,682.55 |
| 23 | **Office Expenses** | 34,189.01 | 34,802.29 |
| 24 | **Parking** | 262.95 | 0.00 |
| 25 | **Postage & Delivery** | 2,054.00 | 1,318.73 |
| 26 | **Printing & Reproduction** | 2,024.32 | 1,949.93 |
| 27 | **Recruitment Expense** | 1,698.65 | 1,573.98 |
| 28 | **Rent** | 0.00 | 0.00 |
| 29 | **Seminars and Training** | 9,448.88 | 1,175.04 |
| 30 | **Supplies** | 5,736.13 | 4,457.79 |
| 31 | **Taxes** | 96,979,166.67 | 87,280,153.50 |
| 32 | **Telephone** | 20,187.62 | 19,701.71 |
| 33 | **Travel** | 9,285.64 | 144.34 |
| 34 | **Total Expenses** | **133,880,744.74** | **122,620,119.21** |
| 35 | **Net Operating Income/ (Loss)** | **5,095,613.62** | **(562,836.14)** |
| 36 | **Other Income** | | |
| 37 | **Other Income** | 147,885.76 | 284,216.53 |
| 38 | **Total Other Income** | **147,885.76** | **284,216.53** |
| 39 | **Net Other Income** | **147,885.76** | **284,216.53** |
| 40 | **Net Income/ (Loss)** | **5,243,499.38** | **(278,619.61)** |

# Item #6

## Attachment 6.B

Compliance Report

| Regulatory Filings | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2022 YTD Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **# of DHCS Filings** | | | | | | | | | | | | | |
| **Administrative/ Operational** | 14 | 24 | 6 | | | | | | | | | | 44 |
| **Member Materials Filed; Provider Materials Distributed** | 4 | 25 | 11 | | | | | | | | | | 40 |
| **# of DMHC Filings** | 4 | 4 | 1 | | | | | | | | | | 9 |

**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** | 6 | 4 | | | | | | | | | | | 10 |
| **High-Risk** | 0 | 0 | | | | | | | | | | | 0 |

| Fraud, Waste, & Abuse Activity | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2022 YTD Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **# of New MC609 Cases Submitted to DHCS** | 1 | 0 | 0 | | | | | | | | | | 1 |
| **# of Cases Open for Investigation (Active Number)** | 21 | 22 | 22 | | | | | | | | | | |

**Summary of Potential Fraud, Waste & Abuse (FWA) cases:** Since the last report, there have not been any new MC609 cases filed.

| Compliance Oversight & Monitoring Activities | Description |
|---|---|
| **CalViva Health Oversight Activities** | **Health Net**<br>CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CalViva Health. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances and appeals, etc. |
| **Oversight Audits** | The following annual audits are in-progress: Access and Availability, Appeals & Grievances, Continuity of Care, and Provider Network/ Provider Relations.<br><br>The following audits have been completed since the last Commission report: |
| **Regulatory Reviews/Audits and CAPS** | **Status** |
| **2021 Department of Managed Health Care ("DMHC") 18-Month Follow-Up Audit** | The Plan is still awaiting the DMHC's final determination on our 2021 CAP response. It appears that the DMHC may wait until our next audit in September 2022 to reassess if the finding, related to processing post-stabilization requests/claims, has been corrected. |
| **Department of Health Care Services ("DHCS") 2020 Medical Audit - CAP** | The Plan is still awaiting DHCS' final response in order to close the 2020 CAP. It's possible that the DHCS is waiting until they complete the 2022 annual audit currently under way to reassess if the finding, related to provider's completion of IHAs/IHEBAs, has been corrected. |
| **Department of Health Care Services ("DHCS") 2022 Medical Audit** | All pre-audit document requests were submitted on 2/25/22. On 3/9/22, the Plan received DHCS' request for verification files. These are scheduled to be submitted by 3/18/22. The Audit Entrance Conference is scheduled for 4/18/22. |
| **Department of Managed Health Care ("DMHC") Financial Audit** | DMHC's financial audit Entrance Conference will take place on 3/15/22. |
| **New Regulations / Contractual Requirements** | **Status** |
| **California Advancing and Innovating Medi-Cal (CalAIM)** | A. <u>Enhanced Care Management (ECM) and Community Supports (CS)</u><br><br>These programs are next scheduled to become effective in Fresno and Madera counties by 7/1/2022. For these counties, the Plan developed and submitted the Models of Care Parts (MOC) 1, 2, and 3 on 2/15/22.<br><br>B. <u>Major Organ Transplant (MOT) Carve-In</u> - This benefit became effective 1/1/22 for all CalViva counties. The CAP that DHCS had issued to the Plan on 12/10/21 has been closed and the Plan's MOT network has been certified. The Plan's Administrator, Health Net, continues to pursue and finalize additional contracts with the various centers of excellence. |

**RHA Commission Compliance – Regulatory Report**

| | |
|---|---|
| **Plan Administration** | |
| **COVID-19 Novel Coronavirus** | 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 further notice |
| **Committee Report** | |
| **Public Policy Committee** | The Public Policy Committee last met on 3/2/22. The meeting was held at CalViva's Administrative Office location. The following reports were presented: The Health Education Semi-Annual Member Incentive Report (Q3 and Q4 2021), the 2021 Annual Compliance Report, and the Q4 2021 Appeals & Grievance Report. There were no recommendations for referral to the Commission.<br><br>The next meeting will be held on June 1, 2022 at 11:30am in the Plan's Administrative Office. |

| Bill | Description | Applies to CalViva | Effective Date | Plan Action / Notes |
|---|---|---|---|---|
| AB 133 | Health Trailer Bill: This bill covers many areas: addresses authorization of CalAIM initiatives and implementation of related CalAIM programs and benefits, various incentive payment programs, establishes the Children and Youth Behavioral Health Initiative, expands full-scope Medi-Cal to low-income undocumented Californians age 50 and older, extends telehealth flexibilities, adds new health equity and quality measures and much more. Details are in the 442 page bill with full text of AB 133 at: http://leginfo.legislature.ca.gov. | Yes | Various from 7/1/21 thriough 1/1/26 | Affects policies & procedures, provider contracts, reporting, staffing, D-SNP, etc. CalViva is working with our administrator to implement these as needed. |
| AB 361 | Open Meetings - state & local agencies, teleconferences: This bill acts to improve and enhance public access to state and local agency meetings during the COVID-19 pandemic and future applicable emergencies, by allowing broader access through teleconferencing options consistent with the Governor's Executive Order No. N-29-20 dated March 17, 2020, permitting expanded use of teleconferencing during the COVID-19 pandemic. Allows local agencies to use teleconferencing during a declared state of emergency without complying with some of the requirements imposed by the Brown Act. State or local officials must have imposed or recommended measures to promote social distancing, or determined that meeting in person would present imminent risks to the health and safety of attendees. Meeting agendas must be posted at all teleconference locations and agencies must give notice of the meeting to allow members of the public to access the meeting and address the agency and give notice of the means by which members of the public may access the meeting and offer public comment, including an opportunity to attend via a call-in option or an internet-based service option. | Yes | 9/16/21 (urgency bill) | Plan must comply with the meeting notice and access requirements. |
| AB 1184 | Medical Information: Confidentiality - Revises certain provisions and definitions in the Confidentiality of Medical Information (CMI) Act to require plans to protect the confidentiality of an enrollee's medical information, to not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care.<br>• Requires plans to direct certain communications regarding a protected individual's receipt of sensitive services directly to the protected individual receiving care.<br>• Prohibits plans from disclosing medical information relating to sensitive health services without obtaining express written authorization of the protected individual receiving care.<br>• Requires plans to notify enrollees that they may request a confidential communication in the following methods: (1) upon initial enrollment and annually thereafter upon renewal, (2) in the EOC, and (3) on the plan's website. | Yes | 7/1/2022 | CalViva may need to update policies & procedures, the EOC if DHCS requires changes, and on the Plan website. |

| | | | | |
|---|---|---|---|---|
| SB 48 | Medi-Cal: annual cognitive health assessment - Plans must cover an annual cognitive health assessment for Medi-Cal beneficiaries who are 65 years of age or older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare Program. Providers can be reimbursed for providing the assessment if they complete cognitive health assessment training and use validated tools determined by DHCS.<br>The law requires DHCS to analyze data related to this benefit and post information on the utilization of, and payment for, the benefit on its internet website. | Yes | 1/1/2022 | CalViva may need to update policies & procedures, the EOC if DHCS requires changes, and ensure encounter data or other reporting occurs as directed by DHCS. |
| SB 221 | Timely Access to Care: This law does the following:<br>• Codifies some of the timely access standards adopted in regulation by the DMHC and requires plans to ensure they have sufficient capacity and numbers of contracted providers to maintain compliance with timely access and other requirements.<br>• Requires that nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. This language does not limit coverage for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.<br>• Requires plans to provide information to an enrollee regarding the standards for timely access to care, including information related to interpreter services at the time of the appointment without imposing delay on scheduling of the appointment, and in a timely manner, no less than annually.<br>• Requires a plan operating in a service area that has a shortage of one or more types of providers to ensure timely access to covered health care services by referring an enrollee to available and accessible contracted providers in neighboring service areas or arrange coverage outside the plan's contracted network when in-network is not available (i.e. out of network or out of service area). | Yes | 1/1/22 for law overall; 7/1/22 to comply with 10-day follow-up appt with nonphysician mental health providers | The Plan processes may already comply with most of this law. CalViva may need to update access, monitoring and UM prior authorization policies & procedures, the EOC if DHCS requires changes, and ensure other reporting occurs as directed by DMHC and/or DHCS. |
| SB 428 | Adverse childhood experience (ACE) screenings: This law essentially codifies the Medi-Cal requirements and applies the benefit to all health plans. Plans that are providing coverage for pediatric services and preventive care must also include coverage for adverse childhood experience (ACE) screenings. Plan will cover ACEs screenings for children and adults, consistent with the Medi-Cal program's ACEs coverage requirements. | Yes | 1/1/2022 | Mimimal to no action needed by CalViva since already comply with Medi-Cal ACEs requirements. |

| | | | | |
|---|---|---|---|---|
| SB 510 | COVID-19 Cost Sharing: This bill has a retroactive "effectiveness" date back to March 4, 2020 and requires health plans to cover the costs associated with diagnostic and screening testing for and immunization against COVID-19 without cost-sharing, prior authorization, utilization management or in-network requirements. This bill also prohibits health plans from delegating such costs to providers without a renegotiation of contract terms. Applies a similar framework for testing and immunization during future public health emergencies.<br>**This bill also applies to COVID-19 testing and treatment covered under Medi-Cal managed care plan (MCP) contracts, but the impact, if any, is not clear. Currrently COVID-19 immunization costs are carved out of MCP contracts, so it is difficult to determine plan responsibility for services currently paid by the federal government, now or in the future.** | Yes | 1/1/2022 | TBD<br>Depending on DHCS guidance, CalViva may need to update policies & procedures, and address any provider contracts that have delegated financial risk for testing or immunizations. |
| SB 535 | Biomarker Testing: This bill prohibits health plans from requiring prior authorization for non-experimental biomarker testing for an enrollee with advanced or metastatic stage 3 or 4 cancer. Allows a plan to require prior authorization for biomarker-testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer. | Yes | 7/1/2022 | CalViva may need to update policies & procedures. |
| | | | | |
| | **New Laws - Information only** | | | |
| AB 457 | Telehealth Provider Act - The law requires health plans to disclose to their enrollees that they may use either a telehealth third-party corporate provider or their primary care provider for such services if offered by the health plan. The law also includes out of network and cost sharing notification requirements.<br>**This law is not applicable to Medi-Cal but does require DHCS to consider the appropriateness of applying the law to the Medi-Cal program.** | No | 1/1/2022 | Information only |

| | | | | |
|---|---|---|---|---|
| SB 306 | Sexually Transmitted Disease Testing: The bill does the following:<br>• Require a health care provider to include "expedited partner therapy" or "EPT" on a prescription if the practitioner does not have the name of a patient's sexual partner, and would authorize a pharmacist to dispense an expedited partner therapy prescription and label the drug without an individual's name if the prescription includes "expedited partner therapy" or "EPT."<br>• Requires plans to cover sexually transmitted disease home test kits, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by a provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.<br>**This law is not applicable to Medi-Cal but does state Medi-Cal coverage of expedited partner therapy shall be implemented only to the extent that the DHCS obtains any necessary federal approvals and federal financial participation is available and not jeopardized. Sexually transmitted disease home test kits for Medi-Cal are subject to existing W&I Code and subject to DHCS obtaining any necessary federal approvals and federal financial participation is available and not jeopardized.** | No | 1/1/2022 | Information only |

# Item #6

## Attachment 6.C

Appeals & Grievances Dashboard

# CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2022

Current as of End of the Month: January
Revised Date: 03/07/2022

| CalViva - 2022 | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Grievances** | **Jan** | **Feb** | **Mar** | **Q1** | **Apr** | **May** | **Jun** | **Q2** | **Jul** | **Aug** | **Sep** | **Q3** | **Oct** | **Nov** | **Dec** | **Q4** | **2022 YTD** | **2021 YTD** |
| Expedited Grievances Received | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 110 |
| Standard Grievances Received | 72 | 0 | 0 | 72 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 72 | 997 |
| **Total Grievances Received** | **76** | **0** | **0** | **76** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **76** | **1107** |
| | | | | | | | | | | | | | | | | | | |
| Grievance Ack Letters Sent Noncompliant | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 |
| **Grievance Ack Letter Compliance Rate** | **98.6%** | **0.0%** | **0.0%** | **98.6%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **98.61%** | **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 | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 111 |
| **Expedited Grievance Compliance rate** | **100.0%** | **0.0%** | **0.0%** | **100.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **100.00%** | **100.0%** |
| | | | | | | | | | | | | | | | | | | |
| Standard Grievances Resolved Noncompliant | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Standard Grievances Resolved Compliant | 79 | 0 | 0 | 79 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 79 | 1033 |
| **Standard Grievance Compliance rate** | **98.7%** | **0.0%** | **0.0%** | **98.7%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **98.75%** | **100.0%** |
| | | | | | | | | | | | | | | | | | | |
| **Total Grievances Resolved** | **84** | **0** | **0** | **84** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **84** | **1144** |
| | | | | | | | | | | | | | | | | | | |
| **Grievance Descriptions - Resolved Cases** | | | | | | | | | | | | | | | | | | |
| **Quality of Service Grievances** | **62** | **0** | **0** | **62** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **62** | **878** |
| Access - Other - DMHC | 15 | 0 | 0 | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 63 |
| Access - PCP - DHCS | 6 | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 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 | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 48 |
| Administrative | 10 | 0 | 0 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 191 |
| Continuity of Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Interpersonal | 14 | 0 | 0 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 | 82 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 80 |
| Pharmacy | 5 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 51 |
| Transportation - Access | 3 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 116 |
| Transportation - Behaviour | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 100 |
| Transportation - Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 37 |
| | | | | | | | | | | | | | | | | | | |
| **Quality Of Care Grievances** | **22** | **0** | **0** | **22** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **22** | **266** |
| Access - Other - DMHC | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 |
| Access - PCP - DHCS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Mental Health | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 56 |
| PCP Care | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 95 |
| PCP Delay | 6 | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 42 |
| Pharmacy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Specialist Care | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 46 |
| Specialist Delay | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 15 |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Exempt Grievances Received** | 280 | 0 | 0 | **280** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **280** | 2877 |
| Access - Avail of Appt w/ PCP | 4 | 0 | 0 | **4** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **4** | 93 |
| Access - Avail of Appt w/ Specialist | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 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 | 7 | 0 | 0 | **7** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **7** | 35 |
| Access - Wait Time - in office for appt | 1 | 0 | 0 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **1** | 17 |
| Access - Panel Disruption | 1 | 0 | 0 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **1** | 57 |
| Access - Shortage of Providers | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 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 | 2 | 0 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **2** | 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 | 1 | 0 | 0 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **1** | 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 | 2 | 0 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **2** | 17 |
| Attitude/Service - Provider | 59 | 0 | 0 | **59** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **59** | 285 |
| Attitude/Service - Office Staff | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 12 |
| Attitude/Service - Vendor | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 11 |
| Attitude/Service - Health Plan | 1 | 0 | 0 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **1** | 11 |
| Authorization - Authorization Related | 2 | 0 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **2** | 25 |
| 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** | 6 |
| Eligibility Issue - Member not eligible per Provider | 2 | 0 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **2** | 37 |
| Health Plan Materials - ID Cards-Not Received | 35 | 0 | 0 | **35** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **35** | 235 |
| Health Plan Materials - ID Cards-Incorrect Information on Card | 2 | 0 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **2** | 7 |
| Health Plan Materials - Other | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 3 |
| PCP Assignment/Transfer - Health Plan Assignment - Change Request | 54 | 0 | 0 | **54** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **54** | 1162 |
| PCP Assignment/Transfer - HCO Assignment - Change Request | 60 | 0 | 0 | **60** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **60** | 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 | 0 | 0 | **3** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **3** | 19 |
| PCP Assignment/Transfer - Rollout of PPG | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 45 |

**CalViva Health Appeals and Grievances Dashboard 2022**

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PCP Assignment/Transfer - Mileage Inconvenience | 5 | 0 | 0 | **5** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **5** | 58 |
| Pharmacy - Authorization Issue | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 5 |
| Pharmacy - Authorization Issue-CalViva Error | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 1 |
| Pharmacy - Eligibility Issue | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 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 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 0 |
| Pharmacy - Pharmacy-Retail | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 45 |
| Transportation - Access - Provider No Show | 14 | 0 | 0 | **14** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **14** | 24 |
| Transportation - Access - Provider Late | 4 | 0 | 0 | **4** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **4** | 52 |
| Transportation - Behaviour | 10 | 0 | 0 | **10** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **10** | 119 |
| Transportation - Other | 1 | 0 | 0 | **1** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **1** | 12 |
| OTHER - Other | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **0** | 7 |
| OTHER - Balance Billing from Provider | 10 | 0 | 0 | **10** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | **10** | 161 |
| | | | | | | | | | | | | | | | | | | |

**CalViva Health Appeals and Grievances Dashboard 2022**

| Appeals | Jan | Feb | Mar | Q1 | Apr | May | June | Q2 | Jul | Aug | Sep | Q3 | Oct | Nov | Dec | Q4 | YTD | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Expedited Appeals Received | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 115 |
| Standard Appeals Received | 34 | 0 | 0 | 34 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 | 918 |
| **Total Appeals Received** | **34** | **0** | **0** | **34** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | 34 | **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%** | **0.0%** | **0.0%** | **100.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **100.00%** | **99.7%** |
| | | | | | | | | | | | | | | | | | | |
| 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 | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | 0 | 114 |
| **Expedited Appeals Compliance Rate** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **#DIV/0!** | **99.1%** |
| | | | | | | | | | | | | | | | | | | |
| 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 | 53 | 0 | 0 | 53 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 53 | 916 |
| **Standard Appeals Compliance Rate** | **100.0%** | **0.0%** | **0.0%** | **100.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **100.00%** | **100.0%** |
| | | | | | | | | | | | | | | | | | | |
| **Total Appeals Resolved** | **53** | **0** | **0** | **53** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **53** | **1031** |
| | | | | | | | | | | | | | | | | | | |
| **Appeals Descriptions - Resolved Cases** | | | | | | | | | | | | | | | | | | |
| **Pre-Service Appeals** | **53** | **0** | **0** | **53** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **53** | 1029 |
| Continuity of Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Consultation | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 17 |
| DME | 2 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 47 |
| 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 | 2 |
| Advanced Imaging | 20 | 0 | 0 | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 20 | 488 |
| Other | 7 | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 | 67 |
| Pharmacy | 19 | 0 | 0 | 19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 19 | 362 |
| Surgery | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 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 | 21 | 0 | 0 | **21** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 21 | 577 |
| **Uphold Rate** | **39.6%** | **0.0%** | **0.0%** | **39.6%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **39.6%** | **56.0%** |
| Overturns - Full | 26 | 0 | 0 | **26** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 26 | 432 |
| **Overturn Rate - Full** | **49.1%** | **0.0%** | **0.0%** | **49.1%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **49.1%** | **41.9%** |
| Overturns - Partials | 2 | 0 | 0 | **2** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 2 | 12 |
| **Overturn Rate - Partial** | **3.8%** | **0.0%** | **0.0%** | **3.8%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.00%** | **3.8%** | **1.2%** |
| Withdrawal | 4 | 0 | 0 | **4** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | **0** | 0 | 0 | 0 | 0 | **4** | 10 |
| **Withdrawal Rate** | **7.5%** | **0.0%** | **0.0%** | **7.5%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **0.0%** | **7.5%** | **1.0%** |
| | | | | | | | | | | | | | | | | | | |
| **Membership** | 398,468 | - | - | | - | - | - | | - | - | - | | - | - | - | | | 4,316,872 |
| Appeals - PTMPM | 0.13 | - | - | 0.13 | - | - | - | - | - | - | - | - | - | - | - | - | 0.13 | 0.24 |
| Grievances - PTMPM | 0.21 | - | - | 0.21 | - | - | - | - | - | - | - | - | - | - | - | - | 0.21 | 0.27 |
| | | | | | | | | | | | | | | | | | | |

# Item #6

## Attachment 6.D

Key Indicator Report

# *Healthcare Solutions Reporting*

## Key Indicator Report

*Auth Based PPG Utilization Metrics for CALVIVA California SHP*

*Report from 1/01/2022 to 1/31/2022*

*Report created 2/23/2022*

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

**Exhibits:**



### Contact Information

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

**Key Indicator Report**
**Auth Based PPG Utilization Metrics for CALVIVA California SHP**
**Report from 1/01/2022 to 1/31/2022**
Report created 2/23/2022

| ER utilization based on Claims data | 2021-01 | 2021-02 | 2021-03 | 2021-04 | 2021-05 | 2021-06 | 2021-07 | 2021-08 | 2021-09 | 2021-10 | 2021-11 | 2021-12 | 2021-Trend | 2022-01 | Q1 2021 | Q2 2021 | Q3 2021 | Q4 2021 | Qtr Trend | CY- 2021 | YTD-2022 | YTD-Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | Quarterly Averages | | | | | | Annual Averages | |
| Expansion Mbr Months | 84,567 | 84,036 | 83,731 | 84,519 | 85,913 | 87,362 | 88,789 | 90,592 | 91,747 | 92,797 | 94,081 | 94,898 | | 95,931 | 84,111 | 85,931 | 90,376 | 93,925 | | 88,586 | 1,210,340 | |
| Family/Adult/Other Mbr Mos | 244,970 | 244,370 | 243,647 | 245,086 | 247,163 | 249,247 | 251,047 | 252,620 | 253,954 | 255,068 | 256,151 | 256,827 | | 257,756 | 244,329 | 247,165 | 252,540 | 256,015 | | 250,013 | 3,134,787 | |
| SPD Mbr Months | 34,628 | 34,649 | 34,581 | 34,662 | 34,713 | 34,814 | 34,878 | 34,955 | 34,994 | 35,098 | 35,167 | 35,207 | | 35,251 | 34,619 | 34,730 | 34,942 | 35,157 | | 34,862 | 424,394 | |
| Admits - Count | 2,050 | 1,840 | 2,221 | 2,119 | 2,166 | 2,256 | 2,258 | 2,314 | 2,199 | 2,181 | 2,249 | 2,246 | | 2,201 | 2,037 | 2,180 | 2,257 | 2,225 | | 2,175 | 3,302 | |
| Expansion | 556 | 491 | 634 | 606 | 597 | 645 | 659 | 695 | 588 | 616 | 598 | 662 | | 666 | 560 | 616 | 647 | 625 | | 612 | 1,042 | |
| Family/Adult/Other | 1,054 | 886 | 1,068 | 1,015 | 1,036 | 1,050 | 1,048 | 1,159 | 1,138 | 1,113 | 1,127 | 1,102 | | 1,046 | 1,003 | 1,034 | 1,115 | 1,114 | | 1,066 | 1,548 | |
| SPD | 433 | 457 | 507 | 489 | 530 | 558 | 547 | 457 | 470 | 449 | 519 | 479 | | 483 | 466 | 526 | 491 | 482 | | 491 | 704 | |
| Admits Acute - Count | 1,402 | 1,234 | 1,550 | 1,531 | 1,551 | 1,589 | 1,641 | 1,602 | 1,510 | 1,518 | 1,564 | 1,594 | | 1,602 | 1,395 | 1,557 | 1,584 | 1,559 | | 1,524 | 2,401 | |
| Expansion | 483 | 407 | 546 | 530 | 523 | 553 | 584 | 584 | 498 | 533 | 512 | 547 | | 564 | 479 | 535 | 555 | 531 | | 525 | 868 | |
| Family/Adult/Other | 510 | 412 | 544 | 543 | 524 | 527 | 559 | 600 | 579 | 567 | 576 | 604 | | 577 | 489 | 531 | 579 | 582 | | 545 | 863 | |
| SPD | 409 | 414 | 460 | 457 | 502 | 509 | 498 | 418 | 432 | 417 | 476 | 443 | | 461 | 428 | 489 | 449 | 445 | | 453 | 669 | |
| Readmit 30 Day - Count | 209 | 199 | 245 | 215 | 228 | 259 | 229 | 214 | 211 | 218 | 225 | 224 | | 190 | 218 | 234 | 218 | 222 | | 223 | 203 | |
| Expansion | 67 | 76 | 86 | 72 | 72 | 88 | 89 | 73 | 69 | 87 | 73 | 94 | | 75 | 76 | 77 | 77 | 85 | | 79 | 82 | |
| Family/Adult/Other | 53 | 39 | 53 | 42 | 38 | 52 | 51 | 57 | 46 | 49 | 46 | 32 | | 41 | 48 | 44 | 51 | 42 | | 47 | 43 | |
| SPD | 89 | 84 | 106 | 101 | 118 | 119 | 89 | 84 | 96 | 82 | 106 | 98 | | 74 | 93 | 113 | 90 | 95 | | 98 | 78 | |
| **ER Visits - Count | 9,474 | 9,383 | 11,117 | 12,140 | 13,756 | 13,397 | 14,433 | 14,872 | 12,997 | 12,788 | 12,100 | 11,959 | | 7,770 | 9,991 | 13,098 | 14,101 | 12,282 | | 12,368 | 7,770 | |
| Expansion | 2,987 | 2,892 | 3,158 | 3,362 | 3,539 | 3,616 | 3,833 | 3,724 | 3,024 | 3,086 | 2,737 | 2,896 | | 2,213 | 3,012 | 3,506 | 3,527 | 2,906 | | 3,238 | 2,213 | |
| Family/Adult/Other | 5,307 | 5,313 | 6,128 | 6,786 | 7,896 | 7,493 | 8,049 | 8,531 | 7,629 | 7,197 | 6,932 | 7,252 | | 4,824 | 5,583 | 7,392 | 8,070 | 7,127 | | 7,043 | 4,824 | |
| SPD | 1,160 | 1,116 | 1,331 | 1,337 | 1,488 | 1,406 | 1,492 | 1,430 | 1,172 | 1,245 | 1,081 | 1,167 | | 727 | 1,202 | 1,410 | 1,365 | 1,164 | | 1,285 | 727 | |
| | | | | | | | | | | | | | | | | | | | | | | |
| Admits Acute - PTMPY | 43.2 | 37.9 | 47.4 | 46.6 | 47.0 | 48.0 | 49.4 | 48.0 | 45.1 | 45.3 | 46.5 | 47.2 | | 46.9 | 42.9 | 47.2 | 47.5 | 46.3 | | 46.0 | 70.3 | |
| Expansion | 68.5 | 58.1 | 78.3 | 75.2 | 73.1 | 76.0 | 78.9 | 77.4 | 65.1 | 68.9 | 65.3 | 69.2 | | 70.6 | 68.3 | 74.8 | 73.7 | 67.8 | | 71.1 | 8.6 | |
| Family/Adult/Other | 25.0 | 20.2 | 26.8 | 26.6 | 25.4 | 25.4 | 26.7 | 28.5 | 27.4 | 26.7 | 27.0 | 28.2 | | 26.9 | 24.0 | 25.8 | 27.5 | 27.3 | | 26.2 | 3.3 | |
| SPD | 141.7 | 143.4 | 159.6 | 158.2 | 173.5 | 175.4 | 171.3 | 143.5 | 148.1 | 142.6 | 162.4 | 151.0 | | 156.9 | 148.2 | 169.1 | 154.3 | 152.0 | | 155.9 | 18.9 | |
| Bed Days Acute - PTMPY | 284.8 | 210.5 | 237.3 | 235.0 | 232.3 | 238.5 | 262.0 | 262.9 | 280.8 | 234.7 | 270.8 | 261.0 | | 254.4 | 244.1 | 235.3 | 268.6 | 255.5 | | 251.0 | 356.3 | |
| Expansion | 478.1 | 338.4 | 432.5 | 410.0 | 384.8 | 387.5 | 453.3 | 456.7 | 442.7 | 375.0 | 437.4 | 414.6 | | 367.6 | 416.4 | 394.0 | 450.9 | 409.2 | | 417.9 | 43.0 | |
| Family/Adult/Other | 135.0 | 97.9 | 106.5 | 111.1 | 103.8 | 100.2 | 120.7 | 133.7 | 144.0 | 116.7 | 115.8 | 116.0 | | 113.4 | 113.1 | 105.0 | 132.8 | 116.2 | | 116.9 | 13.4 | |
| SPD | 1,078.4 | 862.0 | 894.9 | 886.3 | 957.2 | 1,032.7 | 972.6 | 860.0 | 1,015.7 | 847.2 | 1,095.7 | 1,036.8 | | 1,127.8 | 945.1 | 958.8 | 949.5 | 993.4 | | 961.8 | 122.2 | |
| ALOS Acute | 6.6 | 5.6 | 5.0 | 5.0 | 4.9 | 5.0 | 5.3 | 5.5 | 6.2 | 5.2 | 5.8 | 5.5 | | 5.4 | 5.7 | 5.0 | 5.7 | 5.5 | | 5.5 | 5.1 | |
| Expansion | 7.0 | 5.8 | 5.5 | 5.4 | 5.3 | 5.1 | 5.7 | 5.9 | 6.8 | 5.4 | 6.7 | 6.0 | | 5.2 | 6.1 | 5.3 | 6.1 | 6.0 | | 5.9 | 5.0 | |
| Family/Adult/Other | 5.4 | 4.8 | 4.0 | 4.2 | 4.1 | 4.0 | 4.5 | 4.7 | 5.3 | 4.4 | 4.3 | 4.1 | | 4.2 | 4.7 | 4.1 | 4.8 | 4.3 | | 4.5 | 4.1 | |
| SPD | 7.6 | 6.0 | 5.6 | 5.6 | 5.5 | 5.9 | 5.7 | 6.0 | 6.9 | 5.9 | 6.7 | 6.9 | | 7.2 | 6.4 | 5.7 | 6.2 | 6.5 | | 6.2 | 6.5 | |
| Readmit % 30 Day | 10.2% | 10.8% | 11.0% | 10.1% | 10.5% | 11.5% | 10.1% | 9.2% | 9.6% | 10.0% | 10.0% | 10.0% | | 8.6% | 10.7% | 10.7% | 9.7% | 10.0% | | 10.3% | 6.1% | |
| Expansion | 12.1% | 15.5% | 13.6% | 11.9% | 12.1% | 13.6% | 13.5% | 10.5% | 11.7% | 14.1% | 12.2% | 14.2% | | 11.3% | 13.6% | 12.6% | 11.9% | 13.5% | | 12.9% | 7.9% | |
| Family/Adult/Other | 5.0% | 4.4% | 5.0% | 4.1% | 3.7% | 5.0% | 4.9% | 4.9% | 4.0% | 4.4% | 4.1% | 2.9% | | 3.9% | 4.8% | 4.3% | 4.6% | 3.8% | | 4.4% | 2.8% | |
| SPD | 20.6% | 18.4% | 20.9% | 20.7% | 22.3% | 21.3% | 16.3% | 18.4% | 20.4% | 18.3% | 20.4% | 20.5% | | 15.3% | 20.0% | 21.4% | 18.2% | 19.8% | | 19.9% | 11.1% | |
| **ER Visits - PTMPY | 292.2 | 288.2 | 340.0 | 369.6 | 416.9 | 404.5 | 434.3 | 445.9 | 388.5 | 381.4 | 359.6 | 354.5 | | 227.5 | 306.9 | 397.0 | 422.9 | 365.1 | | 373.3 | 227.5 | |
| Expansion | 423.9 | 413.0 | 452.6 | 477.3 | 494.3 | 496.7 | 518.0 | 493.3 | 395.5 | 399.1 | 349.1 | 366.2 | | 276.8 | 429.8 | 489.6 | 468.3 | 371.3 | | 438.6 | 21.9 | |
| Family/Adult/Other | 260.0 | 260.9 | 301.8 | 332.3 | 383.4 | 360.8 | 384.7 | 405.2 | 360.5 | 338.6 | 324.7 | 338.8 | | 224.6 | 274.2 | 358.9 | 383.4 | 334.1 | | 338.0 | 18.5 | |
| SPD | 402.0 | 386.5 | 461.9 | 462.9 | 514.4 | 484.6 | 513.3 | 490.9 | 401.9 | 425.7 | 368.9 | 397.8 | | 247.5 | 416.8 | 487.3 | 468.7 | 397.4 | | 442.5 | 20.6 | |
| Services | TAT Compliance Goal: 100% | | | | | | | | | | | | | pliance Go | TAT Compliance Goal: 100% | | | | | TAT Compliance Goal: 100% | | |
| Preservice Routine | 100.0% | 100.0% | 98.0% | 100.0% | 100.0% | 100.0% | 84.0% | 82.0% | 98.0% | 98.0% | 96.0% | 100.0% | | 100.0% | 99.3% | 100.0% | 88.0% | 98.0% | | | | |
| Preservice Urgent | 96.0% | 100.0% | 98.0% | 98.0% | 100.0% | 100.0% | 100.0% | 96.0% | 100.0% | 98.0% | 98.0% | 100.0% | | 100.0% | 98.0% | 99.3% | 98.7% | 98.7% | | | | |
| Postservice | 98.0% | 100.0% | 98.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% | 94.0% | 100.0% | 100.0% | | 98.0% | 98.7% | 100.0% | 99.3% | 98.0% | | | | |
| Concurrent (inpatient only) | 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% | 99.3% | | | | |
| Deferrals - Routine | 100.0% | 95.4% | 100.0% | 100.0% | 100.0% | 100.0% | 83.3% | 78.6% | 95.2% | 95.2% | 100.0% | 100.0% | | 100.0% | 98.5% | 100.0% | 85.7% | 98.4% | | | | |
| Deferrals - Urgent | 100.0% | Null | 100.0% | null | 50.0% | 100.0% | N/A | 100.0% | 100.0% | N/A | 100.0% | N/A | | 100.0% | 100.0% | 83.3% | 100.0% | 100.0% | | | | |
| Deferrals - Post Service | null | null | null | NA | NA | NA | NA | NA | NA | NA | NA | NA | | null | null | null | null | null | | | | |
| | CCS ID RATE | | | | | | | | | | | | | CCS ID RATE | CCS ID RATE | | | | | CCS ID RATE | | |
| CCS % | 8.17% | 8.29% | 8.25% | 8.21% | 8.17% | 8.33% | 8.36% | 8.37% | 8.37% | 8.37% | 8.48% | 8.33% | | 8.82% | 8.24% | 8.24% | 8.28% | 8.40% | | 8.27% | 8.82% | |
| | Perinatal Case Management | | | | | | | | | | | | | l Case Mana | Perinatal Case Management | | | | | Perinatal Case Management | | |
| Total Number Of Referrals | 136 | 154 | 259 | 173 | 128 | 97 | 145 | 162 | 106 | 118 | 158 | 174 | | 146 | 549 | 398 | 413 | 450 | | 1,810 | 146 | |
| Pending | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 3 | 2 | | 1 | 0 | 0 | 2 | 7 | | 9 | 1 | |
| Ineligible | 7 | 9 | 22 | 23 | 6 | 3 | 2 | 2 | 3 | 8 | 4 | 7 | | 5 | 38 | 32 | 7 | 19 | | 96 | 5 | |

**Key Indicator Report**
**Auth Based PPG Utilization Metrics for CALVIVA California SHP**
**Report from 1/01/2022 to 1/31/2022**
Report created 2/23/2022

| ER utilization based on Claims data | 2021-01 | 2021-02 | 2021-03 | 2021-04 | 2021-05 | 2021-06 | 2021-07 | 2021-08 | 2021-09 | 2021-10 | 2021-11 | 2021-12 | 2021-Trend | 2022-01 | Q1 2021 | Q2 2021 | Q3 2021 | Q4 2021 | Qtr Trend | CY- 2021 | YTD-2022 | YTD-Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total Outreached** | 129 | 145 | 237 | 150 | 122 | 94 | 143 | 160 | 101 | 108 | 151 | 165 | | 140 | 511 | 366 | 404 | 424 | | 1,705 | 140 | |
| **Engaged** | 32 | 40 | 47 | 36 | 34 | 29 | 42 | 40 | 20 | 24 | 29 | 18 | | 35 | 119 | 99 | 102 | 71 | | 391 | 35 | |
| **Engagement Rate** | 25% | 28% | 20% | 24% | 28% | 31% | 29% | 25% | 20% | 22% | 19% | 11% | | 25% | 23% | 27% | 25% | 17% | | 23% | 25% | |
| **New Cases Opened** | 32 | 40 | 47 | 36 | 34 | 29 | 42 | 40 | 20 | 24 | 29 | 18 | | 35 | 119 | 99 | 102 | 71 | | 391 | 35 | |
| **Total Cases Managed** | 257 | 251 | 281 | 286 | 274 | 263 | 278 | 291 | 274 | 262 | 251 | 237 | | 225 | 344 | 354 | 336 | 307 | | 621 | 225 | |
| **Total Cases Closed** | 46 | 17 | 32 | 46 | 36 | 32 | 30 | 39 | 35 | 38 | 33 | 47 | | 44 | 95 | 114 | 104 | 118 | | 431 | 44 | |
| **Cases Remained Open** | 212 | 215 | 225 | 217 | 158 | 115 | 193 | 160 | 166 | 188 | 204 | 180 | | 170 | 225 | 115 | 166 | 180 | | 180 | 170 | |
| | **Integrated Case Management** | | | | | | | | | | | | | **d Case Mar** | | **Integrated Case Management** | | | | **Integrated Case Management** | | |
| **Total Number Of Referrals** | 121 | 116 | 115 | 91 | 81 | 133 | 104 | 136 | 132 | 121 | 86 | 77 | | 91 | 352 | 305 | 372 | 284 | | 1,313 | 91 | |
| **Pending** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 4 | 6 | | 9 | 0 | 0 | 2 | 12 | | 14 | 9 | |
| **Ineligible** | 17 | 9 | 9 | 7 | 7 | 3 | 6 | 10 | 10 | 8 | 9 | 12 | | 7 | 35 | 17 | 26 | 29 | | 107 | 7 | |
| **Total Outreached** | 104 | 107 | 106 | 84 | 74 | 130 | 98 | 126 | 120 | 111 | 73 | 59 | | 75 | 317 | 288 | 344 | 243 | | 1,192 | 75 | |
| **Engaged** | 74 | 76 | 74 | 55 | 51 | 86 | 55 | 77 | 73 | 83 | 48 | 38 | | 47 | 224 | 192 | 205 | 169 | | 790 | 47 | |
| **Engagement Rate** | 71% | 71% | 70% | 65% | 69% | 66% | 56% | 61% | 61% | 75% | 66% | 64% | | 63% | 71% | 67% | 60% | 70% | | 66% | 63% | |
| **Total Screened and Refused/Decline** | 8 | 9 | 11 | 8 | 9 | 17 | 12 | 15 | 12 | 12 | 11 | 3 | | 3 | 28 | 34 | 39 | 26 | | 127 | 3 | |
| **Unable to Reach** | 22 | 22 | 21 | 21 | 14 | 27 | 31 | 34 | 35 | 16 | 14 | 18 | | 25 | 65 | 62 | 100 | 48 | | 275 | 25 | |
| **New Cases Opened** | 74 | 76 | 74 | 55 | 51 | 86 | 55 | 77 | 73 | 83 | 48 | 38 | | 47 | 224 | 192 | 205 | 169 | | 790 | 47 | |
| **Total Cases Closed** | 60 | 60 | 51 | 48 | 51 | 85 | 57 | 84 | 81 | 82 | 78 | 78 | | 75 | 171 | 184 | 222 | 238 | | 815 | 75 | |
| **Cases Remained Open** | 310 | 322 | 330 | 327 | 253 | 166 | 271 | 230 | 224 | 292 | 301 | 258 | | 233 | 330 | 166 | 224 | 258 | | 258 | 233 | |
| **Total Cases Managed** | 378 | 394 | 406 | 408 | 409 | 445 | 416 | 435 | 432 | 431 | 395 | 354 | | 317 | 526 | 537 | 566 | 516 | | 1104 | 317 | |
| **Critical-Complex Acuity** | 60 | 58 | 60 | 58 | 50 | 56 | 56 | 57 | 48 | 46 | 44 | 40 | | 37 | 74 | 64 | 61 | 53 | | 120 | 37 | |
| **High/Moderate/Low Acuity** | 318 | 336 | 346 | 350 | 359 | 389 | 360 | 378 | 384 | 385 | 351 | 314 | | 280 | 452 | 473 | 505 | 463 | | 984 | 280 | |
| | **Transitional Case Management** | | | | | | | | | | | | | **al Case Ma** | | **Transitional Case Management** | | | | **Transitional Case Management** | | |
| **Total Number Of Referrals** | 143 | 201 | 229 | 250 | 212 | 201 | 115 | 138 | 101 | 94 | 105 | 80 | | 85 | 573 | 663 | 354 | 279 | | 1,869 | 85 | |
| **Pending** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | | 3 | 0 | 0 | 0 | 5 | | 5 | 3 | |
| **Ineligible** | 23 | 21 | 26 | 40 | 23 | 21 | 21 | 10 | 10 | 7 | 13 | 8 | | 6 | 70 | 84 | 41 | 28 | | 223 | 6 | |
| **Total Outreached** | 120 | 180 | 203 | 210 | 189 | 180 | 94 | 128 | 91 | 87 | 92 | 67 | | 76 | 503 | 579 | 313 | 246 | | 1,641 | 76 | |
| **Engaged** | 57 | 102 | 116 | 128 | 132 | 148 | 73 | 97 | 66 | 63 | 70 | 45 | | 52 | 275 | 408 | 236 | 178 | | 1,097 | 52 | |
| **Engagement Rate** | 48% | 57% | 57% | 61% | 70% | 82% | 78% | 76% | 73% | 72% | 76% | 67% | | 68% | 55% | 70% | 75% | 72% | | 67% | 68% | |
| **Total Screened and Refused/Decline** | 13 | 24 | 15 | 10 | 10 | 6 | 4 | 6 | 1 | 4 | 3 | 1 | | 1 | 52 | 26 | 11 | 8 | | 97 | 1 | |
| **Unable to Reach** | 50 | 54 | 72 | 72 | 47 | 26 | 17 | 25 | 24 | 20 | 19 | 21 | | 23 | 176 | 145 | 66 | 60 | | 447 | 23 | |
| **New Cases Opened** | 57 | 102 | 116 | 128 | 132 | 148 | 73 | 97 | 66 | 63 | 70 | 45 | | 52 | 275 | 408 | 236 | 178 | | 1,097 | 52 | |
| **Total Cases Closed** | 89 | 49 | 109 | 120 | 122 | 145 | 132 | 74 | 109 | 48 | 65 | 73 | | 48 | 247 | 387 | 315 | 186 | | 1,135 | 48 | |
| **Cases Remained Open** | 76 | 61 | 92 | 103 | 92 | 60 | 64 | 67 | 40 | 50 | 62 | 50 | | 45 | 92 | 60 | 40 | 50 | | 50 | 45 | |
| **Total Cases Managed** | 148 | 161 | 228 | 251 | 263 | 295 | 218 | 182 | 174 | 125 | 147 | 126 | | 104 | 366 | 487 | 388 | 242 | | 1214 | 104 | |
| **High/Moderate/Low Acuity** | 148 | 161 | 228 | 251 | 263 | 295 | 218 | 182 | 174 | 125 | 147 | 126 | | 104 | 366 | 487 | 388 | 242 | | 1214 | 104 | |
| | **Palliative Care** | | | | | | | | | | | | | **alliative Car** | | **Palliative Care** | | | | **Palliative Care** | | |
| **Total Number Of Referrals** | 13 | 12 | 17 | 14 | 10 | 18 | 13 | 9 | 12 | 10 | 15 | 12 | | 7 | 42 | 42 | 34 | 37 | | 155 | 7 | |
| **Pending** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | | 3 | 0 | 0 | 0 | 3 | | 3 | 3 | |
| **Ineligible** | 6 | 4 | 4 | 5 | 4 | 3 | 2 | 3 | 5 | 6 | 7 | 5 | | 3 | 14 | 12 | 10 | 18 | | 54 | 3 | |
| **Total Outreached** | 7 | 8 | 13 | 9 | 6 | 15 | 11 | 6 | 7 | 4 | 8 | 4 | | 1 | 28 | 30 | 24 | 16 | | 98 | 1 | |
| **Engaged** | 5 | 8 | 7 | 4 | 5 | 11 | 9 | 5 | 6 | 2 | 7 | 3 | | 1 | 20 | 20 | 20 | 12 | | 72 | 1 | |
| **Engagement Rate** | 71% | 100% | 54% | 44% | 83% | 73% | 82% | 83% | 86% | 50% | 88% | 75% | | 100% | 71% | 67% | 83% | 75% | | 73% | 100% | |
| **Total Screened and Refused/Decline** | 2 | 0 | 4 | 2 | 1 | 3 | 2 | 1 | 0 | 2 | 1 | 0 | | 0 | 6 | 6 | 3 | 3 | | 18 | 0 | |
| **Unable to Reach** | 0 | 0 | 2 | 3 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | | 0 | 2 | 4 | 1 | 1 | | 8 | 0 | |
| **New Cases Opened** | 5 | 8 | 7 | 4 | 5 | 11 | 9 | 5 | 6 | 2 | 7 | 3 | | 1 | 20 | 20 | 20 | 12 | | 72 | 1 | |
| **Total Cases Closed** | 5 | 2 | 8 | 2 | 8 | 9 | 9 | 5 | 6 | 14 | 4 | 3 | | 11 | 15 | 19 | 20 | 21 | | 75 | 11 | |
| **Cases Remained Open** | 92 | 91 | 91 | 94 | 68 | 46 | 79 | 66 | 71 | 76 | 84 | 83 | | 80 | 91 | 46 | 71 | 83 | | 83 | 80 | |
| **Total Cases Managed** | 102 | 103 | 107 | 104 | 108 | 108 | 110 | 104 | 105 | 101 | 94 | 93 | | 92 | 114 | 116 | 118 | 111 | | 166 | 92 | |
| | **Behavioral Health Case Management** | | | | | | | | | | | | | **ealth Case I** | | **Behavioral Health Case Management** | | | | **Behavioral Health Case Management** | | |
| **Total Number Of Referrals** | 73 | 92 | 86 | 87 | 93 | 82 | 91 | 90 | 111 | 120 | 103 | 82 | | 74 | 251 | 262 | 292 | 305 | | 1,110 | 74 | |
| **Pending** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 13 | | 6 | 0 | 0 | 0 | 14 | | 14 | 6 | |
| **Ineligible** | 6 | 3 | 3 | 1 | 2 | 4 | 2 | 6 | 5 | 3 | 5 | 4 | | 6 | 12 | 7 | 13 | 12 | | 44 | 6 | |
| **Total Outreached** | 67 | 89 | 83 | 86 | 91 | 78 | 89 | 84 | 106 | 117 | 97 | 65 | | 62 | 239 | 255 | 279 | 279 | | 1,052 | 62 | |

**Key Indicator Report**
**Auth Based PPG Utilization Metrics for CALVIVA California SHP**
**Report from 1/01/2022 to 1/31/2022**
Report created 2/23/2022

| ER utilization based on Claims data | 2021-01 | 2021-02 | 2021-03 | 2021-04 | 2021-05 | 2021-06 | 2021-07 | 2021-08 | 2021-09 | 2021-10 | 2021-11 | 2021-12 | 2021-Trend | 2022-01 | Q1 2021 | Q2 2021 | Q3 2021 | Q4 2021 | Qtr Trend | CY- 2021 | YTD-2022 | YTD-Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Engaged** | 29 | 47 | 39 | 40 | 42 | 40 | 41 | 53 | 57 | 63 | 51 | 35 | | 43 | 115 | 122 | 151 | 149 | | 537 | 43 | |
| **Engagement Rate** | 43% | 53% | 47% | 47% | 46% | 51% | 46% | 63% | 54% | 54% | 53% | 54% | | 69.0% | 48% | 48% | 54% | 53% | | 51% | 69% | |
| **Total Screened and Refused/Decline** | 0 | 2 | 3 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | | 0 | 5 | 1 | 1 | 2 | | 9 | 0 | |
| **Unable to Reach** | 38 | 40 | 41 | 46 | 48 | 38 | 47 | 31 | 49 | 54 | 45 | 29 | | 19 | 119 | 132 | 127 | 128 | | 506 | 19 | |
| **New Cases Opened** | 29 | 47 | 39 | 40 | 42 | 40 | 41 | 53 | 57 | 63 | 51 | 35 | | 43 | 115 | 122 | 151 | 149 | | 537 | 43 | |
| **Total Cases Closed** | 52 | 28 | 25 | 33 | 34 | 40 | 50 | 45 | 53 | 53 | 51 | 51 | | 35 | 105 | 107 | 148 | 155 | | 515 | 35 | |
| **Cases Remained Open** | 75 | 92 | 101 | 104 | 80 | 80 | 90 | 84 | 91 | 116 | 128 | 116 | | 123 | 101 | 80 | 91 | 116 | | 116 | 123 | |
| **Total Cases Managed** | 133 | 129 | 140 | 154 | 161 | 163 | 170 | 173 | 182 | 192 | 191 | 176 | | 171 | 220 | 236 | 280 | 278 | | 640 | 171 | |
| **Critical-Complex Acuity** | 7 | 6 | 6 | 9 | 9 | 8 | 9 | 7 | 9 | 12 | 10 | 11 | | 11 | 11 | 15 | 12 | 14 | | 28 | 11 | |
| **High/Moderate/Low Acuity** | 126 | 123 | 134 | 145 | 152 | 155 | 161 | 166 | 173 | 180 | 181 | 165 | | 160 | 209 | 221 | 268 | 264 | | 612 | 160 | |

# Item #6

## Attachment 6.E

Credentialing Quarterly Report

# REPORT SUMMARY TO COMMITTEE

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

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

**COMMITTEE DATE:** March 17th, 2022

**SUBJECT:** CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 1 2022

**Purpose of Activity:**
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 1st Quarter 2022 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on February 17th, 2022. At the February 17th meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the third quarter for 2021 were reviewed for delegated entities, the third & fourth quarters for MHN, and fourth quarter for Health Net. A summary of the third quarter data is included in the table below.

III. Table 1. Third Quarter 2021 Credentialing/Recredentialing

| | Sante | ChildNet | MHN | Health Net | La Salle | ASH | Envolve Vision | IMG | CVMP | Adventist | **Totals** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Initial credentialing | 83 | 17 | 34 | 1 | 47 | 0 | 3 | 5 | 32 | 26 | **248** |
| Recredentialing | 132 | 59 | 13 | 4 | 26 | 0 | 17 | 4 | 6 | 29 | **290** |
| 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** | **215** | **76** | **47** | **5** | **73** | **0** | **20** | **9** | **38** | **55** | **538** |

IV. The 2022 Credentialing Sub-Committee annual policy and procedure review was completed. Three policies were updated with minor or no changes. Three additional policies were revised as follows:

a. A new provider type was added to the *Organizational Provider* policy based upon CalAIM's ECM/CS initiative. This policy was provided for committee review.
b. The *Adverse Action* policy was revised in order to reduce the length of time a provider must wait to re-apply after termination/denial from five (5) years to three (3) years.
c. The *Appeal* policy was revised regarding the process for postponement of a Fair Hearing and also to address requirements related to in-person attendance at hearings contingent upon COVID-19 protocols.

There were other minor edits to policies and their attachments. The policies and procedures were approved.

V. There were no cases to report on for the Quarter 4 2021 Credentialing Report from Health Net.

# Item #6

## Attachment 6.F

Peer Review Quarterly Report

# REPORT SUMMARY TO COMMITTEE

| | |
|---|---|
| **TO:** | Fresno-Kings-Madera Regional Health Authority Commissioners<br>CalViva QI/UM Committee |
| **FROM:** | Patrick C. Marabella, MD<br>Amy R. Schneider, RN |
| **COMMITTEE DATE:** | March 17th, 2022 |
| **SUBJECT:** | CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 1 2022 |

**Purpose of Activity:**

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

I. The Peer Review Sub-Committee met on February 17th, 2022. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 4 2021 were reviewed for approval. There were no significant cases to report.

II. The 2022 Peer Review Sub-Committee Policies and Procedures were reviewed. One policy was reviewed without changes. One policy had more significant changes including a reference to Potential Quality Issues (PQIs) where ever Quality of Care (QOCs) cases were referenced and specification of case types for 6-month track and trend reporting. Also clarified response by investigations team to trends. Other minor edits. This policy was provided for the committee to review. The policies were approved.

III. The Quarter 4, 2021 Peer Count Report was presented at the meeting with a total of two (2) cases reviewed. The outcomes for these cases are as follows:
   - There was one (1) case closed and cleared. There were no cases pending closure for Corrective Action Plan compliance or cases with outstanding CAPs. There was one (1) case pended for further information.

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

# Item #6

## Attachment 6.G

Executive Dashboard

| | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Month** | **January** | **February** | **March** | **April** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** |
| **CVH Members** | | | | | | | | | | | | | |
| Fresno | 304,759 | 305,990 | 307,463 | 308,852 | 310,191 | 311,420 | 312,453 | 313,499 | 314,657 | 315,334 | 316,422 | 317,500 | 321,656 |
| Kings | 31,802 | 31,984 | 32,109 | 32,332 | 32,512 | 32,645 | 32,699 | 32,883 | 33,043 | 33,114 | 33,260 | 33,378 | 34,008 |
| Madera | 40,209 | 40,381 | 40,607 | 40,868 | 41,173 | 41,402 | 41,662 | 41,802 | 41,951 | 42,058 | 42,175 | 42,247 | 42,804 |
| **Total** | 376,770 | 378,355 | 380,179 | 382,052 | 383,876 | 385,467 | 386,814 | 388,184 | 389,651 | 390,506 | 391,857 | 393,125 | 398,468 |
| SPD | 33,854 | 33,850 | 33,872 | 33,913 | 33,987 | 33,964 | 33,946 | 33,941 | 34,219 | 34,573 | 34,722 | 34,783 | 34,882 |
| **CVH Mrkt Share** | 70.02% | 69.92% | 69.84% | 69.74% | 69.64% | 69.56% | 69.51% | 69.44% | 69.41% | 69.33% | 69.27% | 69.20% | 68.85% |
| **ABC Members** | | | | | | | | | | | | | |
| Fresno | 118,389 | 119,495 | 120,612 | 121,802 | 123,048 | 123,939 | 124,688 | 125,549 | 126,085 | 126,859 | 127,696 | 128,522 | 132,511 |
| Kings | 20,697 | 20,865 | 20,994 | 21,100 | 21,271 | 21,446 | 21,498 | 21,602 | 21,733 | 21,824 | 21,978 | 22,078 | 22,652 |
| Madera | 22,253 | 22,415 | 22,609 | 22,831 | 23,055 | 23,316 | 23,490 | 23,712 | 23,892 | 24,064 | 24,196 | 24,366 | 25,154 |
| **Total** | 161,339 | 162,775 | 164,215 | 165,733 | 167,374 | 168,701 | 169,676 | 170,863 | 171,710 | 172,747 | 173,870 | 174,966 | 180,317 |
| **Default** | | | | | | | | | | | | | |
| Fresno | 616 | 597 | 534 | 583 | 734 | 530 | 501 | 596 | 517 | 607 | 759 | 642 | 770 |
| Kings | 150 | 145 | 93 | 115 | 122 | 105 | 95 | 113 | 117 | 126 | 171 | 100 | 158 |
| Madera | 97 | 83 | 69 | 96 | 97 | 93 | 93 | 92 | 75 | 85 | 99 | 87 | 126 |
| **County Share of Choice as %** | | | | | | | | | | | | | |
| Fresno | 59.10% | 56.10% | 59.20% | 56.20% | 56.80% | 60.50% | 58.90% | 58.80% | 63.90% | 54.40% | 58.30% | 57.80% | 56.40% |
| Kings | 48.40% | 53.10% | 54.40% | 54.30% | 50.90% | 49.10% | 53.10% | 60.40% | 56.00% | 47.70% | 51.60% | 47.90% | 54.20% |
| Madera | 57.90% | 58.00% | 61.00% | 62.70% | 64.20% | 54.90% | 58.90% | 54.50% | 50.40% | 57.90% | 55.80% | 56.80% | 54.40% |
| **Voluntary Disenrollment's** | | | | | | | | | | | | | |
| Fresno | 421 | 334 | 387 | 444 | 479 | 446 | 643 | 444 | 441 | 438 | 451 | 477 | 439 |
| Kings | 36 | 29 | 37 | 51 | 42 | 42 | 46 | 42 | 56 | 50 | 49 | 21 | 52 |
| Madera | 59 | 51 | 61 | 75 | 85 | 82 | 56 | 71 | 65 | 72 | 65 | 42 | 64 |

| | | | |
|---|---|---|---|
| **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** | **4 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** | **2021** | **2021** | **2021** | **2021** |
| | | **Quarter** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **(Main) Member Call Center** | **# of Calls Received** | **23,684** | **23,685** | **26,346** | **26,971** | **28,736** | **26,972** |
| | | **# of Calls Answered** | **23,488** | **23,520** | **26,119** | **26,664** | **28,391** | **26,570** |
| | | **Abandonment Level (Goal < 5%)** | **0.80%** | **0.70%** | **0.90%** | **1.10%** | **1.20%** | **1.50%** |
| | | **Service Level (Goal 80%)** | **93%** | **95%** | **93%** | **85%** | **87%** | **92%** |
| | **Behavioral Health Member Call Center** | **# of Calls Received** | **1,798** | **936** | **1,196** | **1,232** | **1,182** | **1,076** |
| | | **# of Calls Answered** | **1,752** | **927** | **1,189** | **1,220** | **1,166** | **1,068** |
| | | **Abandonment Level (Goal < 5%)** | **2.60%** | **1.00%** | **0.60%** | **1.00%** | **1.40%** | **0.70%** |
| | | **Service Level (Goal 80%)** | **78%** | **89%** | **94%** | **89%** | **85%** | **90%** |
| | **Transportation Call Center** | **# of Calls Received** | **10,011** | **9,867** | **7,364** | **7,768** | **6,737** | **8,470** |
| | | **# of Calls Answered** | **9,801** | **9,808** | **7,209** | **7,628** | **6,663** | **8,411** |
| | | **Abandonment Level (Goal < 5%)** | **2.10%** | **0.60%** | **1.60%** | **1.30%** | **0.80%** | **0.40%** |
| | | **Service Level (Goal 80%)** | **44%** | **76%** | **61%** | **61%** | **75%** | **85%** |
| | **CalViva Health Website** | **# of Users** | **22,000** | **25,000** | **33,000** | **26,000** | **26,000** | **22,000** |
| | | **Top Page** | **Main Page** | **Main Page** | **Main Page** | **Main Page** | **Main Page** | **Main Page** |
| | | **Top Device** | **Mobile (63%)** | **Mobile (61%)** | **Mobile (57%)** | **Mobile (62%)** | **Mobile (65%)** | **Mobile (62%)** |
| | | **Session Duration** | **~ 2 minutes** | **~ 2 minutes** | **~ 1 minutes** | **~ 1 minutes** | **~ 2 minutes** | **~ 2 minutes** |
| **Message from the CEO** | At present time, there are no significant issues, concerns, or items to note as it pertains to the Plan's Member Call Center and CalViva Health Website. | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Provider Network Activities & Provider Relations** | **Year** | **2021** | **2021** | **2021** | **2021** | **2021** | **2021** | **2022** |
| | **Month** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** |
| | **Hospitals** | **10** | **10** | **10** | **10** | **10** | **10** | **10** |
| | **Clinics** | **144** | **144** | **144** | **141** | **143** | **143** | **144** |
| | **PCP** | **360** | **352** | **348** | **356** | **357** | **360** | **364** |
| | **PCP Extender** | **256** | **258** | **253** | **253** | **247** | **261** | **263** |
| | **Specialist** | **1422** | **1405** | **1403** | **1404** | **1366** | **1413** | **1409** |
| | **Ancillary** | **211** | **212** | **215** | **244** | **247** | **250** | **247** |
| | | | | | | | | |
| | **Year** | **2020** | **2020** | **2020** | **2021** | **2021** | **2021** | **2021** |
| | **Quarter** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **Behavioral Health** | **357** | **354** | **359** | **376** | **412** | **430** | **447** |
| | **Vision** | **45** | **47** | **46** | **47** | **44** | **45** | **43** |
| | **Urgent Care** | **11** | **12** | **11** | **12** | **12** | **13** | **13** |
| | **Acupuncture** | **5** | **7** | **7** | **7** | **8** | **6** | **5** |
| | | | | | | | | |
| | **Year** | **2020** | **2020** | **2020** | **2020** | **2021** | **2021** | **2021** |
| | **Quarter** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** |
| | **% of PCPs Accepting New Patients - Goal (85%)** | **93%** | **93%** | **94%** | **94%** | **95%** | **96%** | **95%** |
| | **% Of Specialists Accepting New Patients - Goal (85%)** | **94%** | **97%** | **96%** | **96%** | **96%** | **96%** | **96%** |
| | **% Of Behavioral Health Providers Accepting New Patients - Goal (85%)** | **82%** | **95%** | **96%** | **98%** | **97%** | **96%** | **96%** |
| | | | | | | | | |
| | **Year** | **2021** | **2021** | **2021** | **2021** | **2021** | **2021** | **2022** |
| | **Month** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** |
| | **Providers Touched by Provider Relations** | **125** | **148** | **144** | **120** | **139** | **80** | **93** |
| | **Provider Trainings by Provider Relations** | **241** | **245** | **651** | **852** | **292** | **167** | **198** |
| | **Year** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** |
| | **Total Providers Touched** | **2,604** | **2,786** | **2,552** | **1,932** | **3,354** | **1,952** | **93** |
| | **Total Trainings Conducted** | **530** | **762** | **808** | **1,353** | **257** | **3,376** | **198** |
| **Message From the CEO** | At present time, there are no significant issues, concerns, or items to note as it pertains to the Plan's Provider Network Activities & Provider Relations. | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Claims Processing** | **Year** | **2020** | **2020** | **2020** | **2021** | **2021** | **2021** | **2021** |
| | **Quarter** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure** | 99% / 99%<br>NO | 99% / 99%<br>NO | 99% / 99%<br>NO | 99% / 99%<br>NO | 99% / 99%<br>NO | 99% / 99%<br>NO | 99% / 99%<br>NO |
| | **Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure** | 99% / 99%<br>N/A | 97% / 99%<br>N/A | 99% / 99%<br>N/A | 99% / 99%<br>N/A | 99% / 99%<br>N/A | 99% / 99%<br>N/A | 99% / 99%<br>N/A |
| | **Pharmacy Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 99% / 100%<br>NO | 100% / 100%<br>NO |
| | **Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO |
| | **Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 99% / 99%<br>NO |
| | **PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 95% / 97%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 100% / 100%<br>NO | 95% / 99%<br>NO | 93% / 99%<br>NO | 97% / 99%<br>YES |
| | **PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 85% / 100%<br>NO | 95% / 100%<br>NO | 95% / 100%<br>NO | 91% / 98%<br>NO | 91% / 100%<br>NO | 84% / 93%<br>NO | 88% / 95%<br>NO |
| | **PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 93% / 100%<br>NO | 92% / 100%<br>NO | 98% / 99%<br>NO | 89% / 99%<br>NO | 96% / 99%<br>Yes | 63% / 99%<br>Yes |
| | **PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 82%/100%<br>YES | 100% / 100%<br>YES | 99% / 100%<br>YES | 99% / 100%<br>YES | 98% / 100%<br>YES | 98% / 100%<br>YES | 98% / 99%<br>YES |
| | **PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 87% / 100%<br>YES | 98% / 98%<br>YES | 99% / 100%<br>YES | 93% / 98%<br>NO | 100% / 100%<br>NO | 99% / 99%<br>YES | 99% / 100%<br>YES |
| | **PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 73% / 100%<br>YES | 99% / 100%<br>YES | 90% / 92%<br>YES | 100% / 100%<br>NO | 100% / 100%<br>YES | 99% / 100%<br>YES | 98% / 100%<br>YES |
| | **PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 92% / 100%<br>NO | 100% / 100%<br>NO | 99% / 100%<br>NO | 100% / 100%<br>NO | 99% / 100%<br>NO | 96% / 100%<br>NO | 95% / 100%<br>NO |
| | **PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure** | 100% / 100%<br>NO | 100% / 100%<br>NO | 98% / 100%<br>NO | 96% / 100%<br>NO | 93% / 100%<br>NO | 98% / 100%<br>NO | 73% / 98%<br>NO |
| **Message from the CEO** | PPG 2, 3 & 8 did not meet the 30 Day Claims Processing Timeliness Goal for Q4 2021. Management is working with PPGs 1, 3, 4, 5, and 6, on resolving their Deficiency Disclosures | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Provider Disputes** | **Year** | **2020** | **2020** | **2020** | **2021** | **2021** | **2021** | **2021** |
| | **Quarter** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| | **Medical Provider Disputes Timeliness (45 days) Goal ( 95%)** | 99% | 99% | 99% | 99% | 99% | 99% | 99% |
| | **Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)** | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | **Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)** | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | **Vision Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | **Transportation Provider Dispute Timeliness (45 Days) Goal (95%)** | N/A | N/A | N/A | N/A | N/A | N/A | 100% |
| | **PPG 1 Provider Dispute Timeliness ( 45 Days) Goal (95%)** | 100% | 91% | 88% | 95% | 99% | 96% | 94% |
| | **PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | **PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)** | 91% | 97% | 66% | 35% | 66% | 96% | 99% |
| | **PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | 100% | 100% | 100% | 100% | 99% | 100% |
| | **PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)** | 100% | 100% | 100% | 97% | 99% | 97% | 100% |
| | **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% | 98% | 99% | 99% | 98% | 79% | 39% |
| | **PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)** | N/A | 100% | 100% | 100% | 100% | 100% | N/A |
| **Message from the CEO** | PPG 1 & 7 did not meet Provider Dispute Processing Timeliness goal. All other areas met goal. | | | | | | | |