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

Lisa Lewis, Ph.D.
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Michael Goldring
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: February 9, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

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

Thursday, February 15, 2024
1:30 pm to 3:30 pm

Where to attend:

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

2) Family Health Care Network
114 W. Main Street
Visalia, CA 93291

Meeting materials have been emailed to you.

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

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
February 15, 2024
1:30pm - 3:30pm

Meeting Locations: 1) CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B	**Reappointed Board of Supervisors Commissioners** • BL 24-001 2024 Reappointed BOS Commissioners • Appointment confirmations: *Fresno & Kings Counties* *Action: Ratify reappointment County Board of Supervisors Commissioners*	D. Hodge, MD, Chair
4 Action	Attachment 4.A Attachment 4.B Attachment 4.C Attachment 4.D Attachment 4.E Attachment 4.F Attachment 4.G	**Consent Agenda:** • Commission Minutes dated 10/19/23 • Finance Committee Minutes dated 9/28/23 • QI/UM Committee Minutes dated 9/21/23 • QI/UM Committee Minutes dated 10/19/23 • Compliance Report • 2024 Code of Conduct • 2024 Emergency Preparedness & Crisis Response Plan *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
5		**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)**	
Action	Attachment	A. **Public Employee Appointment, Employment, Evaluation, or Discipline:** Title: Equity Officer Per Government Code Section 54957(b)(1)	
Information	No attachment	B. **Conference with Legal Counsel – Anticipated Litigation**: Significant exposure to litigation pursuant to Government Code section 54957.9(d)(2) or (3); one potential case	

Information	Attachment	**C. Conference Report Involving Trade Secret – Discussion of service, program, or facility:** Estimated Date of Public Disclosure: February 2024. Government Code section 54954.5	
6 Information	Attachment 6.A Attachment 6.B *No attachment*	**Annual Administration** • BL 24-002 Annual Administration • Form 700 • Ethics Training (*link will be emailed*)	D. Hodge, MD, Chair
7 Information	Attachment 7.A	**FKM RHA Bylaws**	J. Nkansah, CEO
8 Action	Attachment 8.A Attachment 8.B	**Annual Delegation Oversight of Health Net** • BL 24-003 2023 Annual Delegation Oversight and Monitoring Report of Health Net • Executive Summary 2023 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report *Action: Approve the 2023 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report; and Approve Health Net Community Solutions, Inc. to continue their delegated functions for another year.*	J. Nkansah, CEO
	Handouts will be available at meeting	*PowerPoint Presentations will be used for items 9-11* ***One vote will be taken for combined items 9-11***	
9 Action	Attachment 9.A Attachment 9.B	**2023 Annual Quality Improvement Work Plan Evaluation** • Executive Summary • Year End Evaluation	P. Marabella, MD, CMO
10 Action	Attachment 10.A Attachment 10.B Attachment 10.C Attachment 10.D	**2023 Annual Utilization Management Case Management Workplan Evaluation** • Executive Summary • Year End Evaluation **2024 Utilization Management Program Description & Change Summary** **2024 Utilization Management Case Management Work Plan** *Action: Approve 2023 Quality Improvement Year End Evaluation, and the 2023 Utilization Management Case Management Year End Evaluation, and 2024 Utilization Management Program Description.*	P. Marabella, MD, CMO
11 Action	Attachment 11.A	**Care Management** • 2024 Program Description & Change Summary	
12 Information	No attachment	**HEDIS® Report Update**	P. Marabelle, MD, CMO

13 Action	Attachment 13.A Attachment 13.B Attachment 13.C Attachment 13.D	**Compliance** • 2023 Annual Compliance Program Evaluation • 2024 Compliance Program Description • 2024 Fraud Prevention Program • 2024 Privacy and Security Plan *Action: Approve 2023 Compliance Program Evaluation, 2024 Compliance Program Description, 2024 Fraud Prevention Program, and the Privacy and Security Plan*	M.L. Leone, CCO
14 Action		**Standing Reports**	
		Finance Report	
	Attachment 14.A Attachment 14.B Attachment 14.C	• Financials as of December 31, 2023 • Revised FY 2024 Budget • Moss Adams, LLP Audit Proposal	D. Maychen, CFO
		Medical Management	
	Attachment 14.D Attachment 14.E Attachment 14.F Attachment 14.G Attachment 14.H	• Appeals and Grievances Report • Key Indicator Report • QIUM Quarterly Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
		Executive Report	
	Attachment 14.I No attachment	• Executive Dashboard • Annual Report – *hard copy provided independent of packet* *Action: Accept Standing Reports*	J. Nkansah, CEO
15		**Final Comments from Commission Members and Staff**	
16		**Announcements**	
17		**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	
18		**Adjourn**	D. Hodge, MD, Chair

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

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

Next Meeting scheduled for March 21, 2024 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-B

- 3.A BL 24-001 Reappointed BOS Commissioners
- 3.B Appointment confirmations: Fresno & Kings Counties

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

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Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D. - At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse, Director
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Aftab Naz, M.D.
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Phone: 559-540-7840
Fax: 559-446-1990
www.calvivahealth.org

DATE: February 15, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Appointed / Re-Appointed County BOS Commissioners

BL #: 24-001
Agenda Item 3
Attachment 3.A

Discussion Points:

Fresno County has re-appointed Supervisor Sal Quintero
Fresno County Alternate is Supervisor Pacheco
Kings County has re-appointed Supervisor Joe Neves
Kings County Alternate is Supervisor Rusty Robinson

Term thru:	Commission Seat	Currently Occupied By:
January 2024 January 2024 January 2024 January 2024 January 2026 January 2026	Board of Supervisors—Fresno County Board of Supervisors—Fresno County Alt Board of Supervisors—Kings County Board of Supervisors—Kings County Alt Board of Supervisors—Madera County Board of Supervisors—Madera County Alt	Sal Quintero Brian Pacheco Joe Neves Rusty Robinson David Rogers Jordan Wamhoff
March 2024	Madera At-Large Commission Appointed	Paulo Soares
May 2024	Fresno At-Large County Appointed Community Medical Center	Soyla Griffin Aldo De La Torre
January 2025	Fresno At-Large Commission Appointed	John Frye Jr.
November 2025	Valley Children's Hospital	Michael Goldring
May 2025	Fresno At-Large County Appointed Fresno At-Large County Appointed	David Cardona, MD David S. Hodge, MD
March 2026	Kings At-Large County Appointed	Lisa Lewis, Ph.D.
April 2026	Kings At-Large Commission Appointed	Kerry Hydash
May 2026	Fresno At-Large County Appointed	Joyce Fields-Keene
September 2026	Madera At-Large	Aftab Naz, MD
	Indefinite terms:	
	David Luchini, Fresno County Health Dept	
	Rose Mary Rahn, Kings County Health Dept	
	Sara Bosse, Madera County Health Dept	

BOARDS, COMMISSIONS OR COMMITTEES ON WHICH THE BOARD OF SUPERVISORS SERVE 2024		
	COMMITTEE	**2024**
19	**Fresno-Kings-Madera Regional Health Authority** *Alternate	Quintero *Pacheco
20	**Fresno/Clovis Convention & Visitors Bureau** (Chairman or designees)	Magsig PW&P Designee
21	**Fresno-Madera Area Agency on Aging - Governing Board** *Alternate	Brandau *Remaining 4 Board Members
22	**Fresno Regional Workforce Development Board**	Quintero
23	**Kings River East Groundwater Sustainability Agency** *Alternate	Mendes *PW&P Designee
24	**Law Library Board of Trustees** (Chairman, another Board Member or a member of the Bar Association)	Brandau
25	**Local Agency Formation Commission** *Alternate	Mendes Magsig *Vacant
26	**McMullin Area of Kings Groundwater Subbasin** *Alternate	Pacheco *Mendes
27	**North Fork Kings Groundwater Sustainability Agency**	Mendes
28	**North Kings Groundwater Sustainability Agency** *Alternate	Pacheco *Mendes
29	**Pleasant Valley State Prison Citizens Advisory Committee**	Pacheco Mendes
30	**Retirement Board**	Magsig
31	**San Joaquin River Conservancy** *Alternates	Brandau *Pacheco *Magsig
32	**San Joaquin Valley Insurance Authority (SJVIA)** 4 members *Alternate	Mendes Brandau Magsig Pacheco *Quintero
33	**San Joaquin Valley Supervisors Association**	All Board Members
34	**San Joaquin Valley Unified Air Pollution Control District**	Mendes
35	**San Joaquin Valley Water Infrastructure Authority** *Alternate	Mendes *Pacheco
36	**Selma-Kingsburg-Fowler County Sanitation District** (Chairman and District 4 Supervisor must serve) *Alternates	Magisg Mendes *Remaining Board Members

COUNTY OF KINGS
BOARD OF SUPERVISORS

KINGS COUNTY GOVERNMENT CENTER
1400 W. LACEY BOULEVARD.HANFORD, CA 93230
(559) 852-2362, FAX: (559) 585-8047
Web Site: http://www.countyofkings.com

JOE NEVES – DISTRICT 1
LEMOORE & STRATFORD

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

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

RUSTY ROBINSON – DISTRICT 4
ARMONA & HANFORD

RICHARD FAGUNDES – DISTRICT 5
HANFORD & BURRIS PARK

January 4, 2024

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

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

Dear Cheryl;

At a regular meeting of Kings County Board of Supervisors on January 2, 2024, the following members were appointed to the CalViva - Fresno/Kings/Madera Regional Health Authority:

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

Alternate Appointments
Rusty Robinson, Supervisor Dist. 4
1400 W. Lacey Blvd
Hanford, CA 93230
(559) 852-2367
rusty.robinson@co.kings.ca.us

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

Respectfully,

Catherine Venturella,
Clerk to the Board of Supervisors

Item #4
Attachment 4.A-4.G

Consent Agenda

- 4.A Commission Minutes Dated 10/19/23
- 4.B Finance Committee Minutes Dated 9/28/23
- 4.C QIUM Committee Minutes dated 9/21/23
- 4.D QIUM Committee Minutes dated 10/19/23
- 4.E Compliance Report
- 4.F 2024 Code of Conduct
- 4.G 2024 Emergency Preparedness & Crisis Response Plan

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
October 19, 2023

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

	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,** M.D., 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		**Lisa Lewis**, Ph.D., 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	✓	**Michael Goldring**, Valley Children's Hospital Appointee
✓	**Rusty Robinzon**, *Alternate*, Kings County Board of Supervisors	✓	**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, Director Office/HR
		✓	**Jiaqi Liu,** Director of Finance
	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	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#1 Call to Order	The meeting was called to order at 1:31 pm. A quorum was present.		
#2 Roll Call	A roll call was taken for the current Commission Members.		*A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Cheryl Hurley, Clerk to the Commission			
#3 Madera County BOS Appointed At-Large Commission Seat Action D. Hodge, MD, Chair	Dr. Naz was reappointed by Madera County Board of Supervisors for an additional three-year term.		***Motion**: Appointment was ratified by Commission.* *13 – 0 – 1 – 3* *(Frye / Soares)* *A roll call was taken*
#4 Consent Agenda • *Commission Minutes dated 9/28/23* • *Finance Committee Minutes dated 7/20/23* • *QI/UM Committee Minutes dated 7/20/23* • *Public Policy Committee Minutes dated 6/7/23* • *2024 Calendars – Commission, Finance, QIUM, Peer Review, Credentialing, Public Policy* • *Public Policy Committee Charter* • *QIUM Charter* Action D. Hodge, MD, Chair	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *14 – 0 – 0 – 3* *(Rogers / Rahn)* *A roll call was taken*
5. Community Supports Action J. Nkansah, CEO	The ad-hoc committee met on 9/27/23 to review updated funding recommendations for 2023-2024. The $100K funding for the Poverello House has been moved to contingency as they applied for funding under the Plan's DHCS Housing Homeless incentive program and were awarded over $500K under that initiative. In addition, additional infrastructure support for Marjorie Mason Center		***Motion**: Community Support Funding was approved.* *14 – 0 – 0 – 3*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Courage Takes Root capital support has been added in the amount of $150K, with naming rights for their Speech & Behavior Room in the new Community Resource Center. If the Commission approves today, MMC will match there is an opportunity for the Plan's funds to be matched by other MMC donors.		*(Luchini / Naz)* *A roll call was taken*
#6 Financial Audit Report for Fiscal Year 2023 Presented by Rianne Suico, Moss Adams Action D. Hodge, MD, Chair	Rianne Suico, representative of Moss Adams, presented the results of the audit. Moss Adams' audit will result in the issuance of an unmodified opinion on the financial statements, which is the highest audit opinion that could be provided by an external CPA firm. A discussion of general audit procedures performed including confirmation of various account balances were discussed. The required communications and the organization's accounting policies are in compliance with GAAP. After completing the work, it was found that the financial statements do not need to be adjusted and no issues were encountered when completing the work.	*Commissioner Griffin asked if there were any pre-audit adjustments.* *Rianne Suico replied that there were some adjustments made as they were waiting for additional information related to the June capitation revenue and receivable as those were not received until approximately August. Moss Adams does not consider those items as audit adjustments as this is only information not yet received before closing the books. They are referenced as post-closed adjustments. Examples of audit adjustments are when a liability is not recorded or revenue was recorded incorrectly.* *Commissioner Griffin asked if the internal financial statements get restated or does the Plan/Commission only receive the audit report.* *Daniel Maychen, CFO, stated there were not any*	***Motion:** Financial Audit Report for Fiscal Year 2023 was approved* *14 – 0 – 0 – 3* *(Griffin / Frye)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		adjustments needed to the financial statements. The final numbers were included in the June financials when they were presented.	
#7 2023 Health Equity Executive Summary and Work Plan Mid-Year Evaluation **Action** P. Marabella, MD, CMO	Dr. Marabella presented the 2023 Health Equity Executive Summary and Work Plan Mid-Year Evaluation. The Work Plan consists of four (4) categories: Language Assistance Program Compliance Monitoring Communication, Training, and Education Health Literacy, Cultural Competency & Health Equity All activities were on target for end of year completion at the mid-year, with some already completed. Some of the Activities completed include: • Provided training sessions for new hires and current Appeals & Grievances staff. • Completed fifteen (15) translation reviews. • Supported and provided Barrier Analysis data for new Clinical and Non-clinical Performance Improvement Projects (PIPs). • Thirty-nine (39) staff completed their bilingual assessment or were reassessed. • Completed Language Assistance Program (LAP) assessment for Timely Access Report (TAR) submission. • Reviewed seventeen (17) grievance cases with no interventions and two (2) interpreter complaints. • Supported Sexual Orientation & Gender Identity (SOGI) data field go-live. Language Assistance Program data was shared demonstrating: • CalViva's Member Race/Ethnicity breakdown through June 30th, 2023 • Majority (64%) of members are Latino/Hispanic • Followed by White/Caucasian at eleven percent (11%) • Asian/Pacific Islander at nine percent (9%).	*Commission Dr. Naz asked for clarification with the grievance cases with no interventions.* *Dr. Marabella stated this involves a member complaining about an issue and A&G didn't find that there was any basis or validation for a complaint and*	***Motion**: See item #9 for motion.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Race/Ethnicity data broken down by gender provides very similar results. • Slightly more members self-identify as female (54%) versus male (46%). In summary, Spanish and Hmong are CalViva Threshold Languages. Spanish is the highest volume. Most interpretation is done via telephonic interpreters. Face-to-Face remained at 26% consistent with last year. MHN (behavioral health) language services are also monitored: 31% (532) of Calls in the first 6 months of 2023 were non-English compared to 9% (207) last year during the same time period. Ninety-four percent (94%) of interpretation was provided in Spanish, one percent (1%) Hmong, and five percent (5%) Other which includes sign-language. All the Work Plan activities continue on target for completion by the end of calendar year 2023. The Plan will continue to assess circumstances to modify plans as needed in order to continue to implement, monitor and track Health Equity related services and activities.	*therefore, no intervention was needed.* *Commissioner Griffin asked how the Plan determines, or drills down, on the increase of percentage using translation services.* *Dr. Marabella stated the data presented is what the Plan receives from the database which states what the Plan did and what was noted, which is not always accurate. MHN is a different company from Health Net per se, and they have a different way of tracking their data that doesn't necessarily align.* *Commissioner Griffin asked if the Plan looks at specific events as to the cause for the increase in percentage.* *Dr. Marabella responded stating the Plan does not investigate the events.* *Amy Schneider stated the Plan has an opportunity in the near future to talk with MHN and can ask about the shift and the increase in percentages.* *Dr. Marabella stated that Health Net/Centene has made*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		a decision that MHN as a subsidiary/affiliate will be going away and behavioral health will fold into the Health Net organization which is expected to improve the information that the Plan receives regarding behavioral health. *Dr. Marabella stated that Health Net/Centene has made a decision that MHN as ana subsidiary/affiliate will be going away and behavioral health will fold into the Health Net organization which is expected to will improve the information that the Plan receives regarding behavioral health.*	
#8 2023 Health Education Executive Summary and Work Plan Mid-Year Evaluation **Action** P. Marabella, MD, CMO	Dr. Marabella presented the 2023 Health Education Program Executive Summary and Work Plan Mid-Year Evaluation. The two Areas of Focus for 2023 consist of Programs and Services, and Department Operations, Reporting and Oversight. Health Education activities are selected based upon the Population Needs Assessment. There are fifteen (15) Program Initiatives for 2023 with forty (40) objectives: The objectives status is as follows: • Twenty-one (21) objectives are on track. • Seven (7) pending as contingent on other activities. • Five (5) suspended after Quality Improvement Quadrant Analysis. • Three (3) are in progress and expected to exceed goal. • Two (2) are complete. • Two (2) are off track.		***Motion: S****ee item #9 for motion.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN

	The Health Education Programs Mid-Year outcomes are as follows:
	• Chronic Disease Education-Asthma:
	  ○ On track: Asthma collaborative.
	  ○ Suspended: Email campaign and mail education materials.
	• Chronic Disease-Diabetes:
	  ○ In-progress: Diabetes Prevention Program (DPP).
	  ○ Pended: Two member outreach campaigns; Provider outreach; and Enrollment of fifty (50) members.
	  ○ Suspended: Distribution of education booklets.
	• Chronic disease-Hypertension:
	  ○ Suspended: Distribution of toolkits to members with uncontrolled hypertension.
	• Community Engagement:
	  ○ On-track: Reach 70%-member participation in education charlas; and Increase promotion of preventive screenings.
	  ○ Met: Engage three (3) community stakeholders to address SDoH; Conduct 25 CalAIM presentations; and participate in twenty-five stakeholder meetings.
	• Fluvention:
	  ○ On track: Implement Provider education; Implement member education; and Conduct vaccine Disparity Analysis.
	• Member Newsletter:
	  ○ In-progress: Develop & distribute member newsletter.
	• Mental/Behavioral Health:
	  ○ On track: Promote myStrength enrollment.
	  ○ Complete: Participate in Follow-up on Mental Health (FUM)/Follow-up on Substance Abuse (FUA) PIP by conducting provider surveys and completing action plans.
	  ○ In progress: Support Quality Improvement (QI) Behavioral Health (BH) action plan.
	• Preventive Health:
		Commissioner De La Torre asked how many members that have asthma could have had a home visit? He stated 176 members seems low considering there are thousands that could have had this.
		
		Amy Schneider replied that she was on the Asthma Collaborative committee and that it was a particular study. It was a subset of members and established goals for number of participants were met for the study.
		
		Commissioner Bosse stated the Asthma program is under CalAIM Community Supports program.
		
		Commission Bosse asked about the Diabetes Prevention Program and wanted to know if it was all online, or in person?
		
		Dr. Marabella stated it was phone calls.	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	○ On track: Promote Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS); Develop/implement 1-2 interventions to improve BCS/CCS screenings. • Pediatric Education: ○ On track: Improve Well-child visits by 5% with call outreach ○ Complete: One (1) Provider update on CAIR. • Perinatal Education: ○ On track: Enroll 1,500 women in CVH Pregnancy Program. • Outreach to Undocumented members: ○ Pended: Identify target population; and Outreach & Implement. • Tobacco Cessation Program: ○ On track: Increase CVH member enrollment by 5%. 67 enrolled by mid-year. ○ Suspended: Email campaign. • Obesity Prevention: ○ Off track: Enroll 200+ members in Fit Families for Life (FFFL) home exercise; and Enroll 50+ members in HHHP program. • Compliance Oversight & Reporting: ○ On track: Submit two semiannual reports; update six (6) policies; and complete incentive program reports. • Health Education Materials update, Development, Utilization & Inventory: ○ On track: Ensure required education materials are available; review and approve internal education materials; and review & develop new education materials (gender affirming). Barriers to full implementation of planned activities have been identified and are being addressed or reassessed. The Plan will continue with implementation of 2023 initiatives to meet or exceed year end goals and allocate resources for positive impact.	*Commissioner Bosse questioned if the Perinatal Program was incorporating home visitation?* *Dr. Marabella responded that it is mostly only connecting with members telephonically. Perinatal Case Management connects with members, including in the hospital; however, the education program is at a distance.* *Commissioner Bosse inquired if there could be referral to the home visitation programs; are they linking the programs for members that would need home visitation but are being identified through the Perinatal Education?*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
		Dr. Marabella will follow up to obtain more information on this issue.	
#9 2023 Quality Improvement Health Equity Transformation Plan **Action** P. Marabella, MD, CMO	Dr. Marabella presented the new Quality Improvement Health Equity Transformation Plan (QIHETP) which is a DHCS requirement to address the integration of Health Equity with Quality Improvement in Medi-Cal Managed Care plans. The program provides guidelines on integrating health equity practices throughout the organization and among providers, and with members to successfully engage members, their family members, and communities with the Plan. The Plan's Health Equity Mission is to improve structural determinants of health equity, by working within and across societal institutions and systems. Improve neighborhood-level social determinants of health, by working with and across institutions in defined geographic communities. Improve institutional drivers of health equity, by working within our institution and with providers, and with other key stakeholders. Finally, to improve individual and household-level social needs and networks, by improving access, quality, and value of services for our members. The Plan's Health Equity goals are based on providing support, maintaining compliance, and creating cultural awareness through education and consultation. These goals support the overall goal of promoting cultural responsiveness between Plan staff, members, and contracted providers. The current processes and practices that are already in place are: • Quality Improvement Program & Work Plan • Health Equity Program & Work Plan • Performance Improvement Projects (PIPs) • Population Needs Assessment	*Commissioner Dr. Naz asked about educating Providers and how to obtain the data.* *Dr. Marabella stated educating the Providers is comparable to what the Plan did for Health Education. There needs to be a reason. It will not happen by sending out Provider Updates, it will gradually happen. As for obtaining the data, data can be obtained from anywhere, but what does it prove? The Plan can only look at certain things that are more prominent. You cannot look at everything all at once; that would be set up for failure. The data acquisition can be done, but the data integrity is unknown at this time.* *Commissioner Bosse asked about the data changing and why? She stated when using utilization data its important to look at*	***Motion:** Approve the 2023 Health Equity Executive Summary and Work Plan Mid-Year Evaluation, the 2023 Health Education Executive Summary and Work Plan Mid-Year Evaluation, and the 2023 Quality Improvement Health Equity Transformation Plan* *13 – 0 – 0 – 4* *(Naz / Cardona)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The new QIHETP further integrates the two programs. And utilizes the Health Equity Model to reduce Disparities. Leadership is charged with monitoring the health equity activities, medical management, and quality of care and services provided to members to promote equity through Encounter Data, Grievances and Appeals, Utilization Data, and Satisfaction Surveys (CAHPS). The emphasis will be on member and family engagement, community engagement, and reducing disparities. *Michael Goldring left at 2:29 pm, not included in vote*	*what's not in the utilization data; all members that are not accessing a service is just as important as data that can be accessed. How is this overlapping with the fact that the Plan will have more undocumented members added in January?* *Dr. Marabella responded that is the problem. How do you connect with the undocumented members? How do you know it's real? It is unknown who is undocumented and who isn't.* *Commissioner Goldring stated there is no practicable way to track.*	
#10 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of August 31, 2023:</u> Accounts Receivable's higher balance of $438.5M is due to DHCS not paying the July 2023 capitation until early September 2023, which is two months later than the original capitation month. Correspondingly, Capitation Payable is higher than normal due to late capitation payment from DHCS.	*Commissioner De La Torre asked if the COVID vaccines are paid by Health Net or CVH?* *Daniel Maychen responded it is the responsibility of*	***Motion**: Standing Reports Approved* *12 – 0 – 0 – 5* *(Soares / Bosse)* *A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Total current assets recorded were approximately $585.4M; total current liabilities were approximately $451.5M. Current ratio is approximately 1.3. Total net equity was approximately $143.8M, which is approximately 833% above the minimum DMHC required TNE amount. Interest income actual recorded was approximately $1.2M which is approximately $580K more than budgeted due to when the 2024 budget was created there was a possibility the interest rates on the Plan's money market funds could decrease. This was taken into consideration when budgeting for FY 2024 interest income; however, actual rates on the Plan's money market account stayed above 5% which resulted in higher interest income. Premium capitation income actual recorded was approximately $256.4M which is approximately $36.1M more than budgeted primarily due to enrollment being higher than projected. When the budget was created for FY 2024, projections for disenrollment was approximately 7,500 per month, in actuality it is around 2,500 per month through the first two months of FY 2024. Total cost of medical care expense actual recorded is approximately $243M which is approximately $35.3M more than budgeted due to enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $9.7M, which is approximately $432K more than budgeted due to higher than budgeted enrollment. All other expense line items are below or close to what was budgeted. For the first two months of FY 2024 net income recorded was approximately $2.4M, which is approximately $1.4M more than budgeted primarily due to interest income being approximately $580K higher than projected, and enrollment being higher than projected.	*Health Net. No adjustment to capitation payable is needed for this.*	
• **Compliance** Mary Lourdes Leone, CCO	**Compliance Report** Year to date there have been 209 Administrative & Operational regulatory filings for 2023; 30 Member Materials filed for approval; 135 Provider Materials reviewed and distributed, and 70 DMHC filings.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	There have been no potential Privacy & Security breach cases reported since the last Commission meeting in September. There have been no new Fraud, Waste & Abuse cases filed with DHCS. The Annual Oversight Audits of HN in-progress are Pharmacy, Appeals & Grievances, Emergency Room, UMCM and Privacy & Security. Audits completed since the last report are Claims, PDR (Claims CAP, no PDR CAP), and Credentialing (no CAP). The Plan is currently awaiting determination on the 2021 DMHC 18-month Follow-Up Audit. The Plan is currently awaiting the preliminary report for the DMHC 2022 Medical Audit. The Plan received the final report for the DHCS 2023 Medical Audit. A CAP has been issued as the Plan did not classify, process, review or resolve all expressions of dissatisfaction as grievances. The initial CAP response is due 10/20/23 and DHCS will trace progress over a six-month period with monthly update submissions. On 9/26/23, the Plan submitted the Birth Equity MOC template to demonstrate operational readiness for the Birth Equity POF that is going live 1/1/2024. In August of 2023, the Plan submitted two Amendments to the DMHC under its Knox-Keene license application. These were related to the Plan's request to co-brand with Health Net in support of HN's Exclusively Aligned Enrollment ("EAE") Dual Special Needs Plan ("D-SNP"). The Plan received DMHC approval on our submission on 9/21/2023. Effective 1/1/2024 LTC services will be carved into MCPs statewide. The Plan is required to submit deliverables associated with APL 23-004: INTERMEDIATE CARE		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Medical Management** P. Marabella, MD, CMO	FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES and APL 23-027: SUBACUTE CARE FACILITIES to DHCS by 11/27/2023. The Plan submitted the 2024 CalViva version EOC and Member ID Card on 8/31/24 to DHCS and DMHC and is awaiting approval from both Departments. With reference to the DHCS 2024 Operational Readiness Work Plan & Contract, the Plan has completed the monthly filings to DHCS of the various policies and other required documents through September 2023 and has received approvals on most but is still responding to additional DHCS information requests for some of the items. On 9/1/23, the DHCS informed the Plan's CEO that it is approved to go live on 1/1/24 contingent on closing out any Outstanding Operational Readiness Contract deliverables. The Public Policy Committee meeting held on September 6, 2023, did not have quorum and was unable to approve action items; therefore, a special PPC meeting was held on September 27, 2023 at CalViva Health and all action items were approved. Next Public Policy Committee meeting will be December 6, 2023, 11:30am-1:30pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through August 31, 2023. Grievances received through August 2023 continue to increase. 1. The majority of grievances were Quality of Service; high volume categories were Access, Administrative, Other, and Transportation. 2. Quality of Care Grievances remained consistent, and most were related to Delay in Prior Authorization under PCP delay.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	3. Exempt Grievances have remained consistent in recent months. "Transportation-No Show" had a slight increase. Claims Complaint related to Balanced Billing issues has decreased. 4. Appeals remain consistent. Advanced Imaging remains the highest category and these were all non-cardiac (MRIs & CTs). <u>Key Indicator Report</u> Dr. Marabella presented the Key Indicator Report (KIR) through August 31, 2023. A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through August 2023, which demonstrates that most rates have decreased. • Membership shows a decrease for Expansion, TANF, and the SPD populations. This is related to redeterminations. • For Acute Admissions (adjusted PTMPY), the Expansion population had a slight increase. TANF and SPDs remained consistent. • Bed Days (adjusted PTMPY) for Expansion had a slight uptick, whereas TANF and SPD continue to decrease. • Acute Length of Stay (adjusted PTMPY) increased slightly for Expansion and decreased for both TANF and SPD populations. • Readmits within 30 days (adjusted PTMPY) decreased slightly for all three populations. • ER Visits (adjusted PTMPY) decreased for all three populations. Most recent data must be excluded due to 60-90 days of claims lag. Case Management (CM) results have fluctuated within the various programs; Perinatal CM increased significantly with good engagement rates, Integrated Case Management has stayed consistent, Transitional Case Management (Transitions of Care) continues to increase with recent modifications to the program processes, Palliative Care has trended down the past couple of months, and Behavioral Health CM remained stable.	*Commissioner Bosse asked if this was true for ER visits because the data Madera County is receiving directly from Health Net and ABC show a reduction in ER visits for Madera County residents by as much as half? Commissioner Bosse stated some may be a matter of health literacy*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Regarding Madera, the report references Madera residents and the services they receive, the report does not identify where they are going for care. All categories for Madera remain consistent. Because Madera Hospital closed, members are having to go further for their care. There is no way to see how the close of Madera Hospital changed admissions other than the work the Plan did before which showed most members were going to Saint Agnes <u>QIUM Quarterly Summary Report</u> Dr. Marabella provided the QI, UMCM, and Population Health update for Q3 2023. Two QI/UMCM meetings were held in Quarter 3, one on July 20, 2023, and one on September 21, 2023. The following guiding documents were approved at the July & September meetings: 1. 2022 Care Management Program Evaluation 2. 2023 QI Work Plan Mid-Year Evaluation 3. 2023 UMCM Work Plan Mid-Year Evaluation 4. Population Health Management Strategy Program Description 2023 5. Complete Listing of Medical Policies & Q2 Medical Policy Updates 6. Clinical Practice Guidelines 7. QIUM Committee Charter 2023 Update In addition, two additional presentations were made at these QIUM Committee meetings: 1. Continuity & Coordination of Medical & Behavioral Healthcare- two actions for improvement were approved. A follow up report will be provided in Q1 2024. 2. Member & Provider Satisfaction Survey The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard & Quarterly A & G Reports, Initial Health Appointment (IHA), Potential Quality Issues (PQI), and Lead Screening Quarterly Report. Additional Quality Improvement reports were reviewed as scheduled during Q3.	*and now they are going to urgent care. Commissioner Bosse stated she would share the information with CVH.* *Dr. Marabella stated he would have to research that data. Dr. Marabella stated those are ER visits which are based on claims.* *Commissioner De La Torre stated for his organization, CMC, Madera ER visits have significantly increased. When the closure of Madera Hospital occurred, they began tracking the ER visits for Madera zip codes compared to prior to closure.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	The following Access Reports were reviewed: Access Work Group minutes, and Access Work Group Q2 Summary Report. The Utilization Management & Case Management reports reviewed were the Key Indicator Report & Concurrent Review Report, Case Management and CCM Report, Enhanced Care Management (ECM) & Community Supports, and other reports scheduled during Q3. Pharmacy quarterly reports reviewed were Executive Summary, Operations Metrics, Top Medication Prior Authorization (PA) Requests, and Pharmacy Interrater Reliability Results (IRR). HEDIS® Activity: In Q3, HEDIS® related activities focused on analyzing the results for MY2022 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile. The final HEDIS® results for CalViva for MY 2022 (RY23) were received. A review of these results noted: • Fresno County did not meet the Minimum Performance Level (MPL) of the 50th percentile for the following measures: Follow up after ED Visit for Mental Health/SUD (new), Cervical Cancer Screening, Childhood IZ, Lead Screening in Children, and Child and Adolescent Well-Care Visits. • Kings County did not meet the MPL of the 50th percentile for the following existing measures: Childhood IZs, Immunizations for Adolescents, Lead Screening, and Child and Adolescent Well-Care Visits. • Madera County met the MPL of the 50th percentile for all existing measures but not for the new Follow up after ED Visit for Mental Health/SUD. The three new HEDIS® Measures for 2023 are Asthma Medication Ratio, Topical Fluoride for Children, and Developmental Screening in the First Three Years of Life.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• **Executive Report** J. Nkansah, CEO	SWOT Project is in progress to improve Well Child Visits and Childhood Immunizations. Medical Management's current improvement projects are: 1. Clinical Disparity PIP - Improve Infant Well-Child Visits in the African American Population in Fresno County • Initial proposal submitted to HSAG/DHCS completed 9/8/23. Awaiting feedback. • Planning & Analysis Phase-Analyzing the data & conducting Key Informant Interviews. • Establish proposed interventions with implementation in Q1 2024. 2. Non-Clinical PIP - Improve Follow up After ED Visit for Mental Health or SUD utilizing Community Supports • Initial proposal submitted to HSAG/DHCS completed 9/8/23. Awaiting feedback. • Planning & Analysis Phase-Analyzing the data & conducting Key Informant Interviews. • Establish proposed interventions with implementation in Q1 2024. No significant compliance issues have been identified. Oversight and monitoring processes will continue. **Executive Report** The Plan continues to track redeterminations. Market Share continues to trend up. DHCS has not provided a replacement report to address the discontinued reports which provided data to MCPs around Default, Share of Choice %, and Voluntary Disenrollments. CalViva Health continues to work through its Trade Association to work on getting the missing data. Regarding redeterminations, the Plan is seeing a lot less members being disenrolled from CVH than anticipated. The retention rate is currently at 85% for the first three months based on data currently available.	*Commissioner De La Torre asked if the SPD number is included in the total?* *Jeff Nkansah stated the SPD number is included in the total.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Based on data currently available, most of the disenrollment reasons were procedural. These members are usually placed in a queue for additional follow-up. There are no significant issues or concerns to report as it pertains to IT Communications and Systems, Member Call Center and Website, Provider Network & Engagement Activities, and Claims Processing & Provider Disputes. Changes that have taken place to the Auto Assignment Program, as it impacts the Plan's fiscal year enrollment goals, include an increase in Quality Measures, Safety Net Measures will remain the same, and Encounter Data Quality will be removed from the auto assignment algorithm. These changes will impact CVH and Anthem for the 2024 calendar year. Kaiser will not be taking any default members for 2024. *John Frye left at 2:41 pm – not included in vote.*		
#10 Final Comments from Commission Members and Staff	Dr. Marabella announced CalViva received an award at the DHCS Annual Quality meeting for Certificate of Achievement in Recognition of hard work and high achievement on the Bold Goals aggregated quality factor score for San Joaquin Valley Region 2022-2023. Jeff Nkansah announced the Compliance team has done a wonderful job on the regulatory audits for the last couple of years. Also, the Finance team was recognized for a great job in keeping the financials audited and keeping the Plan's books good from a financial perspective. Pictures of Community Supports project funding were shared with the Commission that included outdoor play and greenspace for Webster Park, and for recreational sports supporting Edison Youth Football. Commissioner Dr. Naz asked if CalViva could assist with funding needed for Madera Community Hospital to reopen.		
#11 Announcements	None.		
#12 Public Comment	None.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#13 Adjourn	The meeting adjourned at 3:06 pm. The next Commission meeting is scheduled for November 16, 2023, in Fresno County.		

Submitted this Day: _____

Submitted by: _____

Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

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

September 28, 2023

	Finance Committee Members in Attendance		CalViva Health Staff in Attendance
✓	Daniel Maychen, Chair	✓	Cheryl Hurley, Office Manager
✓	Jeff Nkansah, CEO	✓	Jiaqi Liu, Director of Finance
✓	Paulo Soares		
✓	Joe Neves		
	David Rogers		
✓	John Frye		
✓	Rose Mary Rahn		
		✓	Present
		*	Arrived late/Left Early
		•	Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:30 am, a quorum was present. Rose Mary Rahn was introduced as the new Finance Committee member, replacing the vacant position previously held by Harold Nikoghosian.	
#2 Finance Committee Minutes dated July 20, 2023 Attachment 2.A Action, D. Maychen, Chair	The minutes from the July 20, 2023, Finance meeting were approved as read. *John Frye arrived at 11:31 am – not included in vote*	Motion: *Minutes were approved* *3 – 0 – 2 – 2* *(Neves / Nkansah)*
#3 Financials – Fiscal Year 2023 Action	Financials are currently being audited by Moss Adams and are in the final stages of the audit. To date there have been no audit adjustments or findings. Moss Adams will be onsite for the October Commission meeting to present the audited FY 2023 Financials.	Motion: *Financials for Fiscal Year End 2023 were approved*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
D. Maychen, Chair	Total current assets recorded were approximately $301.3M; total current liabilities were approximately $170M. Current ratio is approximately 1.77. Total net equity was approximately $141.3, which is approximately 819% above the minimum DMHC required TNE amount. As stated in the previous meeting, as part of the 2024 contract, DHCS was looking to require Plans to have two months of average monthly contract revenues in reserves. For CVH that is approximately $278M; from the current financials the Plan is at $141M and would be substantially short of the proposed required minimum reserve requirement by DHCS. Plans have provided feedback to the State expressing concern that this is not feasible. DHCS has taken concerns into consideration and has adjusted it down to one month of average monthly contract revenues for the reserve requirement. In addition, because DHCS pays the Plan one month late, they stated this would satisfy the one-month average monthly contract revenue requirement. From DHCS' perspective they believe that one-month average contract revenue is their standard reserve requirement. For the Plan, $139M is approximately the current monthly average contract revenue requirement and the Plan's current TNE is approximately $141M which puts the Plan just above the minimum reserve requirement from DHCS. Interest income actual recorded was approximately $5.4M which is approximately $5M more than budgeted primarily due to rates on the Plan's money market funds being higher than projected. Premium capitation income actual recorded was approximately $1.3B which is approximately $134.9 more than budgeted primarily due to rates and enrollment being higher than projected. Total cost of medical care expense actual recorded is approximately $1.12B which is approximately $128.1M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $56.2, which is approximately $4.9M more than budgeted due to higher than budgeted enrollment. Dues and Subscriptions expense actual recorded was approximately $259K which is approximately $53.7K more than budgeted due to the Local Health Plans of California (LHPC) one-time additional assessment related to their work in renewing the MCO tax and allocating dollars to reinvest back into Medi-Cal as opposed to the State general fund. All other expense line items are below or close to what was budgeted. Net income recorded for Fiscal Year 2023 was approximately $13.4, which is	*6 – 0 – 0 – 1* *(Soares / Frye)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	approximately $8.7M more than projected primarily due to interest income being approximately $5M higher than projected, and enrollment and rates being higher than projected.	
#4 Proposed 2024 Finance Meeting Calendar Action D. Maychen, Chair	The proposed 2024 Finance meeting calendar was presented to the Committee. No revisions recommended.	Motion: Meeting *Calendar for 2024 was approved to move to Commission for final approval* *6 – 0 – 0 – 1* *(Frye / Rahn)*
#5 Announcements	None.	
#6 Adjourn	Meeting was adjourned at 11:37 am	

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

Dated: 10-19-23

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 10/19/23

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
September 21st, 2023

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
	David Cardona, M.D., Fresno County At-large Appointee, Family Care Providers	✓	**Iris Poveda**, Senior Medical Management Specialist
✓	**Fenglaly Lee, M.D.,** Central California Faculty Medical Group	✓	**Mary Lourdes Leone,** Chief Compliance Officer
	Carolina Quezada, M.D., Family Health Care Network	✓	**Maria Sanchez**, Compliance Manager
✓	**DeAnna Waugh, Psy.D.,** Adventist Health, Fresno County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**Joel Ramirez, M.D.,** Camarena Health Madera County	✓	**Norell Naoe,** Medical Management Administrative Coordinator
	Rajeev Verma, M.D., UCSF Fresno Medical Center		**Zaman Jennaty,** Medical Management Nurse Analyst
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
	Guests/Speakers		
	None		

✓ = in attendance
* = Arrived late/left early

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 **Call to Order** Patrick Marabella, M.D Chair	The meeting was called to order at 10:30 a.m. A quorum was present.	
#2 **Approve Consent Agenda** - Committee Minutes: July 20th, 2023 - QIUM Committee Meetings Calendar 2024 - Appeals & Grievances Classification Audit Report (Q2) - Appeals & Grievances Inter Rater Reliability Report (IRR) (Q2)	July 20th, 2023, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Any item on the consent agenda may be pulled out for further discussion at the request of any committee member. Dr. Marabella noted that due to the NCQA Accreditation process, the format of the meeting and minutes will be changing slightly to ensure we capture committee discussions for the lookback period beginning November 2023 to allow us to demonstrate full compliance here forward. The consent agenda will be longer to allow more time for committee discussion and feedback. Therefore, as always it is vital that all documents are read prior to the meeting. A link for Medi-Cal Rx Contract Drug List was available for reference.	Motion: *Approve* Consent Agenda (Lee/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Quarterly Appeals & Grievances Member Letter Monitoring Report (Q2) - Customer Contact Center (CCC) DMHC Expedited Grievance Report (Q2) - Member Incentive Programs - Semi-Annual Report (Q1 & Q2) - PA Member Letter Monitoring Report (Q2) - Performance Improvement Project Updates (PIPS & SWOT) - California Children's Service Report (CCS) (Q2) - Initial Health Appointment Quarterly Audit Report (Q1) - Concurrent Review IRR Report (Q2) - County Relations Quarterly Update (Q2) - MedZed Report (Q2) - NIA/Magellan (Q2) - QIUM Committee Charter 2023 (Attachments A-P) **Action** Patrick Marabella, M.D Chair		

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#3 **QI Business** - Appeals & Grievances Dashboard and TAT Report (July) - Appeals & Grievances Executive Summary (Q2) - Appeals & Grievances Quarterly Member Report (Q2) (Attachments Q-S) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented and reviewed the **Appeals & Grievances Dashboard** through midyear 2023 compared to calendar year 2022 totals. He reminded the committee members of the annual comparison he presented in May and that standardized criteria are used to classify each case in order to include them in the appropriate area on the monthly dashboard. Today he will emphasize trends we are seeing so far in 2023. • The total number of grievances received increased in Q2 compared to Q1 and the PTMPM is on an upward trend. The 2023 YTD total received is 897, and in the 2022 full year 1183 were received. Most grievances in Q2 were Quality-of-Service (QOS) with notably 42 in the "other" category for the month of June alone. These 42 grievances were associated with balanced billing from which a formal work plan has been put in place to address these issues as well as streamline the Prior Authorization process. Another trend noted in Q2 QOS grievances were related to Transportation issues. Previously the highest volume of late/no-show cases were resolved by phone as Exempt grievances, but in 2023 we are seeing a trend for more formal grievances associated with late/no show and fewer Exempt cases. A formal grievance includes a more extensive review and written response to the member. • Quality of Care (QOC) grievances have shown a gradual increase month over month as well. • Exempt Grievances decreased when compared to last quarter. Balanced billing complaints continue to increase in this category. • Total Appeals received remained consistent with prior years when adjusted for PTMPM basis. Advanced imaging (MRIs) appeals continue to be a trend. • Trends in the July A & G Dashboard are consistent with the above. **Appeals & Grievances Executive Summary (Q2)** through June 2023 was presented noting the following trends: • Total Appeals & Grievances have increased from Q2 2022 compared to Q2 2023. • Total Exempt Grievances, including Attitude/Service, Transportation, and PCP Assignment Grievances have decreased from Q2 2022 to Q2 2023. Other/Member Billing showed a slight increase.	Motion: *Approve* - Appeals & Grievances Dashboard and TAT Report (July) - Appeals & Grievances Executive Summary (Q2) - Appeals & Grievances Quarterly Member Report (Q2) (Ramirez/Lee) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• For Q2 2023, there were 96 Total Appeals & 499 Total Grievances reported. • Top Access Grievances were Prior Authorization Delay, Specialist Referral and Transportation/Missed Appointment. • MODIVCARE has rolled out an app to aid members with viewing the status of their assigned drivers. It is anticipated that increased use of the app will improve member-driver communication and thereby reduce missed/late appointments. **Appeals & Grievances Quarterly Member Report (Q2)** through June 2023 was presented noting the following trends: • Total number (on a PTMPY basis) of Appeals is lower and Grievances are higher than in 2022. • Pre-Service Appeals were mainly related to Diagnostic MRIs, and Surgery (Arthroscopy). • Quality of Service (QOS) Grievances: Balanced Billing, Prior Authorization, and Transportation were the top grievances in all three counties.	
#3 **QI Business** - Potential Quality Issues (Q1, Q2) (Attachment T) **Action** Patrick Marabella, M.D Chair	The **Potential Quality Issues (PQI) Report (Q1, Q2)** provides a summary of Potential Quality Issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member. PQI reviews may be initiated by a member, non-member, or peer-review activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data was reviewed for all case types including the follow-up actions taken when indicated. Beginning in 2023, peer review results reported for cases with severity code levels 0, I, or II include reporting on further actions taken to address identified issues, such as practitioner/provider education, case management, health equity review, and network management involvement. PQI and PPC cases will continue to be tracked, monitored, and reported. • The Q1 report was previously presented but is included here with the addition of the further actions taken in Table 4. There were twenty-seven further action peer review cases in Q1. • There were zero non-member PQIs in Q2. • There were one-hundred-five (105) member-generated PQIs in Q2. Most of these cases were scored a level zero, followed by level one and then level two. Three cases were at level three and sent to Peer Review. • There were ten cases sent to Peer Review in Q2; with five cases closed and five remaining open.	Motion: *Approve* - Potential Quality Issues (Q1, Q2) (Lee/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• There were thirty-eight (38) further actions taken in Q2. Seven cases were closed and nine remained open. PQI monitoring and reporting will continue.	
#3 **QI Business** - Lead Screening Quarterly Report (Q1) (Attachment U) **Action** Patrick Marabella, M.D Chair	The **Lead Screening Quarterly Report (Q1 2023)** is a Quarterly Assessment of Blood Lead Screening in Children compliance to ensure that CalViva members receive blood lead level testing and follow-up when indicated and that parents/caregivers receive anticipatory guidance related to blood lead poisoning prevention from providers. The Q1 2023 report provides CalViva Health's performance on blood lead level screenings and anticipatory guidance monitoring from Q1 2022 – Q1 2023. • In Q1 2023 the compliance for CPT Code 83655 (lead screening only) ranged from: o 9.3% (Q1 2022) - 80.03% (Q4 2022) in members 6-17 months of age o 14.89% (Q1 2022) - 84.60% (Q4 2022) in members 18-30 months of age o 75.99% (Q1 2022) - 95.04% (Q4 2022) in members 31-72 months of age • In Q1 2023 Anticipatory Guidance Coding remains low (below 6%). A trend is noted for lower compliance in the 18–30-month age group. This trend is attributed to the COVID-19 pandemic which spanned from March 2020 – May 2023. Members in this age group were born amidst the pandemic which impacted appointment availability and member adherence to medical appointments affecting compliance with testing frequency and parent education. **Discussion:** *Dr. Ramirez noted that coding and documenting anticipatory guidance is challenging.* • Action Plan for improvement includes: o Point of Care testing by supplying high-volume providers with the necessary equipment. o Educating all providers on the correct billing codes for testing and anticipatory guidance. o Formal DHCS CAP has been closed, as steps for improvement have been implemented, however close monitoring continues as this is a formal HEDIS® measure and we are held to the 50th percentile for compliance.	Motion: *Approve* - Lead Screening Quarterly (Q1) (Ramirez/Waugh) 4-0-0-3
#4 **Key Presentations** - Quality Improvement Work Plan Mid-Year Evaluation and Executive	**Quality Improvement Work Plan Mid-Year Evaluation and Executive Summary 2023** The 2023 Mid-Year Work Plan has a new organization and format. 1. All Activities are now scored and determined to be "Off Track" or "On Track". (75% complete = On Track)	Motion: *Approve* - Quality Improvement Work Plan Mid-Year Evaluation and Executive

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Summary 2023 (Attachment V) **Action** Patrick Marabella, M.D Chair	2. At the Mid-Year 87% of activities were complete and: o Ten (10) Activities are "On Track." o Three (3) are "Off Track." o One (1) is NA as this is the baseline year. 3. The remaining activities and those planned for July to December will be completed by the end of the year. Performance Improvement Projects (PIPs) Breast Cancer Screening & Childhood IZs: • Final Analyses of 2020-2022 PIPs submitted to HSAG & DHCS in April 2023. • June 2023, CVH received notification from HSAG that both PIPs met all reporting criteria, and they were both determined to receive the highest confidence level indicating: o "The PIP was methodologically sound, the SMART Aim goal and statistically significant improvement were achieved, at least one of the tested interventions could reasonably result in the demonstrated improvement, and the Plan accurately summarized the key findings and conclusions." Planned Activities and QI Focus for 2023 consist of: 1. Behavioral Health - On Track o Improve Follow-up Care for members after ED Visits for Substance Use/Mental Health issues (FUA/FUM). ▪ Follow up within 7 days. ▪ New CalViva Non-Clinical PIP 2023-2026 ▪ Focus on referrals to Community Supports ▪ Initial submission to HSAG/DHCS due 9/8/23 ▪ In Planning Phase. 2. Chronic Conditions – 2/3 On Track o Improve Asthma Medication Ratio – Off Track ▪ Asthma Education Mailer ▪ In-Home Asthma Support Program. o Improve Management of Blood Pressure – On Track ▪ Provider Tip Sheet ▪ Pharmacist Outreach. o Improve Management of Diabetes – On Track ▪ Care Gap Calls	Summary 2023 (Lee/Waugh) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Distribute Diabetes Pocket Guide. 3. Maternal/Women's Health -Off Track o Improve Prenatal/Postpartum Care ▪ Perinatal Care Training for Provider Engagement on Measures and Best Practices ▪ Provider Engagement to educate Providers ▪ CalViva Pregnancy Program – refer based on risk ▪ Refer all African American Pregnant Women to the CVH Pregnancy Program. 4. Member Engagement & Experience – On Track o Increase compliance with Initial Health Appointment (IHA) within 120 days ▪ Send letters to non-compliant Providers ▪ Provider Engagement Re-educates low performing Providers ▪ Update IHA Materials ▪ IHA Quarterly Reporting. o Improve Member Satisfaction ▪ Annual Member Newsletter ▪ Year Over Year Analysis ▪ PPG Webinar ▪ CAHPS Playbook ▪ Provider Training Webinar and CME. 5. Hospital Quality & Patient Safety – On Track o Monitor Hospital Quality and Safety ▪ Major focus on Patient Safety and C-Section rates ▪ Collaborate with local hospitals to improve scores ▪ Identify and work with Low Performing Hospitals – Collaboratives ▪ Track & Produce Hospital Quality Scorecard. ▪ Focus on hospital-acquired infections and other safety metrics. 6. Pediatric – ½ On Track o Improve Infant Well-Child Visits – Off Track ▪ CVH New Clinical PIP ▪ Focus on the African American Population in Fresno County ▪ Initial submission to HSAG/DHCS due 9/8/23	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	▪ Planning Phase o Pediatric SWOT – On Track ▪ Improve Well-Child Visits and Childhood Immunizations for children under 2 years. ▪ Working with two FQHCs to test Converting sick visits to well visits and completing chart prep to immunize at every visit. ▪ Next Report Due to DHCS 11/30/23 7. Preventive Health – On Track o Improve Cancer Screening ▪ Promote Every Woman Counts for BCS/CCS Screening ▪ 19 Mobile Mammography Events ▪ Incentives for Radiology Providers to close care gaps. o Improve Childhood Blood Lead Screening ▪ Point of Care Lead Screening Analyzers for High Volume Pediatricians ▪ Provider Education ▪ Update Written Materials. 8. Provider Engagement – On Track o Evaluating Data to Generate Excellence (Quality EDGE) Support Providers to Overcome Barriers to Improving Performance ▪ Support Obtaining Equipment Needed for Physical Accessibility standards (PARS) for High Volume Specialists ▪ Blood Lead Screening equipment or other opportunities. **HEDIS® Default Measures (50th percentile)** • Childhood Immunizations: Madera County above MPL of 34.79% Fresno & Kings below. SWOT in Fresno/Kings. • Controlling High Blood Pressure: All three counties exceeded the MPL of 59.85%. • Timeliness of Prenatal Care: All three counties exceeded MPL of 85.40% • Comprehensive Diabetes Care – HbA1c testing: All three counties exceeded the MPL of 39.90%. (Inverted measure) • Cervical Cancer Screening: Kings & Madera Counties exceeded the MPL of 57.64%. Fresno County did not. Barely missed it at 57.08%. **Discussion:**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Marabella asked Dr. Waugh if she had any suggestions on how we should address the Behavioral Health Non-Clinical PIP (Completing follow-up visit within 7 days after being seen in the ER for FUA/FUM diagnosis). Considering that our data shows that most often this is their first and only visit to the ER within a year. Also noting that Kings County was the only one of CalViva's Counties to meet the MPL for this measure in MY2022. *Dr. Waugh stated that Adventist Health in Kings County received a grant to have an LCSW (hybrid position) working in their ER to help screen patients on the level of follow-up care needed and will connect them to providers or schedule a follow-up directly with the LCSW. The LCSW is the personal connection to the member as the LCSW can provide patient education on the behavioral health system, so the outreach and recovery process isn't as intimidating which has been found to help increase patient compliance.* *Dr. Marabella agreed that our analysis of the data did demonstrate that the best results occurred when the follow-up happened the same day as the ER visit and with many, there is only one chance to make a difference as we may never see that patient again.* *Amy Schneider shared with the committee that our initial data analysis evaluating many variables such as race/ethnicity, age, gender, housing or food insecurity, language did not identify any statistically significant differences to help focus the team on a particular subpopulation. We did identify some interesting commonalities for age groups and certain zip codes where a majority of these members live, but we are continuing our efforts to learn more through interviews. We will continue to provide updates as the team progresses.*	
#4 **Key Presentations** - Utilization Management /Case Management Work Plan Mid-Year Evaluation and Executive Summary 2023 (Attachment W) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **2023 Mid-Year Utilization Management Case Management Work Plan Evaluation and Executive Summary.** Activities in 2023 Focus on: 1. Compliance with Regulatory and Accreditation Requirements 2. Monitoring the Utilization Management Process 3. Monitoring Utilization Metrics 4. Monitoring Coordination with Other Programs and Vendor Oversight 5. Monitoring Activities for Special Populations Utilization Management processes have remained consistent. Case Management and Disease Management continue to monitor the effectiveness of programs to better serve our members. Key metrics: • Turn-around Time for processing authorizations from January – June was 99.6%.	Motion: *Approve* - Utilization Management/ Case Management Work Plan Mid-Year Evaluation and Executive Summary 2023 (Ramirez/Lee) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Turn-around Time for appeals January – June was 100%. • Bed days/1000 had a decrease in Q1 and Q2 2023. • Admits/1000 remains consistent. • Average Length of Stay (ALOS) remains consistent. • Readmit 30 Day had a decrease in Q1 and Q2 2023. Metrics Too Soon to Tell if they will meet the target: • Only one metric was classified as "Too soon to Tell" at the mid-year. 3.3 PPG Profile - Activities related to PPG Profile performance and monitoring. One PPG fell below target (95%) on turn-around times in the first quarter. Provisions added to address urgent cases during office closures for holidays. Activities on target to meet year-end goals: 1. Compliance with licensure and periodic audits. 2. Review, revise, and updates to Program Descriptions, Work Plans, and Policies at least annually. 3. Creation of new Population Heath documents for NCQA accreditation preparation. 4. A Long-Term Care (LTC) Specialist Social Worker based in Fresno was onboarded in 2023 to support the LTC transition. 5. Health Information Forms (HIF) completed or Outreached Jan to Jun was 3,751 with 541 members referred to Case Management. 6. 2,529 members managed through Q2 in physical, behavioral, and transitional case management. Up from 1,739 for the same time last year. 7. 565 Members managed in the High-Risk Pregnancy Program through Q2. Engagement is steady at 43%. 8. 419 Members managed in Behavioral Health CM through Q2. Engagement rate at 68% this year.	
#4 **Key Presentations** - PHM Strategy Program Description 2023 (Attachment X) **Action**	The **PHM Strategy Program Description 2023** was presented. The PHM Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, free from barriers, using the Health Equity (HE) Improvement Model to identify and design community-anchored interventions which lead to longer, healthier, and happier lives, improved outcomes, and health equity which is the guiding principle. PHM Program categories include Developmental, Physical, Mental Health, SUD, LTSS, Palliative Care, Oral Health, Vision, and Pharmacy.	Motion: *Approve* - PHM Strategy Program Description 2023 (Ramirez/Lee) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair	PHM Data Activities: • Gathering member information; risk stratification; providing services and support. • Population Needs Assessment inclusive of inputs from CBOs, Local Health Jurisdictions, Schools; Higher education, Hospitals, and MCPs. Population Health Management is the framework to achieve health and wellness for all, free from barriers, using the Health Equity Improvement Model to identify and design community-anchored interventions. PHM Program Core Aspects include: • Basic Population Health o Access, Utilization, and Engagement with Primary Care o Care Coordination, Navigation, and Referrals Across All Health and Social Services, Including Community Supports o Information Sharing and Referral Support Infrastructure o Integration of Community Health Workers (CHWs) in PHM o Wellness and Prevention Programs o Programs Addressing Chronic Disease o Programs to Address Maternal Health Outcomes o PHM for Youth and Children under 21 years of age • Risk Stratification, Segmentation & Tiering (RSST) is an important aspect of PHM. o Algorithms include clinical and sociodemographic variables, bias testing, and UM data to stratify the entire population (many data sources utilized). o Classify members into low, medium, and high-risk categories and Case Management Levels 1-5. In order to assign appropriate resources, interventions, and programs. Care Management Enhancements include: • Complex Care Management (CCM) • Enhanced Care Management (ECM) with contracted providers outside of the Health Plan. CalAIM • Transitional Care Services (TCS) - Transitions are defined as when a member transitions from one level of care or setting to another, including acute care, SNF, CBAS, home, or Community Supports. o Under PHM and in line with CalAIM, MCPs are accountable for enhancing TCS beginning on 1/1/23, and fully implementing for all members by 1/1/24, across all	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	settings and delivery systems, ensuring members are supported from discharge planning until they have been successfully connected to all needed services and supports. CVH PHM Model • PH/BH Care Management o Enhanced o Complex o Transitional (May apply to other tiers) o Homebound • PHM Outreach o Member Connections o Clinical Pharmacy o Medication Reconciliation o Care Coordination/Social Work o QI Intervention Strategies • Basic Pop Health Management (BPHM) o Tech-Enabled Solutions o Community Resource Information o Health & Wellness Programs o Member Connections o Cozeva PHM Monitoring Plan • DHCS will review the holistic performance of PHM Program implementation by monitoring performance across multiple PHM categories including specific populations such as Children and Youth, Birthing Populations, and Individuals with Behavioral Health Needs. • Categories are organized by the following monitoring domains: PHM program areas/themes, populations, and cross-cutting priorities. • DHCS will monitor equity across all monitoring domains and categories. • DHCS will conduct routine engagement with MCPs throughout each year on MCPs' PHM programs to ensure regular, bidirectional communication on implementation challenges and successes.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Integrated Approach covers all stages of life from birth to severe illness with Palliative/hospice care always with a focus on Equity and considering the following: o Housing/food/nutrition o Safety/security o Transportation o Justice Involved/Foster Care o Psychosocial o Health literacy o Interpreter/translation/language o Financial/socioeconomic o Cultural/social/familial o LGBTQIA+ o Rural/access deserts o Homebound/disabilities • Members will be supported in the following ways: o Provider, Patient Navigator, Promotores o Prescription Support, Medication Reconciliation, Adherence Counseling o Home visits, CHWs, Doulas, Street Medicine o Coordination of Care (PCP, Specialty, ER, UC, IP, PCP, LTC/SNF, NH) o Chronic Disease and BHM o CM, ECM, CCM, CS o Telehealth Kiosks, Self-Service Tablets/Tools, Emergency Support o Health Education/Wellness/SDoH CVH Population Health Management (PHM) as aligned with DHCS Model: • Gather Member information through various methods, Claims, ADT, Authorizations, Assessments, Initial Screenings, Data Feeds, etc. • Understanding Risk through PHM Categorization, SDoH Reporting, Care Alert Reporting, to CalAIM Populations Of Focus (POF) and Community Supports (CS) POF. Taking all of this information on factors that contribute to risk, you complete: • Risk Tiering on a scale of 0-10, low to high • Finally, identifying the Programs for Members and the Community including Case Management, Chronic Disease Management, Enhanced Care Management, Community	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Supports, Community Health Workers, and other programs and Digital Tools. **Discussion:** *Dr. Marabella stated that Population Health Management is the overarching framework we will use to achieve health and wellness in our CalViva population. It requires a focus on Health Equity to identify and remove barriers in order to support and create a healthy community. It is a heavy lift for the Plans and will require a lot of coordination, communication, and management by the many different points of care and service available for members to access. The services offered go beyond traditional care to address other social issues for high-risk populations. Some of the initial plans for this endeavor include things like adding a Case Manager in high-volume ERs to help with the transitions of care, "bedside enrollment," and obtaining access to ADT data from all participating hospitals to allow for timely intervention. The goal is to have more members access needed services like ECM and Community Supports seamlessly from wherever they are.* *Dr. Lee stated that the burden of care falls on the doctor but, her motto is "help me to help you." Some patients don't follow through on recommendations made by their providers. The language barriers, transportation barriers, missed appointments, and follow-through by members are real roadblocks to better care for a subset of members. For the majority, the additional resources like case management will be helpful.* *Dr. Ramirez stated that initially, the SDoH screenings determined what members needed like transportation, food, or financial help. The challenge became what resources could be identified in the community to address these needs. However, now that the health plans and the state are addressing this need for support implementation should be more successful.*	
#4 **Key Presentations** - Integrated Accessibility Report (Member & Provider Satisfaction) (PowerPoint) **Action** Patrick Marabella, M.D Chair	**Integrated Accessibility Report (Member & Provider Satisfaction)** CalViva Health (CVH) has established care standards and goals to meet compliance requirements to: • Ensure adequate member access to health care services. • Meet DMHC & DHCS regulatory requirements related to timely access. In order to assess compliance, we need to monitor and evaluate: • Access to Medical and Behavioral Health Care Providers • Access to Ancillary services • Provider Satisfaction with Access • Member Experience with Access • Telephone Wait Times • Member Grievances	Motion: *Approve* - Integrated Accessibility Report (Member & Provider Satisfaction) (Ramirez/Lee) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	A component of this monitoring is Satisfaction Surveys and that is the focus of this report: Member and Provider Satisfaction Surveys. 2022 CalViva Health Provider Survey Tool (PSS) • Administered via mail/internet & telephone from 6/2022-9/2022 – by SPH Analytics • Random sample of high-volume providers. Response rate significantly down this year at 2.6% (2021 6.2%). • There are seven (7) access related measures in the CVH Provider Survey this year (MY22). • The overall (composite) score was slightly lower at 69.7% compared to 70.3% in 2021. • Access to Urgent Care, Non-Urgent Primary Care and Current and Accurate Provider Directory data all improved over the last year. • Referral and/or Prior Authorization satisfaction is down this year at 65.5% compared to 72.9% last year. This is consistent with the increase in grievances associated with prior authorizations we have seen recently. • The two remaining measures were slightly lower. • Root cause analysis of grievances is performed quarterly with reporting of results to stakeholders for follow up. 2022 MHN Provider Behavioral Health Survey Tool (PSS) • Administered via email – via Qualtrics from 6/2022 – 9/2022. Response rate is up this year at 51% (2021 44%). • There are six (6) access related measures in the BH Provider Survey this year (MY22). • Perspective on concerns with compliance with the Urgent Care standard (% No) increased over last year. • All other measures reported decreased satisfaction compared to last year. • MHN is currently working on some actions to improve provider satisfaction and reporting on these in their quarterly PIR report. Member Satisfaction Survey (MSS) • CVH Member Annual survey to assess enrollee satisfaction with health care: • Follows NCQA protocol for administering the CAHPS® • Random sample of CVH members who meet CAHPS® eligibility criteria. The survey was conducted by telephone by SPH Analytics on 4/5/2022 – 4/26/2022. • Six (6) questions were asked related to access.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Ability to get routine care and ability to get care, tests and treatment easily improve slightly over 2021 results. • Ease to see a specialist decreased over the last year down to 47% from 65% in 2021. This is consistent with survey results from PCPs and our grievance data. • Two measures decreased slightly (1 to 2%) related to urgent care access and rescheduling a routine appointment. • Behavioral Health member satisfaction survey tool is called Experience of Care and Health Outcomes (ECHO): • Annual survey to assess enrollee satisfaction with behavioral health care services. • MHN-specific survey tool • Randomly sample members meeting eligibility criteria. • Administered by mail in 7/2022 – 9/2022 • Results were broken down by county. • Kings and Madera counties had low sample sizes limiting the ability to analyze the results. • Fresno County's volume of responses was similar to last year. Non-urgent appointments with a psychiatrist improved over last year. • Two questions were new this year and therefore did not have comparative data from last year. • Three measures decreased compared to last year related to non-urgent follow up appointments with psychiatrist, non-urgent initial and follow up appointments with non-physician. MHN is currently working on some actions to improve provider issues which will also impact member satisfaction issues. They are reporting on these in their quarterly PIR report.	
#5 **Access Business** - Access Workgroup Committee Minutes May 30th, 2023 - Access Workgroup Quarterly Report (Q2)	The **Access Workgroup Committee Minutes for May 30th, 2023** were presented and reviewed. The minutes have been approved and accepted by the Access Workgroup and will be brought to this Committee for review and approval going forward. *There were no questions regarding the minutes.* The **Access Workgroup Quarterly Report** provides the QI/UM Committee with an update on the CalViva Health Access Workgroup activities in Quarter 2 of 2023. Reports and topics discussed	Motion: *Approve* - Access Workgroup Committee Minutes May 30th, 2023 - Access Workgroup Quarterly Report (Q2)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
(Attachments Y - Z) **Action** Patrick Marabella, M.D Chair	focus on access-related issues, trends, and any applicable corrective actions. Reports reviewed include: •Appeals & Grievances Executive Report - Q1 2023 •Behavioral Health Performance Indicator- Q1 2023 • Long-Term Support Services (LTSS) - Q1 2023 •Member Services Call Center Metrics Report - Q1 2023 •MHN Triage and Screening Report-Q1 2023 •Network Adequacy Report - Q1 2023 •Open Practice Report - Q1 2023 •Provider Office Wait Times Report- Q1 2023 •Provider Over Capacity Grievance Report – Q1 2023 •Triage and Screening Report - Q 1 2023 •CCC Exempt Grievances Access to Care Trend Report - Q 1 2023 • 274 Monthly Data Quality Check – February & March •PPG Dashboard & Access Narrative -Q4 2022 •Telehealth Program •MY 2021 PAAS and After-Hours CAP and Evaluation – Update • It takes a year to collect and analyze data and CAPs. • 2022 DHCS Annual Network Certification • MY2022 DHCS Subnetwork Certification • MY2022/RY2023 DMHC TAR/ANR Filing • APL 22-007 and APL 22-026 Timely Access and Network Reporting Regulations	(Ramirez/Lee) 4-0-0-3
#6 **UM/CM/PHM Business** - Key Indicator Report and TAT Report (July) - Utilization Management Concurrent Review Report (Q2) (Attachments AA-BB)	Dr. Marabella presented the **Key Indicator Report and Turn Around Time Report** through July. A summary was shared that provided the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through July 2023. • **Membership** shows an increase for Expansion population, slight decrease for TANF, and an increase in the SPD population of approximately 12,500 members. • For **Acute Admissions** (adjusted PTMPY), the Expansion population had an increase and then slight decrease in the first 6 months of 2023 and is decreased compared to 2022. TANF slightly decreased compared to 2022, and SPD decreased compared to 2022. • **Bed Days** (adjusted PTMPY) decreased for all three populations.	Motion: *Approve* - Key Indicator Report and TAT Report (July) - UM Concurrent Review Report (Q2) (Lee/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	• **Acute Length of Stay** (adjusted PTMPY) decreased slightly for Expansion and SPD populations and remained the same for TANF population. • **Readmits within 30 days** (adjusted PTMPY) decreased slightly for Expansion and SPD populations and increased slightly for TANF. • **ER Visits** (adjusted PTMPY) are lower for Expansion and SPD populations through Q2 and slightly increased for TANF. • Perinatal Case Management results have shown a slight increase in referrals in Q2, and the engagement rates have remained consistent. • Integrated Case Management (CM) and Transitional CM have seen an increase in both referrals and engagement rates. • Palliative Care shows an increase in referrals but a decrease in engagement rate. Community Hospital has a new program where Fellows will work with our Palliative Care staff. • Behavioral Health referrals have fluctuated in recent months, but we have started to work with the HN Behavioral Health Team in hopes of improving referrals and engagement rates. **Utilization Management Concurrent Review Report** presents inpatient utilization data and clinical concurrent review activities for Q2 2023. The emphasis of the UM team is on improving member healthcare outcomes, minimizing readmission risk, and reducing post-acute gaps in care delivery via proactive discharge planning and expeditious linkages to medically necessary health and support services. • Data trends are consistent with those described above for KIR. Except for SPD, all Utilization goals have been met (SPD ALOS and Bed Days YTD actuals did not meet set goals).	
#6 **UM/CM/PHM Business** - Case Management & CCM Report(Q2) (Attachment CC) **Action** Patrick Marabella, M.D Chair	**The Case Management Report and CCM Report (Q2)** summarizes the Integrated Case Management, Perinatal Case Management, Transitional Care Management, MemberConnections, Palliative Care, Behavioral Health Case Management, and Emergency Department (ED) Diversion activities for Q2 2023 and utilization-related outcomes through 06/30/23. • After enrollment in Case management, Readmission rates, and ED Claims are noted to decrease consistently. Q2 data continues to reflect positive outcomes. • Those enrolled in Perinatal Case Management show improved outcomes in timeliness of first pre-natal visit, pre-term deliveries, and post-partum visits. Although pre-term delivery	Motion: *Approve* - Case Management & CCM Report (Q2) (Waugh/Lee) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	improvement was lower than seen previously this quarter, all measures showed positive outcomes.	
#6 **UM/CM/PHM Business** - ECM & Community Supports Performance Report (Q1 & Q2) (Attachment DD) **Action** Patrick Marabella, M.D Chair	**ECM & Community Supports Performance Report(Q1 & Q2)** is a new report that summarizes the CalAIM (California Advancing and Innovating Medi-Cal) initiative to improve the quality of life and health outcomes of Medi-Cal Members by implementing a broad delivery system and program and payment reform. A key feature of CalAIM is the introduction of Enhanced Care Management (ECM) as well as a new menu of Community Supports (CS) services, which can serve as cost-effective alternatives to covered Medi-Cal services. Medi-Cal managed care plans (MCPs) are responsible for administering both ECM and CS services. Between January through June 2023, there has been a steady increase in both ECM and CS uptake, including authorization and claims submissions. • For ECM, of 19,074 members were assigned in the three CVH counties, 6,784 were successfully enrolled, accounting for a 36% enrollment rate. • The average assignment to enrollment percentage remains above average in Fresno (34%) and Madera (71%), and slightly below the 25% threshold in Kings County (22%). • For CS, a total of 790 authorizations were submitted between January to June 2023, with 1,312 total claims paid. • 50% of the paid CS claims were for services related to Housing Transition/Navigation Services, followed by 32% for Asthma Remediation, and 14% for Recuperative Care. • Fresno (89%) accounted for the most referrals, followed by Madera (6%) and Kings (5%). Barriers to ECM and CS uptake continue to be focused on lack of accurate or available member contact information, difficulty finding members to refer into the program, lack of awareness by members and other providers of the program, inconsistent engagement with providers by the Plan's provider liaison, and training and technical assistance needs on operational functions. Next steps include but are not limited to: • Partner with the Population Health and Clinical Operations (PHCO) team to systematically screen, engage, and refer members to ECM and CS services. • Engage targeted ECM and CS providers to outreach and enroll members and close authorization to claims gap. • Support CS providers to submit timely claims submission and confirm services rendered relative to their authorizations. • Support ECM and CS providers to cross-refer to one another through a series of monthly	Motion: *Approve* - ECM & Community Supports Performance Report (Q1 & Q2) (Lee/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	"Connecting the Dots" webinar series in partnership with Health Management Associates (HMA).	
#6 **UM/CM/PHM Business** - Medical Policies Complete List & Provider Updates (Q2) (Attachment EE) **Action** Patrick Marabella, M.D Chair	**Medical Policies Complete List & Provider Updates (Q2)** The **Medical Policies Provider Updates** (Q2) were presented to the committee. The *Provider Update* Newsletter is compiled based on a national review by physicians and sent monthly to providers featuring new, updated, or retired medical policies for the Plan. Updated policies include but are not limited to: • CP.BH.1 – ADHD Assessment Testing • CP.MP.37 – Bariatric Surgery • CP.BH.201 – Deep Transcranial Magnetic Stimulation for Obsessive Compulsive Disorder • CP.MP.106 – Endometrial Ablation • CP.MP.134 – Evoked Potential Testing • CP.MP.248 – Facility-Based Sleep Studies for Obstructive Sleep Apnea • CP.MP.130 – Fertility Preservation • CP.MP.209 – Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing • CP.MP.496 – Gender Affirming Procedures • CP.MP.113 – Holter Monitors • CP.MP.58 – Intestinal and Multivisceral Transplant • CP.MP.123 – Laser Therapy for Skin Conditions • CP.MP.244 – Liposuction for Lipedema • CP.MP.91 – Obstetrical Home Health Programs • CP.MP.188 – Pediatric Oral Function Therapy • CP.MP.181 – Polymerase Chain Reaction Respiratory Viral Panel Testing • CP.MP.210 – Repair of Nasal Valve Compromise • CP.MP.146 – Sclerotherapy and Chemical Endovenous Ablation for Varicose Veins • CP.MP.185 – Skin Substitutes for Chronic Wounds • CP.MP.97 – Testing for Select Genitourinary Conditions • CP.MP.87 – Therapeutic Utilization of Inhaled Nitric Oxide • CP.BH.200 – Transcranial Magnetic Stimulation for Treatment-Resistant Major Depressive Disorder • CP.MP.38 – Ultrasound in Pregnancy	Motion: *Adopt* - Medical Policies Complete List & Provider Updates (Q2) (Lee/Ramirez) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CP.MP.98 – Urodynamic Testing • CP.MP.46 – Ventricular Assist Devices • CP.MP.99 – Wheelchair Seating • Updated policies include but are not limited to: • HNCA.CP.MP.349/CA.MP.MP.349 - Artificial Retina • CP.MP.128 - Optic Nerve Decompression	
#7 **Pharmacy Business** - Pharmacy Executive Summary (Q2) - Pharmacy Operations Metrics (Q2) - Pharmacy Top 25 Prior Authorizations (Q2) - Pharmacy Inter-Rater Reliability Results (IRR) (Q2) - Pharmacy Provider Updates (Q2) (Attachments FF-JJ) **Action** Patrick Marabella, M.D Chair	The **Pharmacy Executive Summary Q2** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time (TAT) metrics, and to formulate potential process improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q2. o Overall, TAT for Q4 was 98.5%. PA TAT was higher in Q2 than in Q1. o PA volume was slightly higher in Q2 compared to Q1. • Medication Trend Updates and Formulary Changes were included. The **Pharmacy Operations Metrics** (Q2) provides key indicators measuring the performance of the PA Department in service to CalViva Health members. Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q2 2023. Overall, TAT for Q2 2023 was 98.5%. The **Pharmacy Top 25 Prior Authorizations** (Q2) identifies the most requested medications to the Medical Benefit PA Department for CalViva Health members and assesses potential barriers to accessing medications through the PA process. • Top 25 PA requests in Q2 2023 were consistent with the top 10 drugs in Q1, with a few placement variations. • The drug denied most frequently was Elfapegrastim, a new non-preferred agent for the prevention of infection in cancer patients. There are two other drugs preferred first, when indicated. The **Pharmacy Inter-Rater Reliability Results** Q2 A sample of 10 prior authorizations (4 approvals	Motion: *Approve* - Pharmacy Executive Summary (Q2) - Pharmacy Operations Metrics (Q2) - Pharmacy Top 25 Prior Authorizations (Q2) - Pharmacy Inter-Rater Reliability Results (IRR) (Q2) - Pharmacy Provider Updates (Q2) (Ramirez/Waugh) 4-0-0-3

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	and 6 denials) per month are reviewed quarterly to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold for action of 90%. • 90% threshold met. 95% goal not met; the overall score was 94.17% • Zero cases missed TAT; Five cases criteria misapplied; One case letter language unclear; One case with a questionable denial or approval. • Criteria application was the main issue in Q2 similar to Q1 2023. PA Managers will continue to make sure the criteria are applied correctly. The **Pharmacy Provider Updates** describes the formulary changes and medication safety issues for this quarter.	
#8 **Credentialing & Peer Review Activities** - Credentialing Sub-Committee Quarterly Report (Q3) (Attachment KK) **Action** Patrick Marabella, M.D Chair	**CalViva Health Credentialing Sub-Committee Report** The Credentialing Sub-Committee met on July 20, 2023. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated services. Reports covering Q1 2023 were reviewed for delegated entities, and Q2 2023 for MHN and Health Net. There were four cases to report for the Q2 2023 Credentialing Report from Health Net. Outcomes include in two (2) cases the provider was placed on annual monitoring for compliance with the Board's orders; one (1) case the provider was placed on semi-annual monitoring for compliance with the Medical Board's order; one case was pended awaiting the Medical Board's decision and actions. The **2023 Adverse Events Report** is a new report for the Credentialing Sub-Committee this year. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. There were two (2) cases identified for Q2 2023 with adverse outcomes associated with a contracted practitioner. One (1) case was placed on annual monitoring and one case remained open for Board decision. There were no incidents or patterns of non-compliance resulting in substantial harm to a member or members due to access to care issues in Q2. There were no (0) cases identified outside of the ongoing monitoring process in which an adverse injury occurred during a procedure by a contracted practitioner in Q2. (NCQA CR.5. A. 4)	Motion: *Approve* - Credentialing Sub-committee Report (Q3) (Waugh/Ramirez) 4-0-0-3
#8 **Credentialing & Peer Review Activities**	**CalViva Health Peer Review Sub-Committee Report** The Peer Review Sub-Committee met on July 20, 2023. The county-specific Peer Review Sub-	Motion: *Approve* - Peer Review Sub-

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
- Peer Review Sub-Committee Quarterly Report (Q3) (Attachment LL) **Action** Patrick Marabella, M.D Chair	Committee Summary Reports for Q2 2023 were reviewed for approval. There were no significant cases to report. The **2023 Adverse Events Report** is a new report for the Peer Review Sub-Committee in 2023. There were five (5) cases identified for Q2 2023 with adverse outcomes. Three (3) cases involved a practitioner, and two (2) cases involved a provider. Outcomes included: Two (2) cases were tabled, and three (3) were closed to track and trend. There were no (0) cases that met the pattern of non-compliance for access to care in Q2. There were three (3) cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in Q2. (NCQA CR.5. A. 4) There were 34 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. The Q2 2023 Peer Count Report was presented with a total of ten (10) cases reviewed. There were five (5) cases closed and cleared. There were two (2) cases pending closure for Corrective Action Plan compliance. There were three (3) cases tabled for further information. Ongoing monitoring and reporting will continue.	Committee Report (Q3) (Ramirez/Lee) 4-0-0-3
#9. **Compliance Update** - Compliance Regulatory Report (Attachment MM)	Mary Lourdes Leone presented the **Compliance Report.** **The CalViva Health Oversight & Monitoring Activities** 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 and availability, specialty referrals, utilization management data, grievances, and appeals, etc. **Oversight Audits** The following annual audits are in progress: Pharmacy, Appeals & Grievances, Claims/PDR, UMCM, and Privacy & Security. The following audits have been completed since the last Commission report: FWA (No CAP) **Fraud, Waste & Abuse Activity** Since the 7/20/23 Compliance Regulatory Report to the Committee, there have not been any new MC609 cases filed.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	REGULATORY REVIEWS/AUDITS AND CAPS **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. **Department of Managed Health Care ("DMHC") 2022 Medical Audit** The Plan is awaiting DMHC's 2022 Preliminary Audit Report. **Department of Health Care Services ("DHCS") 2022 Medical Audit** After submitting all the monthly CAP updates, DHCS closed the CAP on 7/27/2023. **Department of Health Care Services ("DHCS") 2023 Medical Audit** The DHCS held its exit conference with the Plan on 8/24/23. The DHCS' draft 2023 Final Report for the State Supported Services Audit had no findings. The DHCS' draft 2023 Medical Audit Report cited one finding: "The Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances." The DHCS' recommendation to the Plan was to revise policies and procedures to monitor inquiry calls and ensure all member expressions of dissatisfaction are classified, processed, reviewed, and resolved as grievances. On 9/1/23, the Plan responded to DHCS stating that we agreed with the finding. The Plan is awaiting DHCS's Final Report and to see if the Department will issue a formal CAP. **NEW REGULATION /CONTRACTUAL REQUIREMENTS/DHCS Initiatives** **California Advancing and Innovating Medi-Cal (CalAIM)** **Enhanced Care Management (ECM) * Community Supports (CS)** The next ECM MOC submission scheduled for 10/2/23 will focus on the Justice Involved POF and Birth Equity MOC questions that will go live on 1/1/24. **Population Health Management and Population Needs Assessment (PNA)** Effective January 1, 2023, MCPs are no longer required to submit an annual PNA and PNA Action Plan as previously required. The annual PNA Action Plan deliverable to DHCS is to be replaced by the annual PHM Strategy, which is informed by the redesigned PNA process. The new annual PHM Strategy requires MCPs to demonstrate that they are meaningfully responding to community needs as well as provide other updates on the PHM Program to inform DHCS' monitoring efforts. To that end, the DHCS is requiring plans to submit their first "modified PHM Strategy" by the end of 2023 (CalViva's initial PHM Strategy document was approved on 12/27/22). CalViva's Plan Administrator, Health Net, has begun to reach out to the LHDs in Fresno, Kings, and Madera Counties. **Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP**	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In August of 2023, the Plan submitted two Amendments to the DMHC under its Knox-Keene license application. These were related to the Plan's request to co-brand with Health Net in support of HN's Exclusively Aligned Enrollment ("EAE") Dual Special Needs Plan ("D-SNP") in which CalViva Health is the affiliated Medi-Cal plan in Fresno, Kings, and Madera Counties. Health Net holds the SMAC contract with the DHCS. The Plan's co-branding request would not apply to the RHA's Medi-Cal Managed Care Plan activities and obligations as required by its own contract with DHCS. As part of these amendments, the Plan provided to the DMHC HN's DHCS and DMHC-approved integrated Member materials (i.e., EOC, Member ID Card, the Annual Notice of Change, and Summary of Benefits). The Plan is waiting for DMHC's approval. **Member Handbook/Evidence of Coverage** The Plan submitted the 2024 CalViva version EOC and Member ID Card on 8/31/24 to DHCS and DMHC and is awaiting approval from both Departments. **PLAN ADMINISTRATION** **DHCS 2024 Operational Readiness Work Plan & Contract** The Plan has completed the monthly filings to DHCS of the various policies and other required documents through August 2023 and has received approvals on most but is still responding to additional DHCS information requests for some of the items. On 9/1/23, the DHCS informed the Plan's CEO that it is approved to go live on 1/1/24 contingent on closing out any Outstanding Operational Readiness Contract deliverables. **New DHCS Regulations/Guidance** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2023 as of September 2023. **Public Policy Committee** The PPC meeting was held on September 6, 2023, at 11:30 in the Camarena Health Conference Room, 344 E. Sixth Street, Madera, CA 93638. The PPC did not have a quorum which rendered the meeting agenda/reports as "informational only". Informational items presented consisted of the Enrollment Dashboard, Member Incentive Program Semi-Annual Report, and the Q2 2023 Appeals and Grievance Report. Dr. Marabella presented the A&G Dashboard and discussed trends. [Note: Due to the lack of quorum on 9/6/23, a separate ad-hoc PPC meeting has been scheduled for 9/27/23 @ 11:00 AM in CalViva Health's Commission Room, 7625 N. Palm Ave., Fresno, CA 93711. The following action items will be presented: the 6/7/23 Meeting Minutes, the Proposed 2024 PPC Meeting Calendar, and the Annual PPC Charter.]	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#10 **Old Business**	None.	
#11 **Announcements**	Next meeting October 19th, 2023	
#12 **Public Comment**	None.	
#13 **Adjourn**	Meeting was adjourned at 12:47 p.m.	

NEXT MEETING: October 19th, 2023

Submitted this Day: October 19, 2023

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

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes

October 19th, 2023

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

Th	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
✓*	**David Cardona, M.D.,** Fresno County At-large Appointee, Family Care Providers	✓	**Iris Poveda**, Senior Medical Management Specialist
	Fenglaly Lee, M.D., Central California Faculty Medical Group	✓	**Mary Lourdes Leone,** Chief Compliance Officer
✓	**Carolina Quezada, M.D.,** Family Health Care Network	✓	**Maria Sanchez**, Compliance Manager
✓	**DeAnna Waugh, Psy.D.,** Adventist Health, Fresno County	✓	**Patricia Gomez,** Senior Compliance Analyst
✓*	**Joel Ramirez, M.D.,** Camarena Health Madera County (arrived at 10:35 AM)	✓	**Zaman Jennaty**, Medical Management Nurse Analyst
✓	**Rajeev Verma, M.D.,** UCSF Fresno Medical Center	✓	**Norell Naoe,** Medical Management Administrative Coordinator
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
	Guests/Speakers		
✓*	Dr. Anshul Dixit, HealthNet Regional Medical Director		

✓ = in attendance
* = Arrived late/left early

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D Chair	The meeting was called to order at 10:32 am. A quorum was present. Dr. Marabella welcomed Dr. Dixit to today's meeting. Dr. Dixit is the HealthNet Regional Medical Director for our service area.	
#2 Approve Consent Agenda Committee Minutes: September 21st, 2023 - Standing Referrals Report (Q2) - Specialty Referrals Report (Q2) - Provider Office Wait Time Report (Q2) - Provider Preventable	September 21st, 2023, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Dr. Marabella reminded the committee that any item on the consent agenda may be pulled out for further discussion at the request of any committee member. A link for the Medi-Cal Rx Contract Drug List was available for reference.	Motion: *Approve* Consent Agenda (Quezada/Verma) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Conditions (PPC) (Q2) - TurningPoint Musculoskeletal Utilization Review (Q2) (Attachments A-F) **Action** Patrick Marabella, M.D Chair		
#3 QI Business - Appeals & Grievances Dashboard (August) (Attachment G) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard** through August 2023 was presented noting the following trends: • The total number of grievances through August 2023 is increasing compared to previous years. Trends associated with this increase are being addressed. • Quality of Service (QOS) for Access (Prior Authorizations), Administrative, Other (Balanced Billing), and Transportation continue to represent most of these grievances. • The volume of Quality of Care (QOC) grievances has increased in August compared to last month. • Exempt Grievances have increased compared to last month. Balanced Billing Grievances have begun to decrease. • Total Appeals received through August 2023 have decreased, while the uphold and overturn rates remain consistent. Advanced imaging (MRI & CT) appeals continue to be a trend.	Motion: *Approve* - Appeals & Grievances Dashboard (August) (Verma/Cardona) 5-0-0-2
#3 QI Business - MHN Performance Indicator Report for Behavioral Health Services (Q2) (Attachment H) **Action** Patrick Marabella, M.D Chair	The **MHN Performance Indicator Report for Behavioral Health Services** (Q2) provides a summary of an array of indicators to evaluate the behavioral health services provided to CalViva members. Fifteen out of the fifteen metrics met or exceeded their targets this quarter. • CalViva Membership increased 1.8% from Q1 2023, utilization is 2.3%. • There were two (2) Life-Threatening Emergent cases and two (2) Non-Life-Threatening Emergent cases, and the appointment access standards were met. • There were ten (10) Urgent cases, and the appointment access standard was met for all cases. • Both Non-ABA and ABA were 100% compliant on timeliness. • There were seven (7) PQIs, with no quality issues found. • MHN is also working on improving: o Communication with members through a targeted provider newsletter, sent on	Motion: *Approve* - MHN Performance Indicator Report for Behavioral Health Services (Q2) (Ramirez/Quezada) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	9/11/23 based upon member recommendations for improved communication. o Data exchange with the County Mental Health Plans.	
#3 QI Business - Health Equity 2023 Language Assistance Program Report (Semi-annual) - Health Equity 2023 Geo Access Report & Executive Summary (Attachments I-J) **Action** Patrick Marabella, M.D Chair	The **Health Equity 2023 Language Assistance Program Report (Semi-annual)** provides information on the language service utilization by CalViva Health members from January 1st to June 30th, 2023. The Language Assistance Program incorporates MHN Services' Mental Health/Behavioral Health language utilization for the same reporting period. It also evaluates telephonic and in-person interpretation services, Sign Language, and document translations. • Member Services Department representatives handled a total of 70,043 calls across all languages during this reporting period. Of these, 12,758 (18%) were handled in Spanish and Hmong languages. • A total of 2,440 interpreter requests were fulfilled for CalViva Health members, 1,743 (71%) of these requests were fulfilled utilizing telephonic interpreter services with 644 (26%) for in-person, 53 (2%) for sign language interpretation, and zero requests for video remote interpreting. • MHN Services' Member Services Department representatives handled a total of 1,753 calls across all languages and 532 (31%) calls handled in a language other than English (Spanish, Hmong, Punjabi, Khmer, Mandarin, and Farsi) with 504 (94%) handled in Spanish and 4 (1%) handled in Hmong. • There were 120 requests for interpreter services with all fulfilled for MHN. Eighty-two (82) or 68% were fulfilled in-person, five (5), or 4% were for sign language interpretation, seven (7), or 6% were for telephone interpretation, and twenty-six (26) or 22% were for Video Remote Interpretation. • One written translation request was received from CalViva Health members during this reporting period. • A total of thirty-four (34) English material reviews were completed for CalViva Health documents/materials, including the member newsletter. • A total of seventeen (17) grievance cases were received and reviewed by the Health Equity Department. There were no follow-up interventions by Health Equity required for these cases. Dr. Marabella shared with the committee that MHN has been an affiliate of HealthNet over the years to provide mild to moderate mental health services for CalViva members including ABA, but as of January 2024, MHN will be folded into HealthNet. This may impact the availability of certain data points and the appearance of some reports. A communication for providers and members is forthcoming regarding this change. The **Health Equity 2023 Geo Access Report & Executive Summary** examines the race, ethnicity, and	Motion: *Approve* - Health Equity 2023 Language Assistance Program Report (Semi-annual) - Health Equity 2023 Geo Access Report & Executive Summary (Quezada/Verma) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	language of CalViva Health's members compared to the provider network for the prior year and examines the concordance of provider languages spoken in the office with member language needs. The data illustrates counties where members who identified as speaking a given language did not live within an appropriate time or distance parameter (10 to 30 miles or 30 to 60 minutes from a member's residence depending on population density). • Gaps were identified for various languages for PCPs and Specialists or both PCPs and Specialists. • All members identifying as Spanish-speaking and residing in Fresno, Kings, or Madera counties had their language access needs met. • Madera appears to be the county with the fewest gaps. • The Culture and Linguistics Services Department staff developed and executed a plan to address the gaps in provider language capabilities and member language needs with the goal of increasing awareness and utilization of the language support services that are available through CalViva Health. Monitoring and reporting will continue. ***Discussion:*** *A discussion followed regarding the state's lack of information about the provider's languages spoken, which is captured upon initial credentialing with the Plan if it is reported but, unlike race and ethnicity, it has not been mandatory, therefore many data gaps exist.* *Dr. Cardona hopes that the state will remediate this gap through the recredentialing process.* *Dr. Marabella indicated that in the meantime, we attempt to address these gaps through in-person, telephonic, and VRI interpreters. HN is also attempting to collect more language and culture-specific data from their providers.* *Dr. Verma indicated that there will always be a language gap between the number of providers in each demographic and the needs of that community for in-person visits. The medical board would have to approve an equitable number of providers to match the target populations, which is impossible.* *For example, Amy Schneider indicated that it is surprising that there is a larger gap in Fresno County among its Hmong population as there are some Hmong-speaking practitioners but not enough are available throughout the county.*	
#3 QI Business - Facility Site & Medical	The **Facility Site & Medical Record & PARS Review Report (Q1 & Q2)** was presented and reviewed for the first and second Quarters of 2023. New FSR/MRR tools and standards began on 7/1/22.	Motion: *Approve* - Facility Site & Medical

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Record & PARS Review Report (Q1 & Q2) (Attachment K)	• There were twenty-four (24) Facility Site Reviews (FSR) and twenty-four (24) Medical Record Reviews (MRR) completed in the 1st and 2nd Quarters of 2023. • The mean rate FSR score for Fresno, Kings, and Madera Counties was 97% for the 1st and 2nd Quarters of 2023. • The mean rate MRR score for Fresno, Kings, and Madera Counties was 92% for the 1st and 2nd Quarters of 2023 with 250 records reviewed. • The Pediatric Preventive Care section's mean score was 88%. • The Adult Preventive Care section's mean score was 91%. • Forty-two (42) Physical Accessibility Review Surveys (PARS) were completed in the 1st and 2nd Quarters 2023. Twenty-nine (29) of the forty-two (42) PARS have Basic level access.	Record & PARS Review Report (Q1 & Q2) (Cardona/Ramirez) 5-0-0-2
#4 Key Presentations - Health Equity Work Plan Mid-Year Evaluation and Executive Summary 2023 - Health Education Work Plan Mid-Year Evaluation and Executive Summary 2023 (Attachments L-M) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **Health Equity Work Plan Mid-Year Evaluation and Executive Summary 2023.** The 2023 Work Plan is divided into 4 Categories: • Language Assistance Program • Compliance Monitoring • Communication, Training, and Education • Health Literacy, Cultural Competency & Health Equity By June 30th all activities were on target for end-of-year completion with some already completed. Some of the Activities Completed include: • Provided training sessions for new hires and current A & G staff. • Completed fifteen (15) translation reviews. • Supported and provided Barrier Analysis data for new Clinical and Non-clinical PIPs. • Thirty-nine (39) staff completed their bilingual assessment or were reassessed. • Completed LAP assessment for TAR submission. • Reviewed seventeen (17) grievance cases with no interventions needed and two (2) interpreter complaints. • Supported Sexual Orientation & Gender Identity (SOGI) data field *go-live* to improve data capture. The Annual Comparative Analysis of language service utilization was presented: Race/Ethnicity, Race/Ethnicity by Gender and Languages, and interpreter utilization data. • Spanish and Hmong are CalViva Threshold Languages. Spanish is the highest with 95%.	Motion: *Approve* - Health Equity Work Plan Mid-Year Evaluation and Executive Summary 2023 - Health Education Work Plan Mid-Year Evaluation and Executive Summary 2023 (Verma/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Most interpretation is done via telephonic interpreters and face-to-face remained at 26% consistent with last year. • MHN (behavioral health) language services are also monitored. o 31% (532) of Calls were non-English compared to 9% (207) last year. o 94% of non-English Calls were in Spanish. All Work Plan activities continue on target for completion by the end of calendar year 2023. Continue to assess circumstances to modify plans as needed to continue to implement, monitor, and track Health Equity-related services and activities. *Dr. Dixit left at 11:09 AM Dr. Marabella presented the **Health Education Work Plan Mid-Year Evaluation and Executive Summary 2023.** The Work Plan has two Areas of Focus for 2023: • Programs and Services • Department Operations, Reporting, and Oversight Health Education activities are selected based on the Population Needs Assessment. Mid-Year outcomes include: • Fifteen (15) Program Initiatives for 2023 with Forty (40) Objectives Objective Status: o Twenty-one (21) objectives on track. o Seven (7) pending as contingent on other activities. o Five (5) suspended after QI Quadrant Analysis. o Three (3) in progress and expected to exceed the goal. o Two (2) are complete. o Two (2) are off track. Barriers to full implementation of planned activities have been identified and are being addressed. Continue with the implementation of 2023 initiatives to meet or exceed year-end goals. ***Discussion:*** *Dr. Verma stated that there are an overwhelming number of metrics and QI measures now as compared to a limited set of core metrics implemented in years prior. Older primary care*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	physicians have left the industry by the dozens and new physicians are having a tough time handling the workload. *Dr. Marabella agreed that now the DHCS has stratified measures in attempts to meet the CalAIM requirements that the state has given to the Plans to implement.* *Dr. Cardona stated that there is already a reduction in access to care because there aren't enough primary caregivers in the workforce.*	
#4 Key Presentations - Quality Improvement Health Equity Transformation Program 2023 (Attachment N) **Action** Patrick Marabella, M.D Chair	Dr. Marabella presented the **Quality Improvement Health Equity Transformation Program (QIHETP) 2023** which is a new DHCS Requirement this year to address the integration of Health Equity with Quality Improvement in Medi-Cal Managed Care Plans. This Program provides guidelines on: • Integrating health equity practices throughout the organization and among providers to reduce disparities. • Engaging members, their families, and communities with the Plan. <u>The Mission of this program is to:</u> • Improve structural determinants of health equity, by working within and across societal institutions and systems. • Improve neighborhood-level social determinants of health, by working with and across institutions in defined geographic communities. • Improve institutional drivers of health equity, by working within our institution with providers, and with other key stakeholders. • Improve individual and household-level social needs and networks, by improving access, quality, and value of services for our members. CVH's Quality Improvement and Health Equity Goals include: • Providing support, maintaining compliance, and creating cultural awareness through education and consultation. • Promoting cultural responsiveness between Plan staff, members, and contracted providers. The QIHET Program enhances current processes and practices already in place, including: • Quality Improvement Program & Work Plan • Health Equity Program & Work Plan • Performance Improvement Projects (PIPs) • Population Needs Assessment.	Motion: *Approve* - Quality Improvement Health Equity Transformation Program 2023 (Quezada/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The QIHETP further integrates the two existing programs and utilizes the Health Equity Model to reduce Disparities. Leadership is charged with monitoring the health equity activities, medical management, and quality of care and services provided to members to promote equity through: Encounter Data, Grievances and Appeals, Utilization Data, and Satisfaction Surveys (CAHPS). Emphasis of the QIHET program is: • Member & Family Engagement • Community Engagement • Reducing Disparities.	
#4 Key Presentations - Appeals Review Job Descriptions (Attachment O) **Action** Patrick Marabella, M.D Chair -	The **Appeals Review Job Description** was presented and reviewed by the committee for approval. This job description utilized by Centene/HealthNet establishes the training, experience, and qualifications of any providers hired to review and adjudicate appeals and denials for CalViva Health members. The individual in this role is responsible for performing medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services. They also provide medical expertise in the operation of approved quality improvement, and utilization management programs in accordance with regulatory, state, corporate, and accreditation requirements. *There were no questions or concerns raised by committee members regarding the job description as presented.*	Motion: *Adopt* - Appeals Review Job Descriptions (Cardona/Ramirez) 5-0-0-2
#5 Access Business - Access Work Group Minutes from 7/25/23 - Provider Appointment Availability & After-Hours Access Survey Results (Provider Update) (Attachments P-Q) **Action** Patrick Marabella, M.D Chair	The **Access Work Group Minutes for July 25th, 2023** were presented and reviewed. The minutes have been approved and accepted by the Access Workgroup and will be brought to this Committee for review and approval. At the July 25th meeting the Access & After-Hours CAP was reviewed, the Exempt Grievance Trend Report for Q2 was reviewed, the Call Center, PPG Dashboard & Access Narrative for Q1 2023 was reviewed, the 274 Data Check Report was discussed, and the Q1 Transportation Oversight Report was reviewed. The minutes from the previous meeting and the reports listed previously were approved (some with minor corrections or edits) including Consent items. The Telehealth Program and Specialty Referrals Reports were tabled for the next meeting. **Provider Appointment Availability & After-Hours Access Survey Results (Provider Update)** **The 2022 annual Provider Appointment Availability Survey (PAAS) and Provider After-Hours Access Survey (PAHAS)** results are used to monitor provider compliance with timely access	Motion: *Approve* - Access Work Group Minutes from 7/25/23 - Provider Appointment Availability & After-Hours Access Survey Results (Provider Update) (Verma/Ramirez) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	and after-hours regulations and evaluate the effectiveness of the network to meet the needs and preferences of CalViva Health members. The following DMHC and DHCS appointment access metrics did not meet the performance goal of 70%: • Urgent care appointment with PCP within 48 hours. • Urgent care appointment with Specialist that requires prior authorization within 96 hours. • Non-urgent appointment with PCP within 10 business days. • Non-urgent appointment with Specialist within 15 business days. • Preventive health or well-child appointment with PCP within 2 weeks. • Physical exam/wellness check appointment with PCP within 30 calendar days. • Initial prenatal appointment with PCP/specialist within two weeks. A Corrective Action Plan (CAP) is issued to contracted PPGs and provider offices that fail any of the urgent or non-urgent metrics. PPGs and providers who receive a CAP are required to submit a written improvement plan (IP) within 30 days. Attendance at a training webinar is required as part of the IP. Upon review of the IP, additional information may be required to validate that corrective action steps were completed. PPGs are required to submit an attestation that they have notified their providers of the access to care standards that were not met. The performance goal of 90% for After-Hours Emergency Instructions was met in all three CalViva counties. A statistically significant increase was noted overall for all counties compared to MY 2021 for Ability to Contact On-Call Physician After Hours. For After-Hours Emergency Instructions, the performance goal of 90% was met in all counties with a slight decrease in Fresno County. The performance goal of 90% for After-Hours Emergency Instructions (Table 18) was met in all three CalViva counties. A statistically significant increase was noted overall for all counties compared to MY 2021 for Ability to Contact On-Call Physician After Hours. The MY2023 Provider Appointment Availability Survey and After-Hours Access Survey are currently underway. *Dr. Cardona left the meeting briefly from 11:44 AM – 11:48 AM.	
#6 UM/CM Business - Key Indicator Report (August) (Attachment R)	Dr. Marabella presented the **Key Indicator Report** through August. A summary was shared that provided the most recent data for Admissions, Bed Days, Average Length of Stay, and Readmissions through August 2023. • Membership demonstrated a decline for TANF, SPD, and Expansion populations associated	Motion: *Approve* - Key Indicator Report (August) (Ramirez/Quezada)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	with redeterminations and the unwinding of the Public Health Emergency. • For Acute Admissions (adjusted PTMPY), the Expansion population had a slight increase. TANF and SPDs remained consistent. • Bed Days (adjusted PTMPY) for Expansion there was a slight increase, whereas TANF and SPD continue to decrease. • Acute Length of Stay (adjusted PTMPY) increased slightly for Expansion and decreased for both TANF and SPD populations. • Readmits within 30 days (adjusted PTMPY) decreased slightly for all three populations. • Turnaround Time (TAT) rates are in compliance. • Perinatal Case Management results have shown an increase in referrals and engagement rate in August. • Integrated Case Management (CM) and Transitional CM have seen an increase in referrals and the engagement rate increased for Transitional CM. • Palliative Care shows a decrease in referrals but an increase in engagement rate. • Behavioral Health CM shows an increase in both referrals and engagement rates.	5-0-0-2
#6 UM/CM Business - Clinical Practice Guidelines - Medical Policies Provider Updates (Q3) (Attachments S-T) **Action** Patrick Marabella, M.D Chair	The **Clinical Practice Guidelines** were presented and reviewed by the Committee. HN reviews and adopts guidelines from Centene's National organization which are then available for CalViva review and adoption. CalViva QI/UM Committee members have the opportunity to provide feedback or ask questions prior to approval. The links to each guideline are listed in the attachment and are also available on the provider portal. No concerns or questions were raised after review and the clinical practice guidelines were adopted for CalViva Health. The **Medical Policies Provider Updates (Q3)** were presented to the committee. The Provider Update Newsletter is compiled based on a national review by physicians and distributed monthly to providers via facsimile featuring new, updated, or retired medical policies for the Plan. Updated policies for Q3 include but are not limited to the following: • CP.MP.249 Omisirge (omidubicel) • CP.MP.92 Acupuncture • CP.MP.93 Bone Anchored Hearing Aids (BAHA) • CP. MP.14 Cochlear Implant Replacements	Motion: *Adopt* - Clinical Practice Guidelines - Medical Policies Provider Updates (Q3) (Quezada/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CP.MP.248 Facility-Based Sleep Studies for Obstructive Sleep Apnea • CP.MP.137 Fecal Incontinence Treatments • CP.MP.129 Fetal Surgery in Utero for Prenatally Diagnosed Malformations • CP.MP. 48 Neuromuscular Electrical Stimulation • CP.MP.49 Physical, Occupational, and Speech Therapy • CP.MP.51 Reduction Mammoplasty and Gynecomastia Surgery • CP.MP.126 Sacroiliac Joint Fusion • CP.MP.542 Testing for Drugs of Abuse <u>The following policies have been retired:</u> • CP.MP.148 Radial Head Implant • HNCA.CP.MP.502/ CA.CP.MP.502 Non-Medically Indicated Elective (Early) Delivery Before 39 Weeks.	
#7 Policy & Procedure - Public Health Policies and Procedures (Attachment U) **Action** Patrick Marabella, M.D Chair	The **Public Health Policy Grid** was presented to the committee. The following policies were up for annual review with no changes made: • PH-006 Vision Care • PH-010 Dental Care • PH-015 Sensitive Services • PH-016 Local Education Agency (LEA) • PH-017 Communicable Disease Reporting • PH-018 Access to Certified Nurse Practitioners • PH-024 Eating Disorder Treatment Services • PH-025 Behavioral Health Treatment Services- autism spectrum disorder • PH-062 Non-Emergency, Non-Medical Transportation Assistance and Coordination The following policies were up for annual review and updated with minor edits: • PH-004 Pediatric Preventative Care Services • PH-014 Immunization Program • PH-019 Minor Consent • PH-042 HIV Testing and Counseling • PH-043 Sexually Transmitted Diseases (STD) Services	Motion: *Approve* - Public Health Policies and Procedures (Verma/Ramirez) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The following policies were up for annual review and had updated Definitions sections: • PH-009 School-Based Health Programs • PH-041 Department of Developmental Services (DDS) Administered Home and Community Based Waiver Program • PH-048 Regional Centers Coordination The following policies were up for annual review and had updates as described: • PH-002 In-Home Operations Waiver and Home and Community-Based Alternatives (HCBA) Waiver added Medi-Cal for Kids and Teens Services reference. Changed "Home and Community Based Alternatives (HCBA) Waiver" to "Home and Community Based Services (HCBS)" through the policy. • PH-003 Adult Preventative Services updated "Initial Health Assessment" to "Initial Health Appointment" through the policy. • PH-008 Early Start Program updated Definitions section. Added Medi-Cal for Kids and Teens through the policy to be in compliance with APL 23-005. Added Community Health Worker 2023 Process. PH-022 Alcohol and Drug Treatment Services deleted the IHEBA reference. • PH-013 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services updated ACE Screenings to be in compliance with APL 23-017. • PH-020 Mental Health Services added Definitions section and County Mental Health Responsibilities section. Updated Purpose. • PH-021 Mental Health Dispute Resolution added Definitions. Changed "The County Relations designated Community Liaisons or Manager' to "The County Relations (Service Coordinator) designated Liaisons or Manager" through the policy. Updated to be consistent with APL 21-013. • PH-022 Alcohol and Drug Treatment Services added Departments that fall under the scope of the policy services. Deleted IHEBA reference. • PH-023 Non-Specialty Mental Health Services added Dyadic services reference. Added Information/Data Exchange section. • PH-050 California Children's Services (CCS) added Medi-Cal for Kids and Teens to the EPSDT definition. • PH-064 Multipurpose Senior Services Program (MSSP) Waiver was retired by HN.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• PH-088 Public Health Coordination was updated to be in compliance with the 2024 DHCS contract. Added Clinical Liaisons section. • PH-101 Perinatal Care updated Purpose and Definitions section. • PH-103 Access to Freestanding Birth Centers and the Provision of Midwife Services updated Definitions section. Added process to locate out-of-network FBCs. • PH-104 Family Planning Services removed reference to APL 10-003 and 10-014. • PH-105 Pregnancy Termination updated Purpose and Definitions sections. Four new policies were included in the meeting packet and reviewed with the committee: o PH-001 Electronic Visit Verification o PH-052 Children with Special Health Care Needs (CSHCN) o PH-053 In-home Supportive Services Program Waiver (IHSS) o PH-102 Doula Services PH-064 Multipurpose Senior Services Program (MSSP) Waiver was retired by HN and is pending. *Committee members had the opportunity to review the contents of all new policies and any significant policy edits since the last review of the Public Health policies. There were no questions or concerns raised by committee members.*	
#7 Policy & Procedure - UM/CM Policies and Procedures (Attachment V) **Action** Patrick Marabella, M.D Chair	The following **UM/CM Policies** were presented to the committee for review, discussion, and approval: UM-113 Criteria for Utilization Management Care Management Decisions added characteristics for applying criteria and a statement regarding CalViva's UM criteria and procedures. This policy provides for clearly written, reasonable, and approved criteria that are based on evidence-based medical literature to appropriately and consistently evaluate clinical services for medical necessity when approving, modifying, or denying requests for UM/Care Management Determinations. It was pointed out that state policy and national medical necessity criteria are used to determine benefit coverage and medical necessity. Where national or state guidelines do not exist, CalViva allows Health Net to develop medical guidelines, using physician experts, medical literature, and usual standards of practice. Such medical policies developed through Health Net's Medical Advisory Council (MAC Policies) will be presented to the CalViva CMO (Chief Medical Officer) and CalViva's QI/UM committee for review and adoption. It was also pointed out that the Plan also	Motion: *Approve* - UM/CM Policies and Procedures (Ramirez/Cardona) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	uses Inter-Qual® Care Planning Criteria along with other company-wide evidence-based medical policies which are approved and updated by the Plan's Medical Advisory Council. *Committee members were in agreement with the policy as stated and voiced no questions or concerns.* • UM-116 Clinical Criteria for Medical Management Decisions added characteristics for applying criteria. • One new policy was included in the meeting packet and reviewed with the committee: o UM-208 Appropriate Professionals and Use of Board-Certified Physicians in UM Decision Making. The purpose of this policy is to specify and standardize the application of licensed healthcare professionals and Board-Certified Physician Consultants to each level of utilization management decision-making. *There were no concerns with the new policy as written.*	
#7 Policy & Procedure - A & G Policies and Procedures (Attachment W) **Action** Patrick Marabella, M.D Chair	The **A & G Policies** were presented to the committee. • AG-001 Member Grievance Process updated the Appeal definition, and Standard Grievances process section including enhancement of the procedures followed during case investigation and resolution. • AG-002 Member Appeal Process updated the purpose statement, added guidance for the Appeal reviewer regarding full investigation and documentation of findings, and clarified actions taken by the Plan during an investigation. Language was also added to further clarify when an expedited review is granted. *Committee members were in agreement with the policy changes as stated and voiced no questions or concerns.*	Motion: *Approve* - A & G Policies and Procedures (Ramirez/Quezada) 5-0-0-2
#8. Compliance Update - Compliance Regulatory Report (Attachment X)	Mary Lourdes presented the **Compliance Regulatory Report.** **CalViva Health Oversight Activities.** 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 and availability, specialty referrals, utilization management data, grievances, appeals, etc. **Oversight Audits.** The following annual audits are in progress: Pharmacy, Appeals & Grievances, UMCM 2019-2020 CAP Closed, UMCM 2021-2022 and Privacy & Security. The following audits	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	have been completed since the last Commission report: Claims/PDR (Claims CAP, no PDR CAP) and Credentialing No CAP. **Fraud, Waste & Abuse Activity.** Since the last report to the Committee, there have been no new MC609 cases filed with DHCS. **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. **Department of Managed Health Care ("DMHC") 2022 Medical Audit.** The Plan is awaiting DMHC's 2022 Preliminary Audit Report. **Department of Health Care Services ("DHCS") 2023 Medical Audit**. The Plan received DHCS' Final Report on 9/20/23. DHCS has issued a final CAP because the Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances. Our initial CAP response is due on 10/20/23 and DHCS will track our progress over a six-month period with monthly update submissions. **California Advancing and Innovating Medi-Cal (CalAIM). Enhanced Care Management (ECM):** On 9/26/23, the Plan submitted the Birth Equity MOC template to demonstrate operational readiness for the Birth Equity POF that is going live 1/1/2024. **Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP.** In August of 2023, the Plan submitted two Amendments to the DMHC under its Knox-Keene license application. These were related to the Plan's request to co-brand with Health Net in support of HN's Exclusively Aligned Enrollment ("EAE") Dual Special Needs Plan ("D-SNP"). The Plan received DMHC approval on our submission on 9/21/2023. **Long-Term Care (LTC) Carve-In Deliverable List – Phase II.** Effective 1/1/2024 LTC services will be carved into MCPs statewide. The Plan is required to submit deliverables associated with APL 23-004: INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES and APL 23-027: SUBACUTE CARE FACILITIES to DHCS by 11/27/2023. **Member Handbook/Evidence of Coverage.** The Plan submitted the 2024 CalViva version EOC and Member ID Card on 8/31/23 to DHCS and DMHC and is awaiting approval from both Departments. **DHCS 2024 Operational Readiness Work Plan & Contract.** The Plan has completed the monthly filings to DHCS of the various policies and other required documents through September 2023 and has received approvals on most but is still responding to additional DHCS information requests for some of the items. On 9/1/23, the DHCS informed the Plan's CEO that it is approved	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	to go live on 1/1/24 contingent on closing out any Outstanding Operational Readiness Contract deliverables. **New DHCS Regulations/Guidance.** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2023 as of October 2023. **Public Policy Committee.** The next meeting will be held on December 6, 2023, at 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.	
#9 **Old Business**	None.	
#10 **Announcements**	At the DHCS Quality Conference yesterday in Sacramento, CalViva Health won a Certificate of Achievement "In recognition of our Hard Work and High Achievement on the Bold Goals aggregated quality factor score for the San Joaquin Valley Region for 2022-2023".	
#11 **Public Comment**	None.	
#12 **Adjourn**	The meeting was adjourned at 12:10 pm	

NEXT MEETING: November 16th, 2023

Submitted this Day: November 16, 2023

Submitted by: Amy B Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick Marabella

Patrick Marabella, MD Committee Chair

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 YTD Total
# of DHCS Filings													
Administrative/ Operational	22	20	28	18	25	23	19	26	23	23	26	37	290
Member Materials Filed for Approval;	2	3	4	3	3	3	4	6	0	3	2	0	33
Provider Materials Reviewed & Distributed	15	12	23	13	10	14	9	17	21	17	10	14	175
# of DMHC Filings	11	8	12	10	8	5	4	9	3	4	4	5	83

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	0	4	3	1	3	2	2	1	3	2	3	0	24
High-Risk	0	0	0	0	0	0	0	1*	0	1	1	0	3

*Case was initially classified as low risk to mirror HN's reporting/classification, however, the case has been updated to High-Risk following CalViva's risk assessment. The business partner of a HN's PPG experienced an infiltration by a threat actor. The threat actor obtained 172 CVH member's PHI before an internal investigation by the PPG ended the threat. The PPG had notified all impacted CVH members, in addition to reporting this breach to the Office of Civil Rights.

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 YTD Total
# of New MC609 Cases Submitted to DHCS	0	0	2	0	1	0	1	0	0	0	0	0	4

# of Cases Open for Investigation (Active Number)	10	12	12	10	9	11	11	14	15	15	15	14	

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 11/16/23 Compliance Regulatory Report to the Commission, there were no new MC609 cases filed by the end of 2023.

Compliance Oversight & Monitoring Activities:	Status
CalViva Health Oversight Activities	**Health Net** CalViva Health's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings and discuss any issues or questions during the monthly oversight meetings with Health Net. CalViva Health and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CalViva Health. The reports cover PPG level data in the following areas: financial viability data, claims, provider disputes, access & availability, specialty referrals, utilization management data, grievances, and appeals, etc.
Oversight Audits	The following annual audits are in-progress: Credentialing, Emergency Room, UMCM, and Quality Improvement. The following audits have been completed since the last Commission report: Appeals and Grievances (No CAP), Continuity of Care (No CAP), Health Education (No CAP), Privacy and Security (No CAP)

Regulatory Reviews/Audits and CAPS:	Status
Department of Managed Health Care ("DMHC") 2022 Medical Audit	The Plan received the **2022 DMHC Preliminary Audit Report** on 11/1/2023 which included a CAP request covering 11 deficiencies. The Plan submitted a response on 12/15/2023 and is awaiting DMHC response.
Department of Health Care Services ("DHCS") 2023 Medical Audit	The Plan received **2023 DHCS' Final Report** on 9/20/23. DHCS has issued a final CAP because the Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances. The Plan submitted its initial response on 10/20/23 and has been submitting monthly updates until the CAP is closed.
DMHC Enforcement Matter (22-724)	On 8/10/23, the Plan received a DMHC Subpoena requesting documents related to a member appeal for services. The Plan complied with the subpoena and submitted all documents on 10/4/23. The Plan has not heard back from the DMHC on this matter.

New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2023.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
California Advancing and Innovating Medi-Cal (CalAIM)	• **Enhanced Care Management (ECM):** The DHCS approved the Plan's Birth Equity POF MOC on 11/7/23 and the Birth Equity Provider Capacity on 11/27/23 in preparation of the 1/124 effective date; On 10/16/23, the Plan submitted the Justice-Involved ("JI") MOC. On 10/20/23, the DHCS announced it moved the JI initiative from 4/1/24 to 10/1/4. On 2/2/24, the Plan received a "Pre-Corrective Action Plan ("Pre-CAP") letter from DHCS regarding its JI ECM provider capacity submission. The letter indicating that the Plan's JI provider network capacity was inadequate and will need to address all inadequate benchmarks. **Note, all Local Health Plan Initiatives also received DHCS Pre-CAP letters.** • **Community Supports (CS)**: On 12/27/23, DHCS approved the Plan's January 2024 Community Supports MOC update, which included updated Community Supports Provider Capacity and Community Supports Final Elections.
Long Term Care (LTC) Carve-In Deliverable List – Phase II (ICF/DD and Subacute Care facilities	Effective 1/1/2024, LTC-ICF/DD and Subacute Care services were carved into MCPs statewide. The Plan submitted deliverables associated with APL 23-004 ("Intermediate Care Facilities for Individuals with Developmental Disabilities"), and APL 23-027 ("Subacute Care Facilities") to DHCS on 11/27/2023 and 1/29/24. The Plan is still working to complete Phase I of the ICF/DD network readiness requirements regarding contracting efforts. On 12/7/23, the DHCS approved Phase I of the Subacute Care Network Readiness requirements. Through post-transitional monitoring starting on 1/1/24, DHCS will evaluate plans on meeting Phase II of the Subacute Care Network Readiness that requires plans to attempt to contract with all Subacute Care facilities where their members reside.
Memorandum of Understanding (MOU)	DHCS requires Plans and Third-Party Entities to submit updated MOU templates and to specify responsibilities under those MOUs. DHCS has provided base templates that the Plan must execute starting January 1, 2024, through January 1, 2025..
Transition to Statewide Exclusively Aligned Eligibility (EAE)-D-SNP	Effective 1/1/24, CalViva and Health Net went live with an Exclusively Aligned Enrollment, Dual Eligible Special Needs Plan ("EAE-DSNP") named, "Wellcare CalViva Health Dual Align (HMO D-SNP)".
Adult Expansion 26-49	Effective 1/1/24, DHCS expanded Medi-Cal eligibility to individuals who are 26 through 49 years of age. The Plan will be working with providers to maintain PCP assignment.
Member Handbook/Evidence of Coverage	The Plan's 2024 Member Handbook/Evidence of Coverage was posted to the CalViva Health website on 1/1/24 as required.

Plan Administration:	**Status**
DHCS 2024 Operational Readiness ("OR") Work Plan & Contract	The Plan has completed the required OR Workplan filings to DHCS. The only remaining documents to be submitted are the DHCS "bespoke" MOU templates that must be sent to the various Local Health Departments, LEAs, Regional Center, WIC Agencies, County Behavioral Health Departments, etc., for their review and execution. In 2024, DHCS will require quarterly status updates on the execution of those MOUs. The 2024 DHCS Medi- Cal Managed Care Contract ("Primary Contract") was executed on December 20, 2023, and the 2024 DHCS State Supported Services Contract ("Secondary Contract") was executed December 16, 2023.
New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2023 and 2024 as of February 2024.
Committee Report:	**Status**
Public Policy Committee (PPC)	The PPC met on December 6, 2023 at 7625 N. Palm Ave Suite 109, Fresno, CA 93711. The following programs and reports were presented: 2023 Health Education Executive Summary and Work Plan Mid-Year Evaluation; 2023 Health Equity Executive Summary and Work Plan Mid-Year Evaluation; 2023 Language Assistance Program Mid-Year Report; 2022 Geo Access Executive Summary and Assessment Report; Quality Improvement & HEDIS Update MY2022; Q3 2023 Grievance & Appeals Report; 2023 DHCS Audit CAP Update; 2022 DMHC Audit Final Report and CAP. Additionally, Dr. Marabella reviewed in detail where the Plan met and did not meet the minimum performance levels for specific HEDIS measures and identified opportunities for improvement. Next Public Policy Committee meeting will be March 6, 2024, 11:30 am-1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.

APPENDIX A

2023 DHCS All Plan Letters:

- APL 23-001 Annual Network Certification (ANC) (Supersedes 21-006)
- APL 23-003 CalAim Medical Incentive Payment Program (IPP)
- APL 23-004 Skilled Nursing Facilities-LTC Benefit Standardization
- APL 23-005 Requirements for Coverage of EPSDT
- APL 23-006 Delegation and Subcontractor Network Certification
- APL 23-007 Telehealth (Supersedes APL 19-009)
- APL 23-008 Prop 56 Directed Payments for Family Planning
- APL 23-009 Authorization for Post-Stabilization Care Services
- APL 23-010 Responsibilities for Behavioral Health Treatment for Mrbs Under 21
- APL 23-011 Treatment of Recoveries of Overpayments to Providers
- APL 23-012 ENFORCEMENT ACTIONS ADMINISTRATIVE AND MONETARY
- APL 23-013 Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework
- APL 23-014 PROPOSITION 56 VALUE-BASED PAYMENT PROGRAM DIRECTED PAYMENTS
- APL 23-015 PROPOSITION 56 DIRECTED PAYMENTS FOR PRIVATE SERVICES
- APL 23-016 DIRECTED PAYMENTS FOR DEVELOPMENTAL SCREENING SERVICES
- APL 23-017 DIRECTED PAYMENTS FOR ADVERSE CHILDHOOD EXPERIENCES SCREENING SERVICES
- APL 23-018 MANAGED CARE HEALTH PLAN TRANSITION POLICY GUIDE & 2024 MCP TRANSITION POLICY GUIDE
- APL 23-019 PROPOSITION 56 DIRECTED PAYMENTS FOR PHYSICIAN SERVICES
- APL 23-020 REQUIREMENTS FOR TIMELY PAYMENT OF CLAIMS
- APL 23-021 PNA and PHM Strategy
- APL 23-022 COC for Beneficiaries Who Newly Enrollee
- APL 23-023 ICF-CC and Model Contract Language
- APL 23-024 Doula Services
- APL 23-025 DIVERSITY, EQUITY, AND INCLUSION TRAINING PROGRAM REQUIREMENTS
- APL 23-026 FEDERAL DRUG UTILIZATION REVIEW REQUIREMENTS DESIGNED TO REDUCE
- APL 23-027 SUBACUTE CARE FACILITIES -- LONG TERM CARE BENEFIT STANDARDIZATION AND TRANSITION OF MEMBERS TO MANAGED CARE
- APL 23-028 DENTAL SERVICES – INTRAVENOUS MODERATE SEDATION AND DEEP SEDATIONGENERAL ANESTHESIA COVERAGE
- APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities
- APL 23-030 Medi-Cal Justice-Involved Reentry Initiative-Related State Guidance
- APL 23-031 MEDI-CAL MANAGED CARE PLAN IMPLEMENTATION OF PRIMARY CARE PROVIDER ASSIGNMENT FOR THE AGE 26-49 ADULT EXPANSION TRA...
- APL 23-032 ECM Requirements (Supersedes 21-012)
- APL 23-033 2024-2025 Medi-Cal Managed Care Health Plan MEDS834 Cutoff and Processing Schedule
- APL 23-034 CALIFORNIA CHILDREN'S SERVICES WHOLE CHILD MODEL PROGRAM (NA for CalViva)
- API 23-035 SBHIP
- APL 23-002 MEDS-834 CutOff and Processing Schedule.pdf

2023 DMHC All Plan Letters:

- APL 23-010 Coverage of Misoprostol-Only Abortion Care
- APL 23-014 Mandatory Signatories to the CalHHS Data Exchange Framework
- APL 23-019 Health Plan Expansion for Medicare Medi-Cal Plans
- APL 23-20 Amendments to Rule1300.67.2.2 (10.26.23)
- APL 23-023 NetworkAdequacyRequirementsAndMentalHealthStandardsAndMethodologyForRY2024
- APL 23-024 RHPI Addendum Change
- APL 23-028 RY2025_MY2024 PAAS Manual and ReportFormAmendments(12.22.2023)
- APL 23-002 - SB 979 - Health Emergencies Guidance APL (OPL 1.12.23).pdf
- APL 23-005 Network Service Area Confirmation Process (2.13.23).pdf
- APL 23-006 - Independent Medical Review Application Form (2.24.23).pdf
- APL 23-007 - Provider Directory Annual Filing Requirements (3_23_23).pdf
- APL 23-008 - Health Plan Requirements to Timely Pay Claims (3.24.2023).pdf
- APL 23-009 - Health Plan Coverage of Preventive Services (3.30.2023).pdf
- APL 23-012 - 2023 Health Plan Annual Assessments.pdf
- APL 23-015 - Supplemental Provider Directory Policy Filing (5.16.23).pdf
- APL 23-017 - Impact of the end of federal Public Health Emergency on health plan coverage of COVID-19 tests, im...
- APL 23-018 -RY 2024-MY 2023 PAAS NPMH Provider Follow-Up Appointment Initial Performance Target for Correc...
- APL 23-019 - HealthPlanExpansionForMediareMedi-CalPlans(9.21.23).pdf
- APL 23-021- Payment of COVID Claims for COVID-19 Tests.pdf
- APL 23-022 - Compliance with Senate Bill 1419 (2022) – Health Information (12.13.23).pdf
- APL 23-025 - Newly Enacted Statutes Impacting Health Plans (2023 Legislative Session) (12.20.2023).pdf
- APL 23-027 - Hospitalization Surge in Fresno County (12.21.23).pdf
- APL 23-029 - Health Equity and Quality Measure Set Benchmark (12.27.23).pdf

Code of Conduct

For inquiries regarding this Code of Conduct, please contact:

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Last Reviewed/Revised 2/15/2024

Table of Contents

I. CalViva Health Overview:

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

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

II. Purpose:

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

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

III. Elements:

The following provisions of the CalViva Health Code of Conduct are intended to guide

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

1. Member Services and Rights:

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Provider/Vendor Relations and Contracts:

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

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

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

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

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

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

4. For services that are not reasonable and necessary.

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

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

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

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

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

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

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

3. Business Operations and Accounting:

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

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

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

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

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

guidelines.

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

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

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

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

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

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

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

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

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

O. CalViva Health prohibits the solicitation or acceptance of gifts, gratuities, favors or other benefits from persons or entities that do business with CalViva Health. Notwithstanding the foregoing, acceptance of common business hospitality, such as occasional meals, entertainment or nominal gifts with a value of $50.00 or less,

are not considered a violation of this paragraph.

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

Q. CalViva Health avoids any activities that unfairly or illegally reduce or eliminate competition, control prices, allocate markets or exclude competitors. To this end, CalViva Health:

1. Does not enter into agreements to unduly influence prices, charges, profits and service or supplier selection;

2. Negotiates contracts with contractors or suppliers on a competitive basis based upon such factors as price, quality and service; and,

3. Employees who attend association or professional association meetings, or who otherwise come in contact with competitors, avoid discussions at those meetings regarding pricing or any other topic which could be interpreted as collusion between competitors.

R. CalViva Health prepares Medicaid Capitation Program reports as necessary. The reports are prepared based upon the Accounting and Auditing Guidelines issued by the California Department of Managed Health Care and California Department of Health Care Services, which administer the various State Regulations as they relate to CalViva Health and its contractors.

S. No employee or person associated with CalViva Health prevents or delays the communication of information or records related to violation of the Plan's Compliance Program to the Chief Compliance Officer (CCO).

T. CalViva Health shall respond appropriately to government subpoenas. If CalViva Health has reason to believe that there is an impending government investigation, it retains all documents that may pertain to that investigation.

U. CalViva Health, in cooperation with subcontractors and regulators, will make all

reasonable efforts to prevent, correct and remedy the operational factors and circumstances under which such noncompliance or violation occurs. Depending on the nature, circumstances and severity of the noncompliance/violation, if any CalViva employee is determined to be involved or responsible, these efforts may include a range of disciplinary and corrective actions up to and including termination. If a subcontractor fails to remedy the circumstance, corrective action may include a range of disciplinary and corrective actions up to and including termination of the contract.

4. Medical Records:

A. Contractually, CalViva Health providers are required to maintain member medical records in accordance with Federal and State laws and regulations. Such records may be forwarded for review by CalViva Health (or CalViva Health is given access to such records) in a confidential manner, with access to medical records limited to t h o s e CalViva Health employees involved in claims adjudication, grievance/appeal review, quality improvement or medical/utilization review management.

B. CalViva Health handles and transmits electronic or paper medical record information in accordance with the HIPAA privacy and security regulations. CalViva Health will timely implement HIPAA-compliant systems. As part of its Compliance Program, CalViva Health will:

1. Enter into written contracts with all business associates (as that term is defined in the HIPAA privacy regulations) to ensure that all entities performing services on behalf of CalViva Health comply with the HIPAA privacy and security regulations.

2. Maintain a member specific log of all requests for access to the medical information of a member by third parties and all releases of medical record information to third parties.

3. Report in a timely manner any suspected privacy and security incidents and/or breaches to the required regulatory agencies.

4. Conduct ongoing training of employees to ensure awareness and adherence with the HIPAA privacy and security regulations.

C. CalViva Health retains records in accordance with a written policy which incorporates Medicaid and all federal, state and local regulatory guidelines.

5. Medical Management and Claims:

A. CalViva Health monitors the claims submitted by providers to ensure honest, fair and accurate claim practices. All entities providing claims functions on behalf of

CalViva Health are required to demonstrate experience and knowledge in performing such functions in accordance with federal, state and local law.

B. CalViva Health monitors and periodically audits (part of delegation audits) the claims process of its contracted administrative organization and when applicable, other contracted delegated organizations, to ensure honest, fair and accurate claims processes.

C. CalViva Health reviews the written claims policies and procedures of its contracted administrative organization and when applicable, other contracted delegated organizations, to ensure that the policies properly reflect CalViva Health's policies and the requirements of the Medicaid program.

D. CalViva Health ensures that its' contracted administrative organization and when applicable, other contracted delegated organizations, properly coordinate benefits with any applicable third-party payor.

E. CalViva Health ensures that its' contracted administrative organization and when applicable, other contracted delegated organizations, have prior authorization policies, as applicable, for all inpatient admissions, partial hospitalizations and therapies requiring prior authorization and that prior authorization numbers accompany all claims from providers. CalViva Health and its contracted administrative organization maintain records to support decisions regarding prior authorization.

F. CalViva Health, its' contracted administrative organization and when applicable, other contracted delegated organizations, send denial letters and provide reconsideration and appeal of denials in accordance with applicable federal or state law.

G. CalViva Health does not compensate its contracted administrative organization and when applicable, other contracted delegated organizations, or contracted providers/vendors in such a manner as to induce improper or up-coded claims.

6. Employee Relations:

A. CalViva Health encourages all employees and contractors to respect the rights and cultural differences of other individuals.

B. CalViva Health does not discriminate on the basis of age, religion, color, race, sex, national origin, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation in personnel policies and procedures.

C. CalViva Health strives to provide equal employment opportunities and a working environment free from harassment.

7. Avoiding Potential Conflict of Interest or Retribution

It is the policy of CalViva Health to promote a working environment free from conflict of interest or retribution against individuals who report suspected fraud. In training sessions with employees regarding fraud prevention, employees are informed that there is no retribution against employees for reporting fraud. Employees and members are notified in writing of the procedures for reporting fraud and that there is no retribution against individuals reporting suspected fraud. If anyone has concerns about retribution, he or she may elect to remain anonymous in reporting suspected fraud.

If the Chief Compliance Officer or any member of the Executive Management Staff has a conflict of interest in an incident of suspected fraud, the person must report the conflict of interest to the Chief Executive Officer or Chairman of the RHA Commission and be disassociated from the investigation. If necessary and appropriate, the report will be referred to outside counsel for investigation.

APPROVAL:

February 15, 2024

_____ Date: _____

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

February 15, 2024

_____ Date: _____

Name: Jeffery Nkansah
Title: Chief Executive Officer

February 15, 2024

_____ Date: _____

Name: David S. Hodge
Title: RHA Commission Chairperson

EMERGENCY PREPAREDNESS & CRISIS RESPONSE PLAN

For inquiries regarding this Plan, please contact:

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TABLE OF CONTENTS

EMERGENCY PREPAREDNESS & CRISIS RESPONSE PLAN

I. INTRODUCTION

A. OVERVIEW

The Fresno-Kings-Madera Regional Health Authority ("RHA"), dba CalViva Health (the "Plan") is a licensed full-service health care service plan contracted with the DHCS to offer health care services to enrollees in its Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. The Medi-Cal Managed Care Plan is the only product line offered by CalViva Health.

The RHA has a Capitated Provider Services Agreement ("CPSA") with Health Net Community Solutions, Inc. ("HNCS" or "Health Net") for the provision of health care services to CalViva Health members through the HNCS network of contracted providers. The RHA also has an Administrative Services Agreement ("ASA") with HNCS to provide certain administrative services on the Plan's behalf. Health Net is the Plan's "Administrator". Although the CPSA with HNCS covers a significant portion of the Plan's network, the RHA also maintains direct contracts with three (3) federally qualified health centers ("FQHC") in Fresno, Kings and Madera counties. HNCS provides the same administrative services for the Plan's direct contracted providers as it does for Health Net's contracted provider network.

As the Plan's Administrator, Health Net maintains the systems typical of health plan operations, including those used for CalViva Health operations, including systems for enrollment, claims, utilization, appeals/grievances, member/provider call center operations, and stores CalViva Health files and case records (e.g. credentialing files, prior authorization and case management files, claim files, etc.). CalViva Health does not interact with the Plan Administrator's systems but nevertheless relies on those systems to provide services to its members and providers.

B. PURPOSE

The purpose of this Emergency Preparedness and Crisis Response Plan is to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack related emergencies. The Plan is reviewed annually, and any changes are conveyed to the Plan's Governing Board (i.e., RHA Commission) and other applicable stakeholders.

In fulfilling the Plan's commitment to providing high quality and cost-effective care to members and a safe environment to staff under any condition, this Emergency Preparedness and Crisis Response Plan supports the Plan's business continuity by facilitating continuous service. This Emergency Preparedness and Crisis Response Plan documents processes and delineates resources that will be used by The Plan and the Plan's Administrator to ensure

continuity of business operations, delivery of essential care to members, and mitigate potential harm caused by emergencies, such as natural or manmade disaster or public health crisis.

C. TYPES OF EMERGENCIES

The Plan's executive management has identified and assessed potential public health crises and natural or man-made Emergencies, including but not limited to epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any of the Plan's business locations, including those of its Administrator.

The Plan also reviews our service areas when an emergency occurs and how that may disrupt business operations. In addition, the Plan reviews any essential supply chain impacts that may disrupt business operations during or after the Emergency.

The Plan reviews its assessment as changes occur, but at least annually.

In this document several words are defined as:

- "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

- "**Emergency Preparedness**" means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor's Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

- **"Emergency Preparedness and Response Plan"** means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

As a result of a crisis or disaster, the following are examples of ways the Plan's workspaces can be affected:

- **Full building closure** – temporary shutdown or reduced operation of a building for a minimum of one day or longer. This would include an incident that would seriously

affect the ability to conduct "business as usual," in the building. An example would be nearby smoke that infiltrated the building.

- **Building inaccessible to employees** – incident that would not seriously affect the ability to conduct "business as usual," in the building, but the employees are not able to access the building. Example would include: employees can't get to the office due to a road closure.

- **Long term building closure** – a situation that seriously impairs the Plan's ability to conduct "business as usual" in an office building. The coordinated effort of an office-wide closure is required to effectively control the situation. Examples may include: a pandemic, severe property damage, etc.

- **Emergency evacuation while employees are working** – situations that will require an evacuation of the workplace. The extent of evacuation may vary for different types of situations. Examples include a nearby explosion, civil disturbances, and workplace violence while employees are working in the building.

D. CONSTITUENTS

Constituents represent the various groups that may be impacted in an emergency. In the Functional Area Responses section below, the various areas provide their processes to address potential impacts to each of these constituents.

- **Members**
  The Emergency Preparedness and Crisis Response identifies plans and processes to ensure that members are informed of support resources that will assist them in responding to a natural disaster or emergency in their area. This includes mechanisms for ensuring information is available proactively to prepare members in the event of a disaster as well as reliable channels of communication and what to expect during a disaster.

- **Providers**
  The Emergency Preparedness and Crisis Response is designed to address provider questions and concerns regarding member access to services and work to resolve barriers to care prior to, during, and immediately following a disaster or emergency event. Additionally, there will be coordination with facilities and vendors in real time to prevent a delay in needed services per the regulator's guidelines.

- **Employees**
  The Emergency Preparedness and Crisis Response outlines plans and procedures to adequately prepare employees to educate and inform members and providers with the latest emergency or disaster information and respective recovery details as well as the Plan's directives. This includes the support of employees who are personally affected by

emergency situations and addressing challenges related to the redistribution of workload and office availability.

- **Regulators**
  The Emergency Preparedness and Crisis Response outlines a plan and process to provide required documentation to the Plan's various regulators, and also to proactively provide regular communication with the regulators during a disaster or crisis, to ensure the regulator is aware of the Plan's progress.

- **Community**
  If there are emergencies that could impact the surrounding community, the community becomes an important audience. Community outreach may include coordination with public safety officials to develop protocols and procedures for advising the public of any hazards. Community outreach may also include providing food, drinking water and other supplies as needed.

- **Elected Government Officials**
  The Emergency Preparedness and Crisis Response will include regular communication with the elected government officials during a disaster or crisis to ensure the elected government officials are aware of the Plan's progress. Elected government officials may request assistance from the Plan in the form of in person support at evacuation sites and/or donations to assist impacted members/community.

- **Vendors**
  The Plan will coordinate and communicate with vendors to implement their emergency process in the event of an emergency that affects the vendor's operations.

- **RHA Commission**
  As the governing board of the Plan, the RHA Commission has ultimate authority over the Plan's management of its operations. The Emergency Preparedness and Crisis Response will include informing the RHA Commission of any disaster and/or emergency that impacts the Plan's operations, and the Plan's actions taken to appropriately respond to the crisis.

II. Disaster & Emergency Preparedness Protocol

The preparation phase occurs before a disaster or emergency event takes place. This process includes the Plan's evaluation of how a potential disaster or emergency impacts the Plan's overall ability to maintain business continuity and ensure members access to care. Impacts to productivity, communities, a provider's or vendor's ability to deliver care, as well as standard processes for accessing available resources and timely information are also evaluated. This method of preparation is designed to ensure that the Plan possesses a

thorough understanding of any potential impact to any constituents and the Plan's role in mitigating risk.

The Plan will maintain Emergency contact information, telephone numbers, and other contact information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, and key Plan Administrator Management staff.

A. Emergency Response Leadership Team

The Emergency Response Leadership Team (ERLT) is notified at the first sign of a potential disaster or emergency event. The ERLT then assesses the disaster or emergency event and determines whether to activate this work plan.

The Plan's Executive staff will constitute the Emergency Response Leadership Team (ERLT):

- Jeffrey Nkansah, Chief Executive Officer
- Mary Lourdes Leone, Chief Compliance Officer
- Patrick Marabella, M.D., Chief Medical Officer
- Daniel Maychen, Chief Financial Officer

The ERLT will maintain contact with key Plan Administrator counterparts in order to communicate and evaluate current or potential disaster impacts, and actions to mitigate to the following:

- Plan Administrator's management information systems (MIS)
- Provider availability
- Members access to care
- Plan's management information systems (MIS)
- Plan' staff's access to the workplace and/or connectivity to Plan's MIS

Oversight of the Emergency Preparedness & Crisis Response

The following Plan executives will have oversight of the following functional areas:

Jeffrey Nkansah	Facilities, Community & Government Relations, Human Resources, Information Technology, Marketing and Communications, & Security
Mary Lourdes Leone	Call Center / Member Services, Compliance, Marketing and Communications, Provider Network, Privacy & Security
Patrick Marabella, M.D.	Population Health, Utilization Management, Pharmacy, Appeals & Grievances, Provider Network

Daniel Maychen	Facilities, Claims, Information Technology, Enrollment,

B. Policies and Procedures

CalViva Health has established a set of policies and procedures. The Policies and Procedures are available to employees and other valuable stakeholders in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Emergency Preparedness and Crisis Response Plan.

In cases where policies and procedures have not been directly established by CalViva Health, CalViva Health has reviewed and approved the use of a Plan and/or policies and procedures by a delegate responsible for activities under the emergency preparedness and crises response plan.

C. Monitoring Functional Area Responses

CalViva Health is committed to responding quickly and appropriately during and emergency and/or crises.

In the event of an emergency and/or crisis, the ERLT will collaborate as needed and as appropriate so the following actions are completed and made available for reporting:

- Actions taken to identify the nature, scope and magnitude of the event's impact
- Actions taken to mitigate and or resolve the event's impacts
- Actions needed to be maintained during the Recovery phase, if needed
- Actions taken to fulfill required regulatory filings to the DMHC (i.e., within 48 hours of the Declaration of an emergency.
- Actions taken to fulfill required regulatory filings to the DHCS (i.e., within 24 hours of a federal, state, or county declared state of Emergency located within the Plan's Service Area, the Plan will notify DHCS if the Plan has experienced or expects to experience any disruption to its operations.)
- Actions taken to update the Plan's Emergency Preparedness and Crises Plan including, but not limited to any training which is conducted, reviewed, and/or updated.

III. FUNCTIONAL AREA RESPONSES

A. Appeals and Grievances

Health Net administers the day-to-day operation of the Appeals and Grievance System on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Health Net Appeals and Grievances Department shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services by taking action, including but not limited to the following:

1. Extended filing deadline for Grievances and requests for Appeals in accordance with Exhibit A, Attachment III, Section 4.6 Member Grievance and Appeal System.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

B. Call Center (Member and Provider Services)

Health Net administers the day-to-day operation of the Call Center on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Health Net Call Center Department shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by taking action, including but not limited to the following:

1. Requirements may be relaxed to better serve members during a crisis.
2. Adding emergency messaging or pointing to a shared resource if appropriate to triage calls.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

C. Claims

Health Net administers the day-to-day operation of claims processing activities on CalViva Health's behalf. Upon the official notification that there is an emergency or

disaster impacting the function, the Health Net Claims Department shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Adjusting work schedules to meet the need of the member or provider and direction from regulatory departments.
2. Working with Information Technology departments to perform Claims adjudication system enhancements which may be required to support/implement state requirements.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

D. Community and Government Relations

CalViva Health understands the role of the public affairs and government relations team is to communicate the Plan's activities during the disaster to local elected officials, key stakeholders, and community-based organizations.

CalViva Health's Chief Executive Officer, along with the support of CalViva Health's Director of Community Relations & Marketing will work collaboratively together as appropriate to ask people and organizations, which may include Health Net, on modalities to amplify information on where Plan members can get continued care such as pharmacy benefits or help coping with the disaster.

In some cases, the Plan may provide financial support and or Plan resources to providers and/or Community Based Organizations in the region.

CalViva Health also requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work on an appropriate response to the emergency and/or disaster.

E. Compliance

CalViva Health Compliance is responsible for receiving and disseminating any regulatory requirements specific to any Emergency Declaration in place. Compliance provides guidance to support implementation / change management processes to sustain compliance with all regulatory requirements. Compliance will review the Business Continuity and Emergency and Member Preparedness Response Plan on an annual basis.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Ensuring Compliance has the ability and resources to maintain interactions with regulatory agencies to respond to any requests or questions that are related to how the Plan is accommodating its membership impacted by the State of Emergency or disaster.
2. Reporting the status of its operations once a day to regulatory agencies or as directed by regulatory agencies.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

F. Enrollment

CalViva Health is responsible for receiving enrollment eligibility files from the State and transferring it securely to Health Net. Health Net administers the day-to-day operation of timely and accurate execution of enrollment processing to avoid member and provider disruption on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Allowing data systems to be available through remote connectivity capabilities to allow the continued transfer of files during an emergency and/or crises.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

G. Facilities

CalViva Health has one building facility. The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer and the Office Director regarding any emergency crises which impact the CalViva Health office.

Health Net has a Facilities team which will respond to an emergency or crisis. The facilities team will report the number of Plan offices that are closed on a daily basis to the appropriate parties. Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Allowing systems and resources to be available through remote connectivity capabilities

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

H. Human Resources

The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer and the Human Resources Director regarding any

emergency crises which impact the CalViva Health office. Health Net has a Human Resources team which will respond to an emergency or crisis.
Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Ensuring the Plan's staff are clear on policies and procedures and any interpretation based on nuances of emergency/disaster needs.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

I. Information Technology

CalViva Health works with an Information Technology ("IT") Vendor which provides hardware and software systems necessary for virtualization of Microsoft Windows Server Operating System, compatible Application software and storing of data. Servers are backed up daily and can be restored from the previous backup. Environmental protection systems (i.e., UPS battery backups, power generators, etc.) are in place to protect data systems. On an annual basis, the Plan's Business Continuity and Disaster Recovery Protocols are tested. Every other year a Cybersecurity Assessment which includes penetration testing, vulnerability scanning, phishing simulations, force entry, etc.) are conducted.

Lessons learned are incorporated into updated versions of the Plan's overall Emergency Preparedness and Crises Plan.

The CalViva Health Chief Executive Officer works collaboratively with the IT vendor regarding any emergency crises which impact the CalViva Health office.

Health Net Information Technology capability consists of over 200 IT security and risk personnel assigned all aimed at recovering as quickly as possible, including those related to member care and provider payment services within 24 hours from the time the disaster is declared.

Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Allowing systems and resources to be available through remote connectivity capabilities.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

J. Marketing and Communications

CalViva Health understands there is a need to develop and distribute communications to key audiences when an emergency or disaster arises.

CalViva Health's Chief Executive Officer, Chief Compliance Officer, along with the support of CalViva Health's Director of Community Relations & Marketing will work collaboratively together and as appropriate to:

1. Distribute communications to members that are mandated by regulations, laws and/or contracts.
2. Distribute communications focused on actions that employees need to take to ensure their safety and/or to continue butines operations in the crisis-impacted areas
3. Distribute communications to providers that are mandated by regulations, laws and/or contracts.
4. Distribute communications to news media outlets and for posting to company-owned social media platforms.

CalViva Health also requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work on an appropriate response to the emergency and/or disaster.

K. Pharmacy

Health Net administers the day-to-day operation of ensuring member's have access to their medications on CalViva Health's behalf. In cases which are not related to Physician-Administered Drugs, the responsibility will also be shared with the State as a result of Medi-Cal RX which became effective 1/1/2022. Upon the official notification that there is an emergency or disaster impacting the function, the Health Net Pharmacy team shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. If applicable, entering claim overrides in the pharmacy claims processing system.
2. If applicable, lifting certain prior authorization procedures.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

L. Population Health and Utilization Management

Health Net administers the day-to-day operation of population health and utilization management activities on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Population Health and Utilization Management Team(s) shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Identifying members with special health care needs in the affected area using a data driven risk stratification approach.
2. Establishing cooperative arrangements with other local health care organizations to assist and provide mutual aid during an Emergency when business operations are affected.
3. Reviewing prior authorization requests from members and providers in impacted areas to ensure determinations are reviewed and determined quickly.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

M. Provider Network

Health Net administers the day-to-day operation of ensuring appropriates teams are aware of the impact to the delivery system in the affected area(s) on CalViva Health's behalf. Upon the official notification that there is an emergency or disaster impacting the function, the Provider Network Team shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Verify impact on providers in affected disaster areas.
2. Educate providers on the Plan's Emergency policies and procedures and ensuring they are following requirements and aware of any temporary requirements published by regulations.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

N. Security

CalViva Health has a Security Management Process to ensure it has implemented the appropriate security measures to reduce risks and vulnerabilities. The CalViva Health Chief Executive Officer will work collaboratively with the CalViva Health Chief Financial Officer, Chief Compliance Officer, Chief Medical Officer, IT Vendor, and the Office Director regarding any emergency crises which impact the CalViva Health office.

Health Net has a Physical Security team which will secure facilities during a natural disaster or emergency. Upon the official notification that there is an emergency or disaster impacting the function either within CalViva Health or Health Net, the respective teams shall initiate their Emergency Preparedness and Crises Response Plan. CalViva Health has reviewed and approved the Health Net Emergency Preparedness and Crises Response Plan.

The Plan ensures that members and providers impacted by a federal, State, or county declared state of Emergency continue to have access to the function and Covered Services by acting, including but not limited to the following:

1. Working with all parties to ensure safety after an event including building walks, assessments, deployment of security officers as necessary for compliance, security or health and safety concerns.

CalViva Health requires that Health Net notifies the CalViva Health ELRT team immediately of any notification where there is an emergency or disaster impacting the function within Health Net where it has been determined the impact will also impact CalViva Health business.

The CalViva Health ELRT team with oversight responsibilities will work with Health Net on an appropriate response to the emergency and/or disaster.

IV. References

1. Health Net Emergency Preparedness and Crises Response Plan
2. CalViva Health Policies and Procedures related to the following Functional Areas:

Administration	Health Education
Appeals and Grievances	Member Services
Case Management	Pharmacy
Claims	Privacy and Security
Compliance	Provider Services
Cultural and Linguistics	Public Health
Finance	Quality Improvement
Human Resources	Utilization Management

APPROVAL:

		Date:	**February 15, 2024**
Name:	Mary Lourdes Leone		
Title:	Chief Compliance Officer		
		Date:	**February 15, 2024**
Name:	Jeffrey Nkansah		
Title:	Chief Executive Officer		
		Date:	**February 15, 2024**
Name:	David S. Hodge, M.D.		
Title:	RHA Commission Chairperson		

Program Description History		
Date	**Section #**	**Comment(s)**
2/16/2023		New Program Description
2/15/2024		Annual Review: No changes

Item #6
Attachment 6.A-6.B

Annual Administration

- 6.A BL 24-002
- 6.B Form 700

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 Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D. - At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Michael Goldring
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

Jeffrey 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: February 15, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Dr. David Hodge, Chairman

RE: Annual Administration

BL #: 24-002
Agenda Item 6
Attachment 6.A

Discussion Points:

Ethics Training:

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

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

Form 700:

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

Please complete and return to the Clerk, Cheryl Hurley, by April 2, 2024.

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

STATEMENT OF ECONOMIC INTERESTS
COVER PAGE
A PUBLIC DOCUMENT

Date Initial Filing Received
Filing Official Use Only

Please type or print in ink.

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

1. Office, Agency, or Court

Agency Name *(Do not use acronyms)*

Division, Board, Department, District, if applicable

Your Position

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

Agency: _____ Position: _____

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

☐ State

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

☐ Multi-County _____

☐ County of _____

☐ City of _____

☐ Other _____

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

☐ **Annual:** The period covered is January 1, 2023, through December 31, 2023.

-or-

The period covered is _____/_____/_____, through December 31, 2023.

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

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

☐ The period covered is January 1, 2023, through the date of leaving office.

-or-

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

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

4. Schedule Summary (required)

► ***Total number of pages including this cover page:*** _____

Schedules attached

☐ **Schedule A-1 -** *Investments* – schedule attached

☐ **Schedule A-2 -** *Investments* – schedule attached

☐ **Schedule B -** *Real Property* – schedule attached

☐ **Schedule C -** *Income, Loans, & Business Positions* – schedule attached

☐ **Schedule D -** *Income – Gifts* – schedule attached

☐ **Schedule E -** *Income – Gifts – Travel Payments* – schedule attached

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

5. Verification

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

DAYTIME TELEPHONE NUMBER
( )

EMAIL ADDRESS

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

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

Date Signed _____
(month, day, year)

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

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

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

__/__/23 ACQUIRED __/__/23 DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

__/__/23 ACQUIRED __/__/23 DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

__/__/23 ACQUIRED __/__/23 DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

__/__/23 ACQUIRED __/__/23 DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

__/__/23 ACQUIRED __/__/23 DISPOSED

► NAME OF BUSINESS ENTITY

GENERAL DESCRIPTION OF THIS BUSINESS

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

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

IF APPLICABLE, LIST DATE:

__/__/23 ACQUIRED __/__/23 DISPOSED

Comments: ____________

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

Check one

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

GENERAL DESCRIPTION OF THIS BUSINESS

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

IF APPLICABLE, LIST DATE:
__/__/23 ACQUIRED __/__/23 DISPOSED

NATURE OF INVESTMENT
☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

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

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

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

☐ None or ☐ Names listed below

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

Check one box:

☐ INVESTMENT ☐ REAL PROPERTY

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

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

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

IF APPLICABLE, LIST DATE:
__/__/23 ACQUIRED __/__/23 DISPOSED

NATURE OF INTEREST
☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership

☐ Leasehold _____ Yrs. remaining ☐ Other _____

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

---

► 1. BUSINESS ENTITY OR TRUST

Name

Address *(Business Address Acceptable)*

Check one

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

GENERAL DESCRIPTION OF THIS BUSINESS

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

IF APPLICABLE, LIST DATE:
__/__/23 ACQUIRED __/__/23 DISPOSED

NATURE OF INVESTMENT
☐ Partnership ☐ Sole Proprietorship ☐ _____ Other

YOUR BUSINESS POSITION _____

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

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

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

☐ None or ☐ Names listed below

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

Check one box:

☐ INVESTMENT ☐ REAL PROPERTY

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

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

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

IF APPLICABLE, LIST DATE:
__/__/23 ACQUIRED __/__/23 DISPOSED

NATURE OF INTEREST
☐ Property Ownership/Deed of Trust ☐ Stock ☐ Partnership

☐ Leasehold _____ Yrs. remaining ☐ Other _____

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

Comments: _____

SCHEDULE B
Interests in Real Property
(Including Rental Income)

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

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

IF APPLICABLE, LIST DATE:
__/__/23 ACQUIRED __/__/23 DISPOSED

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

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

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

► ASSESSOR'S PARCEL NUMBER OR STREET ADDRESS

CITY

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

IF APPLICABLE, LIST DATE:
__/__/23 ACQUIRED __/__/23 DISPOSED

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

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

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

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

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE _____% ☐ None

TERM (Months/Years)

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

☐ Guarantor, if applicable

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

INTEREST RATE _____% ☐ None

TERM (Months/Years)

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

☐ Guarantor, if applicable

Comments: _____

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

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name

► 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

YOUR BUSINESS POSITION

GROSS INCOME RECEIVED

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

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

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

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

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

☐ Loan repayment

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

_____ *(Describe)*

☐ Other _____ *(Describe)*

► 1. INCOME RECEIVED

NAME OF SOURCE OF INCOME

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

YOUR BUSINESS POSITION

GROSS INCOME RECEIVED

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

CONSIDERATION FOR WHICH INCOME WAS RECEIVED

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

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

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

☐ Loan repayment

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

_____ *(Describe)*

☐ Other _____ *(Describe)*

► 2. LOANS RECEIVED OR OUTSTANDING DURING THE REPORTING PERIOD

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

NAME OF LENDER*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF LENDER

HIGHEST BALANCE DURING REPORTING PERIOD

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

INTEREST RATE

_____% ☐ None

TERM (Months/Years)

_____

SECURITY FOR LOAN

☐ None ☐ Personal residence

☐ Real Property _____ *Street address*

_____ *City*

☐ Guarantor _____

☐ Other _____ *(Describe)*

Comments: _____

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION

Name ______________________

SCHEDULE D
Income – Gifts

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$________	____________
____/____/____	$________	____________
____/____/____	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$________	____________
____/____/____	$________	____________
____/____/____	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$________	____________
____/____/____	$________	____________
____/____/____	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$________	____________
____/____/____	$________	____________
____/____/____	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$________	____________
____/____/____	$________	____________
____/____/____	$________	____________

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

BUSINESS ACTIVITY, IF ANY, OF SOURCE

DATE (mm/dd/yy)	VALUE	DESCRIPTION OF GIFT(S)
____/____/____	$________	____________
____/____/____	$________	____________
____/____/____	$________	____________

Comments: ____

CALIFORNIA FORM **700**
FAIR POLITICAL PRACTICES COMMISSION

Name _____

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

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

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

DATE(S): ____/____/____ - ____/____/____ AMT: $_____
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description _____

► If Gift, Provide Travel Destination _____

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

DATE(S): ____/____/____ - ____/____/____ AMT: $_____
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description _____

► If Gift, Provide Travel Destination _____

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

DATE(S): ____/____/____ - ____/____/____ AMT: $_____
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description _____

► If Gift, Provide Travel Destination _____

► NAME OF SOURCE *(Not an Acronym)*

ADDRESS *(Business Address Acceptable)*

CITY AND STATE

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

DATE(S): ____/____/____ - ____/____/____ AMT: $_____
(If gift)

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

☐ Made a Speech/Participated in a Panel

☐ Other - Provide Description _____

► If Gift, Provide Travel Destination _____

Comments: _____

Item #7
Attachment 7.A

FKM RHA Bylaws

Bylaws of the

Fresno-Kings-Madera Regional Health Authority Commission

BYLAWS OF THE
FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY COMMISSION

TABLE OF CONTENTS

B Y L A W S O F T H E
FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY COMMISSION

ARTICLE I. AUTHORITY AND PURPOSE

These Bylaws are adopted by the Fresno-Kings-Madera Regional Health Authority Commission, hereinafter referred to as the "Commission," to establish rules, policies, and procedures for its proceedings. The Commission was established under the Joint Exercise of Powers Agreement Between the Counties of Fresno, Kings, and Madera for the Joint Provision of Medi-Cal Managed Care and Other Health Services Programs, hereinafter referred to as the “Joint Exercise of Powers Agreement,” pursuant to ordinances adopted by the Boards of Supervisors of Fresno County, Kings County, and Madera County under the statutory authority of Welfare and Institutions Codes section 14087.38. The purpose of the Commission is to provide Medi-Cal managed care systems or other health care systems to serve eligible residents of the counties of Fresno, Kings, and Madera and to negotiate and enter into contracts under the provisions of Welfare and Institutions Codes section 14087.38 and /or under Chapter 7 of Part 3 of Division 9 of the California Welfare and Institutions Code (commencing with Section 14000 thereof). The Commission may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals.

ARTICLE II. COMMISSIONERS

2.1 Number and Appointment. The Commission shall consist of seventeen (17) voting members, six of whom shall be appointed by the Board of Supervisors of Fresno County, three of whom shall be appointed by the Board of Supervisors of Kings County, three of whom shall be appointed by the Board of Supervisors of Madera County and five of whom shall be appointed by the Commission, as set forth in paragraph 2.6, below. Each Commission member shall serve at the

pleasure of the Board appointing him or her.

2.2 Qualifications. Each member of the Commission has a commitment to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances, delivers high quality care and is financially viable. Members of the Commission shall likewise have an abiding commitment to, and interest in, a quality publicly assisted health care delivery system. The Commission shall be generally representative of the diverse skills, backgrounds, interests, and demography of persons residing in the three Counties.

2.3 Commission Composition

2.3.1. Fresno County Appointees. The Commission members from Fresno County shall be the following:

2.3.1.1. One member of the Fresno County Board of Supervisors;

2.3.1.2. The Director of the Department of Public Health or Director of the Department of Social Services of Fresno County, as designated by the Fresno County Board of Supervisors; and

2.3.1.3. Four persons appointed by the Board of Supervisors of Fresno County who are representative of the interests of physician providers of Medi-Cal covered health care services, health care consumers, community representatives or community clinics.

2.3.2. Kings County Appointees. The Commission members from Kings County shall be the following:

2.3.2.1. One member of the Kings County Board of Supervisors;

2.3.2.2. The Director of the Department of Public Health or Director of the Department of Social Services of Kings County, as designated by the Kings County Board of Supervisors; and

2.3.2.3. One person appointed by the Board of Supervisors of Kings County who is representative of the interests of physician providers of Medi-Cal covered health care services, health care consumers, community representatives or community clinics.

2.3.3. Madera County Appointees. The Commission members from Madera County shall be the following:

2.3.3.1. One member of the Madera County Board of Supervisors;

2.3.3.2. The Director of the Department of Public Health or Director of the Department of Social Services of Madera County, as designated by the Madera County Board of Supervisors; and

2.3.3.3. One person appointed by the Board of Supervisors of Madera County who is representative of the interests of physician providers of Medi-Cal covered health care services, health care consumers, community representatives or community clinics.

2.3.4 Commission Appointees. The Commission shall appoint three persons who are representative of the interests of health care consumers, providers of pharmacy services or other health care services, or other person meeting the qualifications as stated in paragraph 2.2 above. Appointments to be made by the Commission shall be nominated, selected, replaced, or removed, as may be necessary, in accordance with the Joint Exercise of Powers Agreement and with these bylaws adopted by a majority of the voting members of the Commission.

2.3.5. One Commission member shall be a representative of the Children's Hospital Central California (the "Hospital"), and one Commission member shall be a representative of the Community Regional Medical Center (the "Medical Center"). The designation of these two Commission members shall be made by the Hospital and Medical Center respectively, but each such designation is subject to confirmation by the Commission. The Commission may, in its discretion, reject any person designated by the Hospital or the Medical Center and request additional designations.

2.3.6. If a Commissioner no longer qualifies for his/her prescribed position on the Commission, the position shall be vacant and the appointing authority shall appoint a replacement.

2.4. Selection of Commission Appointees. The Clerk of the Commission shall publicly notice the availability of appointment(s) to be made by the Commission and an

application for appointment shall be required of candidates to establish his/her qualifications. The Chairperson, in consultation with the Vice Chairperson, will determine which applications meet the requirements for appointment. Candidates meeting the requirements for appointment may be interviewed by the Chairperson and other Commissioners. Candidates approved by the Chairperson will be submitted to the Commission for a vote.

2.5. Term. Initial terms of Commission members shall be staggered as set forth in the Joint Exercise of Powers Agreement, Section 6, Subsection 6. Once the initial term is fulfilled, the appointing party shall make succeeding appointments for a full three-year term. At the conclusion of any term, a commission member may be reappointed to a subsequent three-year term. Terms for Commission members serving pursuant to subsections 2.3.1.1, 2.3.1.2, 2.3.2.1, 2.3.2.2, 2.3.3.1, and 2.3.3.2 shall be coterminous with their County positions unless the appointing Board of Supervisors replaces such member on its own motion.

2.6. Resignation. A Commissioner may resign effective on giving written notice to the Clerk of the Commission, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors of the County appointing the Commissioner or the Chief Administrator, if the Commission itself is the appointing authority. The Clerk of the Commission shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

2.7. Removal. Commission members designated for appointment by a county Board of Supervisors shall be appointed by a majority vote of the Board of Supervisors of the respective County. Any Commission member so appointed may be removed from office by a majority vote of the Board of Supervisors of the County appointing that member. Any Commission members designated for appointment or confirmation by the Commission shall be appointed by a majority vote of the Commission. Any Commission member so appointed or confirmed may be removed from office by a majority vote of the Commission.

2.8. Alternate Members. There shall be one (1) person appointed as an alternate

member for each regular member holding an elected office, for a total of three (3) alternate members, to attend and participate in meetings of the Commission in the event of the absence of any of the members appointed as provided in subsection 2.3, above. The qualifications, representation of interests or organizations, appointment, and terms of the alternate members shall be the same as the regular members for which they stand as alternates. When attending a meeting in place of a regular member, an alternate member shall be entitled to participate in the same manner and under the same standards as the regular member, to the extent that the alternate member is not otherwise disqualified from participating in discussion and voting on an item due to a conflict of interest.

2.9. Vacancies. Any vacancy on the Commission shall be filled by the Board of Supervisors of the County appointing the Commissioner or by the Commission, pursuant to the Joint Exercise of Powers Agreement. The individual must be appropriately qualified for the position in accordance with Section 2.2 and satisfy the applicable compositional requirements of Section 2.3.

2.9.1. If a Hospital or Medical Center fails to appoint a Commissioner for their Commission Seat within thirty (30) days of a request to appointment, the Commission will appoint an individual to that vacancy who shall serve a term as defined in these by-laws or until the Hospital or Medical Center appoints a Commissioner.

2.10. Reimbursement. The Commission may provide for a stipend and reimbursement of reasonable expenses incurred in connection with a member's service on the Commission.

ARTICLE III. OFFICERS

3.1. Designation of Officers. Officers of the Commission shall be:

3.1.1. A Chairperson who shall be a Commissioner and preside over all meetings.

3.1.2. A Vice-Chairperson who shall be a Commissioner and who in the absence of the Chairperson shall preside at the meetings of the Commission. If both Chairperson and Vice-Chairperson are absent, the Commissioners present

will select one Commissioner to act as temporary Chairperson to conduct the meeting.

3.1.3. A Clerk of the Commission who shall report to the Chief Administrator and who would attend all the Commission meetings, keep the minutes, witness signatures on all documents executed on behalf of Commission, keep the seal of the Commission, if one is adopted, give notice of all meetings of the Commission and committees of the Commission, as required by law, and have other duties as resolved by the Commission. The Clerk would not be a member of the Commission. An Assistant Clerk shall perform the duties of the Clerk in the Clerk's absence. The Assistant Clerk shall not be a member of the Commission.

3.1.4. Treasurer. The Chief Financial Officer of CalViva Health shall be and shall act as the Treasurer of the Commission. The Treasurer shall have the custody of the Commission money and disburse Commission funds pursuant to the accounting procedures developed in accordance with the provisions of the Joint Exercise of Powers Agreement, the Act, and with those procedures established by the Commission. The Treasurer shall assume the duties described in Section 6505.5 of the Government Code, namely: receive and receipt for all money of the Commission and place in the Treasury of the Treasurer to the credit of the Commission; be responsible upon an official bond as prescribed by the Commission for the safekeeping and disbursement of all Commission money so held; pay, when due, out of money of the Commission so held, all sums payable, only upon warrants of the officers performing the functions of the Auditor-Controller who has been designated by the Commission; verify and report in writing on the first day of July, October, January and April of each year to the Commission and to the Counties of Fresno, Kings, and Madera the amount of money held for the Commission, the amount of receipts since the last report, and the amount paid out since the last report; and perform such other duties as are set forth in the Joint Exercise of Powers Agreement or specified by the Commission.

3.1.5. Auditor-Controller. The Chief Financial Officer of CalViva Health shall be the Auditor-Controller of the Commission. The Auditor-Controller shall draw warrants to pay demands against the Commission when such demands have been approved by the Commission or by any other person authorized to so approve such by the Joint Exercise of Powers Agreement or by resolution of the Commission. The Auditor-Controller shall perform such duties as are set forth in the Joint Exercise of Powers Agreement and such other duties as are specified by the Commission. There shall be strict accountability of all funds and reporting of all receipts and disbursements. The Auditor-Controller shall establish and maintain such procedures, funds and accounts as may be required by sound accounting practices. The books and records of the Commission in the hands of the Auditor-Controller shall be open to inspection at all reasonable times by representatives of the Counties of Fresno, Kings, and Madera. The Auditor-Controller, with the approval of the Commission, shall contract with an independent certified public accountant or firm or certified public accountants to make an annual audit of the accounts and records of the Commission, and a complete written report of such audit shall be filed as public records annually, within six months of the end of the fiscal year under examination, with the Counties of Fresno, Kings, and Madera. Such annual audit and written report shall comply with the requirements of Section 6505 of the Government Code. The cost of the annual audit, including contracts with, or employment of such independent certified public accountants in making an audit pursuant to the Joint Exercise of Powers Agreement shall be a charge against funds of the Commission available for such purpose. The Commission, by unanimous vote, may replace the annual audit with a special audit covering a two-year period.

3.2. Election. The Commission shall elect the Chair and Vice-Chair for one (1) year terms, at the last meeting of each fiscal year. Commissioners may be nominated by other Commissioners or may nominate themselves for offices.

3.3. Resignation. An officer may resign effective on giving written notice to the Clerk of

the Commission, unless the notice specifies a later date for his/her resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and shall enter the notice in the proceedings of the Commission. The acceptance of a resignation shall not be necessary to make it effective.

3.4. Vacancies. A vacancy in any office shall be filled by resolution of the Commission at a regular or special meeting of the Commission.

3.5. Designation of Employees. Employees of the Commission shall include, but not be limited to:

3.5.1. Chief Administrator. The Commission may employ by contract or otherwise, an Administrator who shall act as the Chief Administrator of the Commission to direct the day-to-day operations of the Commission. Serving at the will of the Commission and subject to its policies, rules, regulations and instructions, the Chief Administrator shall have the powers described below and those delegated and assigned by the Commission. The Chief Administrator shall have the following powers and all those other powers necessarily inherent therein:

3.5.1.1. To appoint, remove and transfer employees of the Commission, including management level officers, except for the Treasurer, Auditor-Controller and General Counsel of the Commission and such others as the Commission may designate;

3.5.1.2. To enforce all orders, rules and regulations adopted by the Commission relating to the regulation, operation or control of personnel, funds, facilities, properties and apparatus of the Commission;

3.5.1.3. To enter into contracts or authorize other expenditures whenever the Commission shall have approved and authorized any work, improvement or task and shall have budgeted or appropriated the necessary money therefore;

3.5.1.4. To have custody of and accountability for all property of the Commission except money.

The Chief Administrator shall act as representative of the Commission in all matters that

the Commission has not authorized someone else to do. At the inception of the Joint Exercise of Powers Agreement, the Director of the Fresno County Department of Public Health shall act as the Commission's Chief Administrator and shall serve until replaced by the Commission.

3.5.2. Auditor-Controller, as described in Section 3.1.5 of these Bylaws.

3.6 Designation of Advisors. Advisors to the Commission shall include, but not be limited to:

3.6.1. Consultants. Subject to the availability of funds, the Commission may employ such consultants, advisors and independent contractors as are deemed necessary and desirable in implementing and carrying out the purposes of the Joint Exercise of Powers Agreement.

3.6.2. General Counsel to the Commission. The Madera County Counsel shall serve as counsel to the Commission. The Commission may appoint new counsel as necessary. The Commission may employ by contract or otherwise specialty counsel.

3.7. Reimbursement. Officers and employees of the Commission who are employees of the Counties of Fresno, Kings, or Madera, excepting those Officers and employees who are also members of the Commission or who are designated in the Joint Exercise of Powers Agreement to provide services to the Commission, shall be reimbursed by the Commission for their actual costs of providing such services. In addition, additional services provided by officers and employees of the Counties of Fresno, Kings, and Madera pursuant to contracts with the Commission shall be reimbursed as provided by the contracts. All reimbursements by the Commission shall be made after receiving an itemized billing for services rendered.

ARTICLE IV. MEETINGS

4.1. Regular and Special Meetings. The Commission shall establish the time and place for its regular meetings. The date, hour, and location of regular meetings shall be fixed by resolution of the Commission. The Commission shall hold at least one regular meeting each quarter of every calendar year. Special meetings

and adjourned meetings may be held as required or permitted by law.

4.2. Open and Public. Except as expressly set forth in Welfare and Institutions Code Section 14087.38, all meetings of the Commission, including, without limitation, regular, special and adjourned meetings, shall be called, noticed, held and conducted in accordance with the provisions of the Ralph M. Brown Act (commencing with Section 54950 of the California Government Code.

4.3. Notice. At least seventy-two (72) hours prior to each regular meeting, an agenda for the regular meeting shall be mailed to each Commission member, and to each representative of the news media and to each other person who has submitted a written request to the Commission for notification of meetings, and shall be posted at least seventy-two (72) hours prior to the regular meeting at a location that is freely accessible to the public. The agenda shall contain a brief general description of each item of business to be transacted or discussed at the meeting. No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of the Commission may briefly respond to statements made or questions posed by persons exercising their public testimony rights or ask a question for clarification, refer the matter to staff or to other resources for factual information, or request staff to report back at a subsequent meeting concerning any matter. Notwithstanding the foregoing, action may be taken on an item of business not appearing on the posted agenda upon a determination by two-thirds vote of the membership of the Commission, or if less than two-thirds of the members are present, by unanimous vote of those members present, that there is a need to take immediate action and that the need for action came to the attention of the Commission subsequent to the agenda being posted.

4.4. Attendance and Participation. Commissioners must attend the regular meetings of the Commission and of committees to which they are appointed. If a Commissioner is unable to attend a meeting, he/she must notify the Clerk of the Commission of the reason and the Clerk, in turn, will notify the Chairperson. Except in the case of an emergency, if a Commissioner fails to attend a meeting without first notifying the Clerk, the absence will be considered unexcused. Two

unexcused absences during a six-month period shall be grounds for the party appointing the Commission member, either a Board of Supervisors or the Commission, to consider removing the Commissioner.

4.5. Quorum. Nine members of the Commission shall constitute a quorum. Each member of the Commission shall be entitled to one vote. A vote of the majority of the members present with at least a quorum in attendance shall be required to take action, except for adjournment of a meeting which shall require only a majority of those present, and as provided in Section 4.9. No proxy or absentee voting shall be permitted, except by alternate members who are present in the event of members' absences.

4.6. Special Meeting. At least twenty-four (24) hours prior to each special meeting, an agenda for the special meeting shall be mailed to each Commission member and to each representative of the news media and to each other person who has submitted a written request to the Commission for notification of meetings; and shall be posted at least twenty-four (24) hours prior to the special meeting at a location that is freely accessible to members of the public. No business other than that listed on the agenda shall be considered at a special meeting. However, the Commission may hold an emergency meeting without complying with the twenty-four (24) hour notice and posting requirements if an emergency situation exists as defined by California Government Code Section 54956.5.

4.7. Conduct of Business.

4.7.1. Items on the agenda will be considered in order unless the Chairperson announces a change in the order of consideration.

4.7.2. Unless an agenda item identifies a particular source for a report, (such as the Chairperson, Commissioners, Advisory Groups, Chief Administrator, or Treasurer), the Chief Administrator, the Commissioners, the Commission staff and consultants shall report first on the item. The item will then be open to public comment upon recognition of the speaker by the Chairperson.

4.7.3. Confidential information shall not be subject to disclosure at meetings of the Commission.

4.8. Resolutions and Motions. All official acts of the Commission shall be taken either

by resolution or a motion, duly made, seconded, and adopted by vote of the Commissioners. Motions and seconds may be made by any Commissioner, including the Chair.

4.9. Voting. All actions of the Commission shall be adopted by an affirmative vote of a majority of the Commissioners present and eligible to vote, provided that at least nine Commissioners are present and eligible to vote. Commissioners disqualified or recused from voting shall not be counted as present for the purpose of maintaining a quorum.

4.10. Disqualification from Voting. A Commissioner shall be disqualified from voting on any contract in which he/she has a financial interest, as required by law and the Conflict of Interest Code of the Commission. Commissioners will not be disqualified from continuing to serve on the Commission and such contracts may not be avoided for the sole purpose of avoiding the conflict of financial interest.

4.11. Minutes. The Clerk of the Commission shall prepare the minutes of each meeting of the Commission. The minutes shall be an accurate summary of the Commission's or committee's consideration of each item on the agenda and an accurate record of each action taken by the Commission. At a subsequent meeting, the Clerk shall submit the minutes to the Commission for approval by a majority vote of the Commissioners in attendance at the meeting covered by the minutes. Once approved, the Clerk will sign the minutes and keep them with the proceedings of the Commission. The official Minutes, as approved by the Commission, recording any motions or actions taken by the Commission shall be prepared and submitted to the Board of Supervisors and the County Administrative Offices of each County.

4.12. Closed Sessions. The Commission may meet in closed sessions as permitted by applicable law. The Commission shall report actions taken at a closed session to the public as required by applicable law. 4.13. Public Records. Except as expressly set forth in Welfare and Institutions Code section 14087.38, all records of the Commission shall be kept and provided to the public in accordance with the provisions of the California Public Records Act (commencing with Section 6250 of the California Government Code).

4.14. Adjournment. The Commission may adjourn any meeting to a time and place specified in the resolution or motion of adjournment, notwithstanding less than a quorum may be present and voting. If no members of the Commission are present at regular or adjourned meeting, the Clerk may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided for special meetings, unless such notice is waived as provided in Section 4.3 of these Bylaws for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

4.15. Reports. On or before January 31st of each year, the Commission shall submit an annual report to each respective Board of Supervisors and County Administrative Officer. The report shall highlight the activities, accomplishments, and future goals of the Commission.

4.16. Progress Reports. Any of the respective Boards of Supervisors may request the Commission to submit progress reports and recommendations at any time. The Commission shall respond to such requests within a reasonable period of time.

4.17. Communications with the Public. Public participation in Commission meetings shall be allowed as follows:

4.17.1. An opportunity for members of the public to directly address the Commission on any item on the agenda of interest to the public shall be provided before or during the Commission's consideration of the item.

4.17.2. The agenda will provide for public comment on items not on the agenda which are within the subject matter jurisdiction of the Commission at the beginning of each regular meeting agenda. The total time for public comment on matters not on the agenda shall not exceed fifteen (15) minutes, and each speaker is limited to a maximum of three (3) minutes.

4.17.3. The Chairperson of the Commission may establish reasonable limits on the amount of time allotted to each speaker on a particular item, and the Commission may establish reasonable limits on the total amount of time allotted for public testimony on a particular item. When further discussion is required, the Commission may vote to allot time in the agenda of the

following meeting.

4.18. Robert's Rules of Order. To the extent that conduct of the meetings is not governed by these bylaws or the Ralph M. Brown Act, the current edition of Robert's Rules of Order shall apply.

ARTICLE V. COMMITTEES OF THE COMMISSION

5.1. Appointment. The Commission may establish such advisory committees as it deems necessary for the exercise of its powers. Such Committees must be composed of less than a quorum of voting Commissioners. The Commission may designate one (1) or more alternates for the committees to serve during any absences.

5.2. Authority. All committees are advisory only. Notwithstanding the foregoing, the Commission delegates to each committee, the authority to develop or approve operational policies and procedures within the areas of focus defined in each committee charter.

5.3. Meetings. Regular meetings of committees shall be held at times and places determined by resolution of the Commission. Special meetings may be held at any time and place as designated by Chairperson, Chief Administrator, or a majority of members on the committee. A majority of the appointed members of a committee shall constitute a quorum.

5.4. Notice and Agenda. All committees shall comply with the notice and agenda requirements otherwise applicable to the Commission in these bylaws, except for subcommittees composed solely of less than a quorum of the members of the Commission which are not standing subcommittees of the Commission with either a continuing subject matter jurisdiction or a meeting schedule fixed by resolution or other formal action of the Commission.

5.5. Minutes. The Clerk of the Commission or designated individual shall prepare the minutes of each meeting of committees of the Commission. Official minutes shall record motions entertained and actions taken at each meeting. The minutes shall be an accurate summary of the committee's consideration of each item on the agenda and an accurate record of each action taken-by the committee. At a

subsequent meeting, the Clerk or designated individual shall submit the committee meeting minutes to the Commission.

5.6. Open and Public. Meetings of standing committees shall be open and public as required by the Charter adopted by the Commission.

5.7. Public Policy Committee. The Commission shall have a Public Policy Committee, as required by Health and Safety Code section 1369 and Title 28, section 1300.69 of the California Code of Regulations, which shall be a standing committee whose meetings shall be conducted in compliance with this Article. The Public Policy Committee shall be responsible for participation in establishing public policy of the Health Authority's service plan and shall regularly and timely submit recommendations and reports to the Commission.

5.7.1. The Public Policy Committee shall consist of at least seven (7) members, all of whom shall be appointed by the Commission Chairperson, and the membership shall be comprised as follows: At least one member shall be a member of the Commission, at least one member shall be a provider of health care services, and a majority of the members shall be subscribers and/or enrollees in the plan.

5.7.2. Two (2) Community Based Organization (CBO) representatives shall be appointed as alternate Public Policy Committee members to attend and participate in meetings of the Committee in the event of a vacancy or the absence of any of the subscriber/enrollee Committee members. Alternates shall represent different CBOs that serve Fresno, Kings, and/or Madera Counties and provide community services or support services to members entitled to health care services from the Plan.

5.7.3. Subscriber/enrollee members and Community Based Organization (CBO) alternates shall not be employees of the plan, providers of health care services, subcontractors to the plan or group contract brokers, or persons financially interested in the plan. Subscriber/enrollee members' and CBO alternates' terms shall be of reasonable length (one, two, or three years) and shall be staggered or overlapped so as to provide continuity and experience in representation. Subscriber/enrollee members and CBO

alternates shall have access to information available from the plan regarding public policy, including financial information and information about the specific nature and volume of complaints received by the plan and their disposition. The process for selection and appointment of subscriber/enrollee members and CBO alternates shall include a consideration of the subscriber and enrollee population of the plan, including but not limited to ethnicity, demography, occupation, and geography.

5.7.4. The Public Policy Committee shall meet at least quarterly.

5.8 Committee Membership.

5.8.1. Membership of the Finance Committee shall include at least three (3) Commissioners, the Chief Executive Officer, and the Chief Financial Officer of the Commission.

5.8.2. All other committees shall be comprised as mandated by the adopted committee charters and as amended from time to time.

ARTICLE VI. ADVISORY COUNCILS

6.1. Purpose. The Commission may establish Advisory Councils as it deems necessary for the exercise of its powers. Advisory councils provide review and recommendations on policies and procedures considered by the Commission, and to the extent deemed appropriate by the Commission, shall participate in the Commission's consideration of policies and procedures prior to their adoption.

6.2. Authority. Advisory councils shall be considered advisory by nature

6.3. Composition. Advisory councils shall be decided by the Commission. Such Councils or committees shall be comprised of persons possessing the commitment set forth in Section 2.3 of these bylaws. Commissioners may be members of advisory councils.

6.4. Selection. The number of members to an advisory council shall be limited to a specific number as deemed appropriate by the Commission. The Commission shall consider all nominations to advisory councils from members of the public and from Commissioners. Members to an advisory council shall be appointed by a

majority vote of the Commission.

6.5. Appointment. Advisory council members shall serve one (1) year terms at the end of which the Commission shall vote on advisory council membership.

6.6. Officers. The advisory council members shall select a Chairperson and a Vice-Chairperson.

6.7. Conduct of Proceedings. The provisions of Article IV of these Bylaws pertaining to regular and special meetings of the Commission shall apply equally to such meetings of advisory councils, and all references to the "Commission", "Commissioners" and "Clerk" shall be deemed to mean the "advisory councils", the "members of the advisory councils" and the "secretary of the advisory councils", respectively.

ARTICLE VII. EXECUTION OF DOCUMENTS

7.1. Contracts and Instruments. The Commission may by resolution authorize any officer(s), agent(s) or employee(s) to enter into or execute any contract in the name of and on behalf of the Commission. The authority given may be general or confined to specific instances. Unless authorized or ratified by the Commission, no officer, agent or employee shall have the power or authority to bind the Commission by any contract or to render it liable for any purpose or for any amount.

7.2. Checks, Drafts, Evidence of Indebtedness. All checks, drafts or other orders for payment of money on behalf of or payment to the Commission shall be signed or endorsed by such persons as determined by either motion or resolution of the Commission.

ARTICLE VIII. CONFLICT OF INTEREST POLICY

8.1. Adoption. The Commission shall by resolution adopt and may amend a Conflict of Interest Code for the Commission as required by applicable law.

8.2. Definition. A member of the Commission shall not be deemed to be financially interested in a contract entered into by the Commission (within the meaning of Government Code Section 1090 et seq.) if all the following apply:

8.2.1. The Board appointed the member to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

8.2.2. The contract authorizes the Commissioner or the organization the Commissioner represents to provide services to Medi-Cal beneficiaries under the Commission's program.

8.2.3. The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the Commissioner was appointed to represent.

8.2.4. The Commissioner does not influence or attempt to influence the Commission or other Commissioners to enter into a contract in which the Commissioner is interested.

8.2.5. The member discloses the interest to the Commission and abstains from voting on the contract.

8.2.6. The Commission notes the Commissioner's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of the majority of the Commission without counting the vote of the interested member.

ARTICLE IX. MISCELLANEOUS

9.1. Purchasing, Hiring, Personnel. The Commission shall adopt either by motion or by resolution and may amend procedures, practices, and policies for purchasing and acquiring the use of equipment and supplies, acquiring, constructing, and leasing real property, and improvements, hiring employees, managing personnel, and for all other matters as deemed appropriate. These policies shall be kept with the minutes of the proceedings of the Commission.

9.2. Insurance. The Commission shall procure property, casualty, indemnity and workers' compensation insurance, including without limitation directors' and officers' liability and professional liability coverage, in such amounts and with such carriers as the Commission shall from time to time determine shall be prudent in the conduct of its activities; provided, the Commission may in its

discretion provide self insurance or participate in consortia or similar associations to obtain coverage in lieu of commercial coverage.

9.3. Bonds. The Commission shall require all of its members, officers, employees, and agents to be covered by fidelity bonds as required by law and as the Commission shall determine shall be prudent in the conduct of its activities.

9.4. Enforcement. Subject to the authority of Commission, the Chief Administrator shall implement all procedures, practices and policies adopted by the Commission.

ARTICLE X. AMENDMENT OF BYLAWS

These Bylaws may be amended only by a motion or resolution of the Commission at any meeting of the Commission. Notice of such proposed amendment shall be given in the manner prescribed in Section 4.3 for notices of special meetings of the Commission.

CERTIFICATE OF CHAIRPERSON

I, the undersigned, do hereby certify that I am the duly elected and acting Chairperson of the Fresno-Kings-Madera Regional Health Authority Commission, a local joint powers public agency and political subdivision of the State of California, and that the foregoing Bylaws, comprising 23 pages, including this page, constitute the Bylaws of the Commission, as duly adopted by the Commission at a regular meeting, duly called and held on the 19th day of November 2015 in Fresno County, California.

David S. Hodge

Chairperson of the Commission

Item #8
Attachment 8.A-8.B

- 8.A BL 24-003 2023 Annual Delegation Oversight and Monitoring Report of Health Net
- 8.B. Executive Summary 2023 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report

Jeffrey 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: February 15, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

RE: 2023 Annual Delegation Oversight and Monitoring Report of Health Net

BL #: **24-003**
Agenda Item **8**
Attachment **8.A**

RHA Commissioners received and reviewed the full Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions, Inc. (Health Net) Calendar Year 2023 Report in Closed Session. A summary of the scoring and report is being provided to the public.

Scoring

- Pass (P) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is acceptable to CalViva.
- Fail (F) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is not acceptable to CalViva.
- Not Scored (NS) = CalViva has determined that based on its oversight and monitoring review(s) conducted, there is not enough data available to score performance.

Oversight and Monitoring Reviews Conducted	Score
Quality Assurance	P
Performance Standards	P
Reporting Completeness, Timeliness, & Accuracy	P
Oversight Audits	P

RECOMMENDED ACTION:

1. Approve the 2023 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report.

2. Approve Health Net Community Solutions, Inc. to continue their delegated functions for another year.

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority ("RHA") Commission

FROM: Jeffrey Nkansah, Chief Executive Officer

COMMITTEE DATE: February 15, 2024

SUBJECT: Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions – Calendar Year ("CY") 2023 Report & Executive Summary

Executive Summary

PURPOSE:

This report describes CalViva Health's delegation model and its processes for overseeing compliance of the activities delegated to ensure compliance with CalViva Health's contract with delegated entities, the Department of Health Care Services ("DHCS"), Department of Managed Health Care ("DMHC") contractual and regulatory requirements as well as the National Committee of Quality Assurance ("NCQA") accreditation requirements.

SUMMARY OF THE DELEGATION MODEL:

CalViva Health ("CalViva") has an Administrative Services Agreement ("ASA") with Health Net Community Solutions, Inc. ("Health Net") to provide certain administrative services on CalViva's behalf. Health Net is CalViva's Subcontractor/Plan Administrator.

CalViva also has a Capitated Provider Services Agreement ("CPSA") with Health Net for the provision of health care services to CalViva members through Health Net's network of contracted providers. Under the terms of the ASA and CPSA, Health Net has been delegated responsibility for performing a wide variety of administrative, clinical and provider network activities on CalViva's behalf.

CalViva oversees activities performed by Health Net through a variety of mechanisms including adherence to CalViva's performance standards, review of applicable Health Net policies and procedures, marketing materials, monthly, quarterly, semi-annual, and annual data or summary activity reports. Comprehensive report schedules listing all reports and

due dates are monitored by CalViva to ensure receipt and review of the required reports.

Periodic oversight audits of functions delegated to Health Net are also done throughout the year. All discussion(s) on reports, audit finding(s), corrective action(s) are presented to one or more of the Plan's oversight committees (i.e. Compliance Committee, QI/UM Committee, Finance Committee) and the Commission, as applicable.

Through the monitoring and oversight auditing processes discussed above, this report conveys CalViva's annual Compliance Assessment of Health Net and whether it is recommended for delegation to be continued.

SCORING:

- Pass (P) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is acceptable to CalViva.

- Fail (F) = CalViva has determined that based on its oversight and monitoring review(s) conducted, the performance is not acceptable to CalViva.

- Not Scored (NS) = CalViva has determined that based on its oversight and monitoring review(s) conducted, there is not enough data available to CalViva to score performance.

Oversight and Monitoring Reviews Conducted	Score
Quality Assurance	P
Performance Standards	P
Reporting Completeness, Timeliness, & Accuracy	P
Oversight Audits	P

NEXT STEPS:

Continue to perform oversight and monitoring of functions handled by Health Net on the Plan's behalf and work with Health Net to improve administration of activities as applicable. Upon completion and review of the activities referenced in this report for CY 2023, CalViva recommends Health Net continue their delegated functions for another year.

OVERSIGHT AND MONITORING REVIEW(S):

Quality Assurance:

Accreditation Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Review and confirm NCQA Health Plan Accreditation Status	➢ Review Accreditation Certificate & NCQA website o Screenshot of NCQA website o Copy of HN Accreditation Certificate Received	No
Review and confirm NCQA Health Equity Accreditation Status	➢ Review Accreditation Certificate & NCQA website o Screenshot of NCQA website o Copy of HN Accreditation Certificate Received	No
Quality Improvement (QI) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual Review of QI Program	➢ Reporting – o QI/UM 56 Annual Program Description, o QI/UM 57 Annual Work Plan, o Calendar Year 2023 QI/UM Report Matrix o Calendar Year 2023 QI/UM Committee/Workgroup Meeting Minutes ➢ Audit – o QI Oversight Audit	No

Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 26 Blood Screening Performance ○ QI/UM 36 IHA Quarterly Audit Report ○ QI/UM 58 Work Plan Mid-Year Evaluation and Executive Summary ○ QI/UM 59 Work Plan End of Year Evaluation and Executive Summary ○ QI/UM 65 Continuity and Coordination of Medical Care (Analysis and Opportunities Report) ○ QI/UM 67 Continuity & Coordination b/w Medical and Behavioral Healthcare Report ○ Calendar Year 2023 QI/UM Report Matrix & Calendar Year ○ 2023 QI/UM Committee/Workgroup Meeting Minutes	No
Population Health Management (PHM) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual review of PHM Program	➢ Reporting – ○ QI/UM 79 PHM Program Strategy Description ○ QI/UM 80 Case Management Program Description ○ Calendar Year 2023 QI/UM Report Matrix ○ Calendar Year 2023 QI/UM Committee/Workgroup Meeting Minutes	No

Annual audit of complex case management files	➢ Audit – ○ UM Oversight Audit ▪ Calendar Year 2023 Completion of UM Oversight Audit (Audit Tool and Summary Findings)	Yes
Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 16 Case Management and CCM Report ○ QI/UM 36 IHA Quarterly Audit Report ○ QI/UM 50 Enhanced Care Management (“ECM”) and Community Supports (“CS”) Performance Report ○ QI/UM 75 PHM Assessment Report ○ QI/UM 76 PHM Segmentation Report ○ QI/UM 77 PHM Effective Analysis Report ○ QI/UM 84 Case Management Program Evaluation ○ Calendar Year 2023 QI/UM Report Matrix ○ Calendar Year 2023 QI/UM Committee/Workgroup Meeting Minutes	No

Network Management (NET) Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Annual review of Network Management Program	➢ Reporting – o QI/UM 9 / Access 9 Geo Access Report o Access 27 Practitioner Availability Report o Access 28 Primary Care Accessibility Report o Access 29 Behavioral Health Accessibility Report o Access 30 Specialty Care Accessibility Report o Access 31 Non-Behavioral Health Network Adequacy Report o Access 32 Behavioral Health Network Adequacy Report o Access 33 Physician Directory Accuracy Report o Calendar Year 2023 QI/UM Report Matrix o Calendar Year 2023 QI/UM Committee Workgroup Meeting Minutes o Calendar Year 2023 Access Report Matrix o Calendar Year 2023 Access Workgroup Meeting Minutes ➢ Audit – o Access and Availability Oversight Audit ▪ Calendar Year 2023 Completion of Access and Availability Oversight Audit (Audit Tool and Summary Findings) o Provider Network Oversight Audit	No
Annual review of Network Management Procedures	➢ Access 16 P&P Review Access, Availability, Telehealth	No

Member Experience (ME) Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 1 A&G Dashboard & TAT Report ○ QI/UM 2 A&G Executive Summary ○ QI/UM 3 A&G IRR ○ QI/UM 4 A&G Member Report ○ QI/UM 5 A&G Audit Report ○ QI/UM 6 A&G Member Letter Monitoring Report ○ QI/UM 7 CCC Expedited Grievance Report ○ QI/UM 8 A&G Validation Audit Summary Report ○ QI/UM 9 / Access 9 Geo Access Report ○ QI/UM 57 QI Annual Workplan ○ QI/UM 58 QI Mid-Year Evaluation ○ QI/UM 59 QI End of Year Evaluation ○ QI/UM 78 Provider Appointment / After Hours Access Survey Results ○ Access 3 Member Satisfaction Survey with Access Report ○ Access 13 Member Satisfaction with Behavioral Health Care ○ Access 38 Quality and Accuracy of Member Calls ○ Access 39 Accuracy of Prior Auth and Referrals Information ○ Calendar Year 2023 QI/UM Report Matrix & Calendar Year 2023 QI/UM Committee/Workgroup Meeting Minutes, Calendar Year 2023 Access Report Matrix & Calendar Year 2023 Access Workgroup Meeting Minutes	No

Credentialing (CR) Delegate Review	Method of CalViva Oversight	Formal Corrective Action Requested (Yes/No)
Annual review of credentialing policies and procedures.	➢ Reporting – o Medical Management 6 Health Net Credentialing Policies and Procedures ➢ Audit – o Credentialing Oversight Audit ▪ Calendar Year 2023 Completion of Credentialing Oversight Audit (Audit Tool and Summary Findings)	Yes
Annual audit of credentialing and recredentialing files	➢ Audit – o Credentialing Oversight Audit ▪ Calendar Year 2023 Completion of Credentialing Oversight Audit (Audit Tool and Summary Findings)	Yes
Semi-Annually Evaluates Regular Reports	➢ Reporting – o QI/UM 29 Adverse Events Report o QI/UM 41 System Controls Oversight Report o Calendar Year 2023 QI/UM Report Matrix o Calendar Year 2023 Credentialing Sub-Committee Meeting Minutes	No

At least annually monitor Health Net's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with Health Net's policies and procedures at least annually. If necessary, Act on all findings from Factor 5 and implement a quarterly monitoring process until Health Net demonstrates improvement for one finding over three consecutive quarters	➢ Reporting – ○ QI/UM 41 System Controls Oversight Report	No
Utilization Management (UM) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual review of UM Program.	➢ Reporting – ○ QI/UM 69 UM/CM Work Plan ○ QI/UM 72 UM/CM Program Description ○ Calendar Year 2023 QI/UM Report Matrix ○ Calendar Year 2023 QI/UM Committee Workgroup/Meeting Minutes	No
Annual audit of UM denials and appeals	➢ Audit – ○ UM Oversight Audit ▪ Calendar Year 2023 Completion of UM Oversight Audit (Audit Tool and Summary Findings)	Yes

Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 3 A&G IRR ○ QI/UM 42 Pharmacy IRR, ○ QI/UM 45 System Controls Denials ○ QI/UM 63 KIR TAT Report ○ QI/UM 70 UM/CM Mid-Year Evaluation Report ○ QI/UM 71 UM/CM End of Year Evaluation Report ○ Calendar Year 2023 QI/UM Report Matrix ○ Calendar Year 2023 QI/UM Committee Workgroup Meeting Minutes	No
At least annually monitor Health Net's UM denial and appeals system security controls to ensure that Health Net monitors its compliance with the delegation agreement or with Health Net's policies and procedures at least annually. If necessary, Act on all findings from Factor 5 and implement a quarterly monitoring process until Health Net demonstrates improvement for one finding over three consecutive quarters	➢ Reporting – ○ QI/UM 45 System Controls Denials Report ○ QI/UM 48 System Controls Appeals Report	No
Health Equity (HE) Delegate Review	**Method of CalViva Oversight**	**Formal Corrective Action Requested (Yes/No)**
Annual review of Health Equity Program.	➢ Reporting – ○ QI/UM 11 Health Equity Program Description ○ QI/UM 12 Health Equity Work Plan ○ Calendar Year 2023 QI/UM Report Matrix ○ Calendar 2023 QI/UM Committee/Workgroup Meeting Minutes	No

Semi-Annually Evaluates Regular Reports	➢ Reporting – ○ QI/UM 9 / Access 9 Geo Access Report ○ QI/UM 10 Language Assistance Program Report ○ QI/UM 13 Health Equity Mid-Year Work Plan Evaluation ○ QI/UM 14 Health Equity Work Plan End of Year Evaluation ○ QI/UM 86 Disparities Analysis and Actions Report ○ Calendar Year 2023 QI/UM Report Matrix ○ Calendar 2023 QI/UM Committee/Workgroup Meeting Minutes	No

HEALTH NET'S ADHERENCE TO CALVIVA's PERFORMANCE STANDARDS CY 2023:

MEASUREMENT	DEFICIENT	DESCRIPTION OF DEFICIENCY	CAP REQUESTED	MONETARY PAYMENT ASSESSED
HEDIS / MCAS	YES	Sanction Notice – HEDIS/MCAS Measures below MPL.	TBD	TBD
Encounters	NO	N/A	N/A	N/A
Provider Network	NO	N/A	N/A	N/A
Regulatory Audits	NO	N/A	N/A	N/A
Reporting	NO	N/A	N/A	N/A

1. Section 2.05 of the ASA describes Health Net's obligation to comply with the CalViva Performance Standards set forth in Exhibit B of the Agreement.

2. Section 2.05 also describes CalViva's obligation to evaluate the specific Performance Standards Health Net failed along with the amount of Performance Penalty CalViva intends to assess against Health Net's Administrative Fees.

HEALTH NET'S REPORTING COMPLETENESS, TIMELINESS & ACCURACY TO CALVIVA:

Health Net's Reporting to CalViva have been categorized by function, requesting agency, or workgroup in which they are presented (See Table below). Comprehensive report

schedules listing all reports and due dates are monitored by CalViva to ensure receipt and review of the required reports.

Management Oversight Meeting (MOM) reports	DMHC_DHCS Regulatory reports
Quality Improvement /Utilization Management (QI/UM) reports	OPERATIONAL reports
ACCESS reports	FINANCE reports
ENCOUNTERS reports	COMPLIANCE reports
DHCS Regulatory reports	MEDICAL MANAGEMENT reports
DMHC Regulatory reports	Ad-Hoc Reports

Health Net reports were received for oversight and if applicable reviewed/approved/adopted during CY 2023 at one or more of the Plan's oversight meeting forums with accompanying meeting minutes (i.e. QI/UM Committee, Peer Review Sub-Committee, Credentialing Sub-Committee, QI/UM Workgroup, Appeals and Grievances Workgroup, Access Workgroup/Committee,) and the Commission, as applicable.

CALVIVA OVERSIGHT AUDIT(S) OF HEALTH NET:

CalViva employs both "desk review" and "on-site" audit methods. Various types of evidence are requested to confirm compliance with DHCS/DMHC contractual requirements and regulations, NCQA Accreditation Requirements, and Health Net Administrative/Capitated Provider Service Agreement contractual obligations to CalViva.

Evidentiary materials include but are not limited to a comprehensive oversight audit report schedule listing all oversight audits, look back period(s), schedules, statuses, and corrective actions is monitored and available by CalViva.

The schedule is reviewed, and discussed at least quarterly at the Plan's Compliance Committee oversight meeting forum with accompanying meeting minutes during CY 2023. The table below identities the functional areas audited by CalViva for compliance and the respective agency/entity/standard being assessed for compliance.

Functional Area Audited	CalViva Contract	DHCS Contract	DMHC Knox Keene	NCQA Standards
Appeals and Grievances	X	X	X	UM, ME
Access and Availability	X	X	X	NET
Behavioral Health	X	X	X	QI, PHM, UM, NET, CR, ME

Call Center / Member Services	X	X	X	ME
Claims	X	X	X	
Continuity of Care	X	X	X	PHM
Credentialing	X	X	X	CR
Emergency Room Services	X	X	X	
Fraud, Waste, Abuse	X	X	X	
Health Education	X	X	X	
Health Equity	X	X	X	ME, HE
Marketing	X	X	X	ME
Member Rights	X	X	X	ME
Pharmacy*	X	X	X	PHM, UM, ME
Privacy and Security	X	X	X	ME, HE
Provider Network	X	X	X	NET, ME
Provider Dispute Resolutions	X	X	X	
Quality Improvement	X	X	X	QI, PHM, HE, ME
Utilization Management	X	X	X	UM, PHM

* Statewide policy. Medicaid/Medi-Cal members pharmacy benefit is under Medi-Cal RX administered directly by the State.

CY 2023 AUDIT OVERSIGHT AUDIT RESULTS & ANALYSIS

The following table below summarizes the Oversight Audits **that were completed** in CY 2023.

Functional Area Audited	Completion Date	CAP
Access and Availability	1/6/2023	NO
Appeals and Grievance	12/8/2023	NO
Call Center / Member Services	6/16/2023	NO
Claims	10/24/2023	YES
Credentialing	5/23/2023	YES
Fraud, Waste, & Abuse	7/31/2023	NO
Pharmacy	10/25/23	YES

Privacy and Security	11/15/2023	NO
Provider Disputes	10/24/2023	YES
Utilization Management	1/4/2023	YES

Item #9
Attachment 9.A-9.B

2023 Annual Quality Improvement
Work Plan Evaluation

- 9.A Executive Summary
- 9.B Year End Evaluation

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Patrick Marabella, MD, Chief Medical Officer Amy Schneider, RN, Director Medical Management
COMMITTEE DATE:	February 15, 2024
SUBJECT:	2023 CalViva Quality Improvement (QI) Program Evaluation Executive Summary 2023 – Year-End

Summary:

CalViva Health annually assesses the overall effectiveness of its Quality Improvement (QI) Program at improving network-wide clinical and service practices. Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for both Health Plan (HPA) Health Equity (HEA) and Health Equity Plus Accreditation. As part of the CalAIM strategy, CalViva plans to be "NCQA accredited" by January 1, 2026 for HPA and HEA. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

The Quality Improvement (QI) Program Evaluation Executive Summary 2023 Year-End includes:

- Summary of Overall effectiveness of QI Program
- Goals and Quality Indicators
- Overall Effectiveness of QI Work Plan Initiatives
- QI Reporting
- Summary of Key Accomplishments
- Annual QI Program Changes

Quality Improvement (QI) Program Evaluation Executive Summary 2023 – Year-End

Table of Contents

Section 1: Summary of Overall Effectiveness of QI Program

CalViva Health ("CalViva") annually assesses the overall effectiveness of its Quality Improvement (QI) Program at improving network-wide clinical and service practices. Health Net is a National Committee for Quality Assurance (NCQA) accredited health plan for its Medi-Cal product line for both Health Plan (HPA) Health Equity (HEA) and Health Equity Plus Accreditation. The 2023 NCQA Health Plan Ratings (HPRs) for Health Net Medicaid was three and a half out of five stars. As part of the CalAIM strategy, CalViva plans to be "NCQA accredited" by January 1, 2026 for HPA and HEA.

Health Net and CalViva collaboratively and continually strive to incorporate a culture of quality across their organizations and conduct operations to improve service and satisfaction for CalViva members. This philosophy also extends across the provider network to improve provider quality outcomes, as evidenced by the plan's Healthcare Effectiveness Data and Information Set (HEDIS®); provider access, availability, and satisfaction surveys; and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) rates. The Quality Management (QM) Department is a centralized team with specialized knowledge of each population and collaborates with a dedicated analytics team.

Health Net has maintained the NCQA Multicultural Health Care Distinction for Medicaid which transitioned to HEA in 2022. This accreditation status recognizes organizations that lead the market in providing culturally and linguistically responsive services, and work to reduce health care disparities. Additionally, Health Net obtained HEA Plus accreditation which builds on the HEA requirements and focuses on collaboration with a broad range of stakeholders to mitigate social risks and address social needs. Current CalViva disparity projects include Comprehensive Diabetic Care-Control and CalViva Health Diabetes Disparity Leadership Program.

QI Committee Structure

CalViva's QI Program was successfully supported by the CalViva QI/UM Committee which met seven times in 2023. The committee oversaw the QI Program, provided feedback, decision support, and recommendations for the QI program throughout the year. The QI/UM Committee reported to the CalViva RHA Commission six times in 2023.

CalViva's Credentialing and Peer-Review Subcommittees also successfully supported CalViva's QI Program, as demonstrated in the organizational chart below. These subcommittees met 4 times each in 2023. Additionally, QI/UM Workgroup, Appeals and Grievance Workgroup, and Access Workgroup meetings were held in 2023 to develop, monitor, and evaluate activities supporting the QI Program.

The QI/UM Workgroup supports the efforts of the QI/UM Committee by scheduling, receiving, reviewing, editing, and approving reports for presentation at the QI/UM Committee. QI Workgroup aids in the identification and pursuit of opportunities to improve health outcomes, safety, access and member and provider satisfaction.

The QI/UM Workgroup met thirty-four (34) times in 2023 and was chaired by CalViva's Chief Medical Officer. Members of the Workgroup consisted of CalViva staff including Director of Medical Management (Registered Nurse) and a Manager of Medical Management Services; and Health Net staff from Quality Improvement, Appeals and Grievances, Health Equity, Pharmacy, Credentialing, Customer Contact Center, Population Health Management, Provider

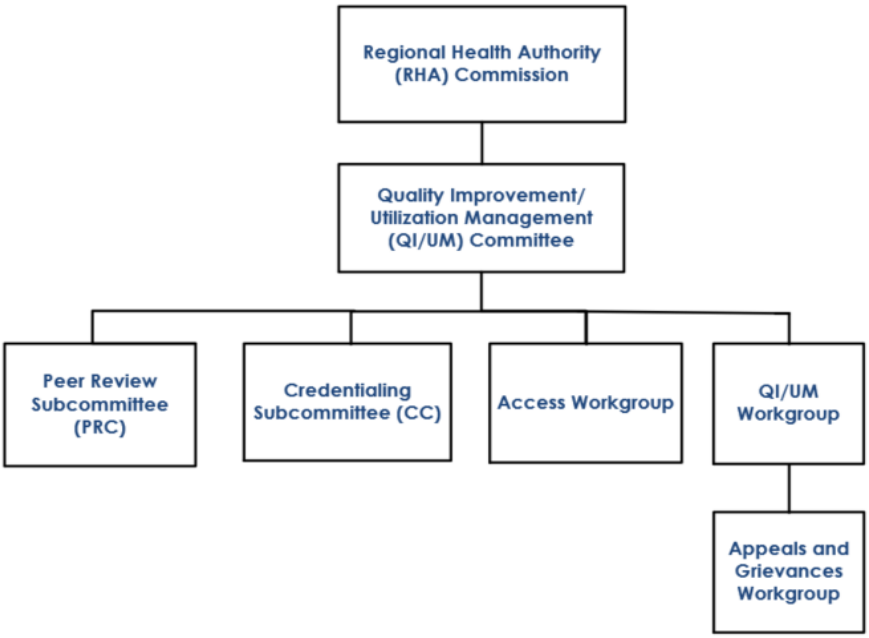
Network Management, and Provider Relations. The Workgroup conducted performance improvement review and discussions of monitoring of QI/UM activities, findings, barriers, and interventions to develop and implement actions. Significant findings and follow-up were reported to the QIUM Committee and RHA Commission.

CalViva's Access Workgroup met seven times in 2023. The CalViva Health Access Workgroup included representatives from CalViva Health and Health Net departments with access and network adequacy related functions. The Workgroup reviewed findings from ongoing monitoring of access to plan services, identified gaps, and developed and evaluated activities that addressed those gaps in access to care. The Workgroup submitted issues that required escalation to the Management Oversight Meeting ("MOM"), QI/UM Committee and/or RHA Commission for final decision and approval of recommended actions.

The Appeal and Grievance Workgroup reports to the QI/UM Workgroup and supports the QI program through the review and analysis of appeal and grievance data. The Appeals and Grievances Workgroup met nine times in 2023. The workgroup processed, tracked and trended member grievances and appeals at the provider and plan level. The Workgroup submitted reports to the QIUM Workgroup and Peer Review Subcommittee to review, act on and follow-up on identified significant events or trends.

Please refer to the 2023 Quality Improvement Program Description for more information on the sub-committees.

CalViva's Quality Improvement Committee Organizational Chart



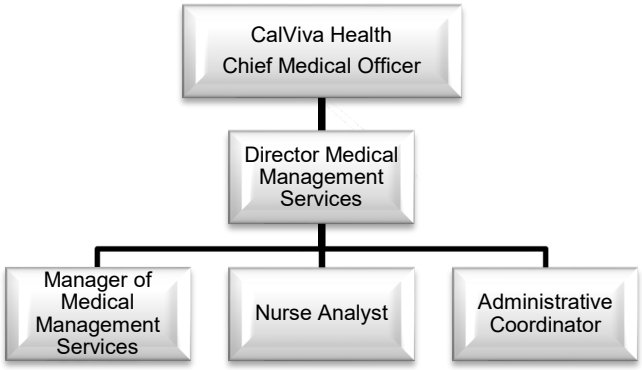
Practitioner Participation and Leadership Involvement in the QI Program
The committee structures for CalViva ensured that external and internal physicians with various specialties participated in the planning, design, implementation, and review of the QI Program. Six external providers were participants in the QIUM Committee and both the Credentialing and Peer Review Sub-Committees with specialties in Pediatrics, Family Medicine, behavioral health,

Internal Medicine, Obstetrics and Gynecology, and general surgery. CalViva's Chief Medical Officer chaired the committees and invited external practitioners to participate.

Practitioner involvement in 2023 included: reviewing and approving the 2022 QI Work Plan Annual Evaluation, and the 2023 QI Program Description and Work Plan. Practitioners discussed opportunities for improvement based on Reporting Year (RY) 2023 HEDIS© results and performance. Practitioners were also involved in performance improvement projects to address underperforming measures. In 2023, CalViva worked with high volume, low performing providers and clinics in Fresno County. Health Net and CalViva established multidisciplinary improvement teams that worked collaboratively to determine the current processes, identify potential barriers, and establish plans for improvement to address potential barriers with work plan projects and outcomes. This included projects on Breast Cancer Screening, Childhood Immunizations, and Well-child Visits.

Adequacy of QI Program Resources

In 2023, CalViva's QI Team included a Chief Medical Officer who oversaw the QI Program. The CalViva QI Program is led by the Director of Medical Management Services who worked in collaboration with the Health Net Quality Management Departments and teams to implement QI programs and activities to address and improve quality of care and service, patient safety, and member and provider satisfaction. Monthly QI Meetings occurred between the CalViva QI Team and the Health Net departments to provide high level updates from Quality Improvement, Provider Engagement, and Medical Affairs teams and discuss any issues that may require follow up.



In 2023, the delegated Quality Management Department at Health Net led by the Vice President of Quality Management, remained a centralized, interdisciplinary team working to support members in a coordinated manner, resulting in focused efforts to improve HEDIS and CAHPS performance. Participating provider groups (PPGs) could access HEDIS report cards, highlighting their performance on key measures compared to national benchmarks, as well as care gap reports including member and practitioner-level information for PPGs to determine actionable approaches to close care gaps. Five departments comprised Quality Management, each with a separate leadership structure: 1) Quality Improvement and Health Education, 2) Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review, 3) Program Accreditation and CAHPS, 4) Health Equity, and 5) HEDIS. The Quality Improvement Analytics team supports data needs across all Quality Management teams and departments.

Quality Improvement Department

Under the direction of the Medi-Cal QI Director, the Medi-Cal QI team included a Sr. QI Manager, a QI Manager, and a Health Education Manager (for most of the year), and three Program Managers. The two QI Managers oversaw a team of Senior QI Specialists, QI

Specialists, and Project Managers, ensuring compliance to all required activities. One of the QI Managers who had oversight of the Physical Accessibility Review Survey (PARS) for high volume specialists, ancillary and CBAS providers, oversaw three PARS reviewers (QI Specialists). The Health Education Manager oversaw a team implementing health education programs, compliance activities and comprised of Senior Health Education Specialists, Health Education Specialists, and Training Coordinators. The Program Managers drove long term strategy for their geography or topical areas to address health education and quality outcomes improvement. In 2023, resources were assessed to identify improved ways to deliver quality and health education programs and projects. With regulatory requirements changing and the plan preparing for accreditation, new approaches were warranted. To gain efficiency across the QI Team, Program Owners and Drivers (PODs) were established that became responsible for leading each program/measure strategy. The program managers, the POD teams, including the health education team, were integrated to drive strategy by measure/area of focus. As needed, external providers, clinics and clinic staff are brought in as guest partners on formal QI projects.

Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site Review Department
Credentialing/Clinical Quality of Care/Potential Quality Issues/Facility Site review was led by a QI Director of Clinical Services and included two Senior Managers of Provider Data Management and Credentialing, and a QI Manager of Clinical Grievance for PCPs for Medi-Cal.

The Facility Site Review (FSR) team collaborated with other Medi-Cal Managed Care plans throughout the state to maintain and refine a standardized system-wide process for conducting reviews of primary care physician facility sites, along with Medical Record Review (MRR) and Physical Accessibility Review Surveys (PARS). This process minimized duplication and supported consolidation of FSR surveys. The process incorporated evaluation criteria and standards in compliance with DHCS contractual requirements and was applicable to all Medi-Cal Managed Care plans. The FSR department also conducted provider education, provider outreach, and other QI activities. The FSR QI Director provided regular updates of FSR/MRR/PARS activity via reports to the CH&W Utilization Management and Quality Improvement Committee (UMQIC). These evaluation reports identified overarching areas of noncompliance by sections and selected elements, reported at the regional level with year-over-year (YOY) comparison. This detailed analysis allowed for monitoring and identification of improvement opportunities. The FSR team collaborated with the Regional Medical Directors and Credentialing, Provider Network, Clinical Grievances, Health Education, Health Equity, and Provider Relations departments to implement process improvements.

Program Accreditation Team
The QI Sr. Director led the Program Accreditation team. The Program Accreditation team included a Senior Compliance Administrator, two Compliance Specialists, and a Compliance Analyst. This team led activities to ensure ongoing organization-wide compliance with requirements of accrediting bodies for Health Plan Accreditation (HPA), Health Equity Accreditation (HEA), and external and internal audit readiness. At year end, in review of staff resources and support, the Sr. Compliance Administrator position was promoted to Manager of Program Accreditation to help lead NCQA accreditation work and action plans.

CAHPS Team
The QI Sr. Director also led the CAHPS team that included two Program Manager IIIs focused on implementing the CAHPS member experience survey. The team also led improvement strategies including root cause analysis of member pain points, CAHPS exposure and training, mock CAHPS implementation, and improvement initiatives in partnership with operations and provider-facing teams.

Health Equity Team
The Health Equity team was unique in its cross-functional support structure. The Health Equity team had representation throughout the State and was staffed by a Vice President of Quality Management, a Manager of Health Equity, one Program Manager III, five Senior Health Equity Specialists, two Health Equity Specialists, and one supplemental staff position. There was a strong governance structure to oversee and provide support to cultural and linguistic/health equity services. The Health Equity team had a breadth of knowledge as it related to the integration of cultural and linguistic services within the health plan and across operational areas of cultural competency, health literacy, language assistance services, addressing health disparities and compliance. The Health Equity team analyzed, designed, and implemented strategies to support the reduction of health disparities and facilitates the Health Equity workgroups, which were responsible for developing and implementing an action plan to reduce health disparities in targeted HEDIS measures.

CalViva adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS standards represented 15 different standards that served as the foundation for the development of the Health Equity Department strategic plans. To ensure that the plan was continually striving to be responsive to the membership. The Health Equity Team conducted data analysis and designed and implemented services to meet the needs of our members. Internally, the Health Equity Team surveyed new employees to determine staff diversity and cultural and linguistic, and supported and trained bilingual associates. In 2023, there were 88 certified bilingual staff members who supported the CalViva service area. Externally, the Health Equity team conducted a biennial Geo Access report, which used member zip code data and correlated it with member language preference. These data were further overlaid with provider network language capabilities and a gap analysis is conducted to target network expansion. The Human Resources Department and Diversity and Inclusion team were responsible for the overall coordination to ensure a diverse leadership and workforce.

HEDIS Department
A Senior Director of HEDIS Reporting and Business Analytics led the HEDIS Department. There were two Senior Managers, three Managers, three Supervisors, and four HEDIS Program Managers, along with Medical Record Abstractors, Analysts and Customer Service Advocates that comprised the team. The HEDIS team was responsible for HEDIS measurement and reporting of annual rates as well as outward facing provider and member outreach to support data and care gap closure.

The HEDIS team also had a QI Director of Data Analysis and a Manager of Health Care Analysis. The QI Director of Data Analysis oversaw the Analytics team within the department and was responsible for ensuring the production of detailed reporting and analytics. The QI Research and Analysis (QIRA) team reported to the Manager and was responsible for providing data and analytical support for QI projects. Additional staff were hired in 2023 resulting in a total of seven analysts (six Biostatistician I and one Biostatistician II) on the QIRA team. Additionally, there were two Quality Analytics Program Managers (QAPMs) who supported CalViva. The QAPMs, and the QIRA Manager reported directly to the QI Director of Data Analysis.

Section 2: Goals and Quality Indicators

The Quality Improvement 2023 Work Plan includes nine categories. To determine CalViva's success in achieving specified goals, the plan calculated the number and percentage of activities completed and

objectives met per category (***Tables 2.1 and 2.2***) and outlined RY 2023 performance against the goals in the Appendix.

Table 2.1 Activities Completed by Category

Category	2023 Activities Completed	Rate (%)
BEHAVIORAL HEALTH	9/10	90%
CHRONIC CONDITIONS	6/6	100%
MATERNAL/WOMEN'S HEALTH	4/5	80%
MEMBER ENGAGEMENT AND EXPERIENCE	14/14	100%
HOSPITAL QUALITY/ PATIENT SAFETY	36/36	100%
PEDIATRIC	2/2	100%
PHARMACY	4/4	100%
PREVENTIVE HEALTH	12/12	100%
PROVIDER ENGAGEMENT	12/16	75%
Total Rate	**99/105**	**94.29%**

Table 2.2 Objectives Met

Category	2023 Objectives Met	Rate (%)
BEHAVIORAL HEALTH	2/6	33.33%
CHRONIC CONDITIONS	6/6	100%
MATERNAL/WOMEN'S HEALTH	5/6	83.33%
MEMBER ENGAGEMENT AND EXPERIENCE	1/1	100%
HOSPITAL QUALITY/ PATIENT SAFETY	9/12	75%
PEDIATRIC	3/9	33.33%
PHARMACY	2/3	66.67%
PREVENTIVE HEALTH	12/13	92.31%
PROVIDER ENGAGEMENT	6/11	54.55%
Total Rate	**46/67**	**68.66%**

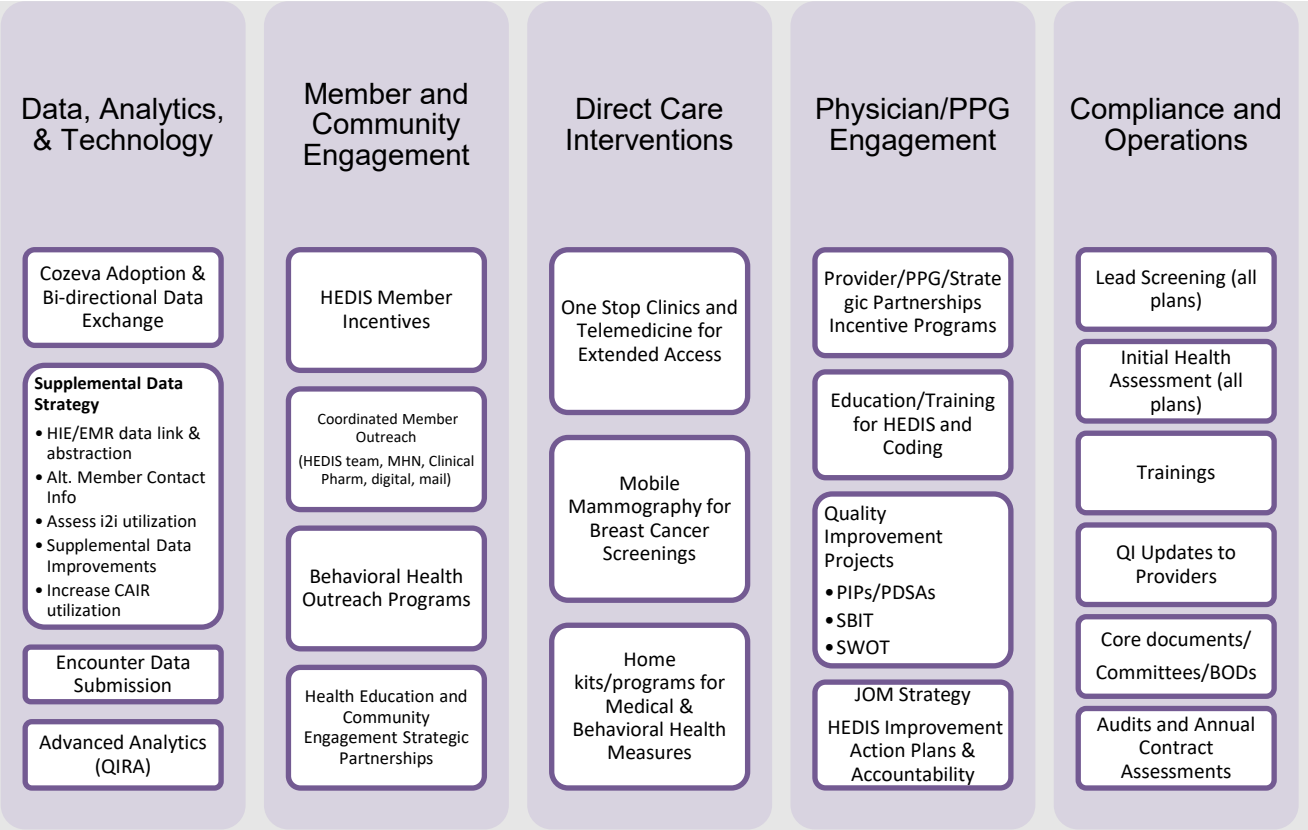
As shown in **Table 2.1**, 94.29% of the total 2023 work plan activities were completed as planned. Overall, Health Net met 68.66% of the total year work plan objectives **(Table 2.2)**.

Quality goals follow regulatory and accreditation standards, which can change annually. **Appendix Table A-1** provides the performance goals of the plan. These goals were the overall percentiles or health plan ratings that CalViva seeks to achieve. Additionally, the objectives were tied to how much of the goals were accomplished within the year, which can include

meeting directional improvement (e.g., improved performance year-over-year, **Appendix Table A-5 to Table A-20**).

For Medi-Cal performance, rates must exceed the minimum performance level (MPL) of 50th percentile for all MCAS measures as set by DHCS; the CalViva performance goal for CAHPS was to meet the NCQA 25th percentile national benchmark; the goal for provider surveys was to meet the 70% or 90% performance rate for provider access survey measures; and for all behavioral health MCAS HEDIS measures, reach or exceed the 50th Percentile. The outcomes tables in the Appendix provides detailed measure-level progress toward goals.

To meet or exceed the MPL, CalViva carried out numerous targeted programs and performance improvement projects to close care gaps. The team continued to prioritize interventions along the strategic tracks noted below. Critical interventions that address data and targeted analysis, member supportive and direct care services, provider engagement and compliance, all worked cohesively to support goal achievement.



In addition, the QI Team collaborated with the Medical Affairs and Provider Engagement Teams to continue implementation of Quality EDGE (Evaluating Data to Generate Excellence). Quality EDGE is a systematic five step change management cycle that integrates quality improvement tools, focused measure sets and provider engagement strategic assessments to drive providers to rapid improvements in HEDIS outcomes. The mission of Quality EDGE is to outperform all market competitors on quality metrics by providing unparalleled consultative services, innovative programs and actionable reports while improving health equity. The Vision: We are the partner of choice, collaborating internally and with our providers to deliver the highest quality of care in the most vulnerable population. The team collaborated to identify the following goals for 2023:

1. Complete and deploy action plans for priority providers (specific targets in development).

2. Continually measure, evaluate, and improve processes to ensure efficacy of Quality EDGE and full engagement among the staff.
3. Improve results for "voice of the provider" (specific target in development).

Goals Met:

Quality of Care: MCAS

Overall, CalViva achieved 64% of MCAS measures above the MPL for MY 2022. **Appendix Table A-2** provides a breakdown of the percent of required MCAS measures above MPL for each of the three CalViva Medi-Cal counties. Fresno County met 47% of its objectives. Kings County met 60% of its objectives. Madera County met 87% of its objectives. Refer to **Section 5** for a summary of key accomplishments by county and measure category.

Hospital Quality/Patient Safety

Hospital quality performance is measured across CVH's network based on facilities with sufficient publicly available data across priority metrics (5 facilities total). Overall, CalViva hospitals showed either appropriate performance, improvement or continued avoidance of outlier performance for most hospital-acquired infection metrics. The network showed directional improvement for hospitals meeting the standardized infection ratio of 1.0 or lower for *catheter-associated urinary tract infections* (CAUTI) and *central line-associated bloodstream infection* (CLABSI), while 100% of hospitals continued to meet the goal for *Clostridioides difficile* (C.Diff). The proportion of hospitals meeting the goal for *Methicillin-resistant Staphylococcus aureus* (MRSA) and *Surgical site infection following colorectal surgery* (SSI-Colon) was unchanged. The network avoided outliers for 4 of the 5 infections, with 1 hospital with reportable data reporting an outlier for CLABSI. Hospitals meeting the NTSV C-section rate standard of 23.6% did show directional improvement, however most facilities did not meet the goal.

Behavioral Health

For 2023, the focus was on improving antidepressant medication adherence, measured by the HEDIS metric, *Antidepressant Medication Management* (AMM). Overall, CalViva did not meet the 50th Percentile Quality Compass performance goal for both *Antidepressant Medication Management – Acute Phase of Treatment*, or the *Continuation Phase of Treatment* (**Appendix Table A-6)**.

CalViva Member Access Survey

Results from the MY 2021 Annual Access Survey showed YOY improvement in two of the four measures: Got Routine Care As Soon As Needed and Ease of Getting Care/Test/Treatment. The measure *Ease To Get Specialist Appointment* dropped 18 percentage points from the year prior, highlighting the need to improve specialist access for members. The goal of YOY improvement was seen in two of the four measures (**Appendix Table A-8)**.

Regulatory CAHPS Survey

In 2023, the annual Regulatory CAHPS survey was conducted for CalViva. Results showed 5/8 measures met the Outcome Quality Compass (QC) 25th percentile goal: How well Doctor Communicates, Getting Care Quickly, Rating of All Health Care, Rating Personal Doctor and Rating of Specialist. (**Appendix Table A-7)**.

Provider Access, Availability, Satisfaction Survey Measures

Results from provider surveys showed directional YOY improvement achievement or met the 70 (PAAS) or 90% (PSS, PAHAS) rate objectives in 48.39% of total measures. CalViva met the following goals:

- 100% of PAAS (DMHC) - Access to Ancillary measures (**Appendix Table A-12**)
- 100% of Provider After-Hours Survey measures (**Appendix Table A-17**).
- 50.82% of PAAS measures (**Appendix Tables A-9 to A-13**).
- 50% of the Telephone Access Survey measures (**Appendix Table A-14**).
- 44% of Provider Satisfaction Survey (PSS) measures and 50% of BH PSS measures (**Appendix Tables A-15, A-16 and A-18**).
- 22.22% of ECHO survey measures (Appendix Table A-9)
- 100% of Behavioral Health PAAS by Risk Rating measures. **(Appendix Tables A-9 to A-20).**

*Refer to the **Appendix Tables A-3 and A-5** for the summary of goal attainment by program category for RY 2023.*

As the tables demonstrate, there is still progress needed to reach the goals set for each county/category, despite meeting a majority of the MCAS objectives, meeting directional improvement on CAHPS measures, and reaching the 70 or 90% performance goal rate for several provider survey measures. There also remains an opportunity to reach the goals set for CalViva. Opportunities by category are found in **Appendix Table 4:** Summary of Opportunities.

Barriers to Achieving Goals and Objectives:

MCAS

- Initial outreach calls to members resulted in a low reach rate. A portion of members who were contacted were not successfully reached after three (3) phone attempts and thus remained noncompliant for their chronic illness.
- A portion of members who were reached lacked the understanding/desire to learn about how to manage their chronic illness through basic education, lifestyle changes, medication management, etc.
- Members reported transportation issues, such as only having one car to transport all family members to their activities, broken down vehicles and/or unexpected family emergencies.
- Members stated they could not commit to attending the classes because they work long varied hours, needed more advance notice, have to arrange for childcare, and encountered family emergencies.
- Many of these members reported that a standard classroom setting during regular business hours may not be feasible and expressed interest through a virtual or hybrid class model.

Measure Barriers.

- *Breast Cancer Screening* (BCS) in Fresno County:
    - Disparities in BCS in the Hmong population.
    - There are language barriers and low health literacy, so that it may take several attempts to explain a mammogram so that the members understand. The Healthy Equity Team, Health Education and Provider Engagement must work together for successful outreach, education and events with on-site mammograms.
    - Unable to reach members due to disconnected phone numbers, no voice mail set-up, and wrong numbers.
    - Members often do not arrive at their scheduled time and adjustments may be required to fit them in the schedule.
    - Inadequate access to screening mammography.
    - Variable provider referral and follow-up practices.

- *Childhood Immunization Status – Combination 10* (CIS-10) in Fresno and Kings Counties:
    - Lack of member understanding of the importance of immunizations.
    - The complicated and time-bound immunization schedule – immunizations completed out of timeframe.
    - Parent refusals for vaccines during office visits.
    - Missing one or both flu vaccines.
    - Missing Hep B vaccines from hospitals.
    - Members not completing the vaccine series after turning one year.
    - Language barriers.
    - Turnover of key leadership staff in high volume FQHCs.

- *Immunizations for Adolescents – Combination 2* (IMA-2)
    - Missing HPV vaccines.
    - Member vaccine hesitancy for the HPV vaccine.
    - Providers not starting HPV vaccine series at age 9.

- *Well-Child Visits in the First 30 Months of Life - 0 to 15 Months* (W30-15) in Fresno County
    - Lack of members understanding of the importance of infant well-care checkups.
    - Lack of connection of pregnant members to pediatricians to get the parent established with the pediatrician so the parent knows when to bring in the newborn after discharge from the hospital.
    - Newborn enrollment – the health plan does not get the newborn information until approximately 60 days or more after the baby is born. Two to four infant well care visits should have happened before the baby shows on the health plans eligibility files.
    - Data gap of W30-6+ visits. Completed W30-6+ visits are not getting to the health plan.

- *Well-Child Visits in the First 30 Months of Life - 15 to 30 Months* (W30-30) in Fresno and Kings Counties
    - Members not completing infant well-care after babies turn one year.
    - Parents unable to bring children to well-care appointments during regular business hours.

- *Child and Adolescent Well-Care Visits* (WCV) in Kings County:
    - Lack of provider outreach to members to complete WCV.
    - Lack of member engagement with child and adolescent well-care.
    - Parents are unable to bring children to well-care appointments during regular business hours.
    - Lack of access to well-care visits. It could take weeks or months to get well-care appointments. Lack of dedicated provider time to well-care visits.

- *Cervical Cancer Screening* (CCS):
    - Members could not be reached by phone.
    - Members refused the CCS screening.
    - Lack of knowledge regarding the test.
    - Fears related to COVID-19.
    - Some members were unable to come into the clinic because of either testing positive for COVID-19 or being exposed to COVID-19.

- Staff turnover.

- Controlling Blood Pressure (CBP)
  - Poor medication adherence.
  - Lack of follow-up.
  - Fear of side effects.
  - Knowledge gap.
  - Inaccurate home BP monitoring.
  - Unable to reach members due to outdated or inaccurate contact information.

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
  - Poor medication adherence.
  - Lack of follow-up.
  - Knowledge gap.
  - Unable to reach members due to outdated or inaccurate contact information.

Hospital Quality/ Patient Safety

- Hospitals continue to recover from the pandemic period, with respect to re-establishing effective QI programs, as well as staffing challenges that continue to present barriers at many facilities.
- Hospital leadership may not assign quality performance sufficient importance among other institutional priorities.
- Hospital Acquired Infections and C-section rates are all-payer data. While Health Net is a leader among California health plans engaged in driving hospital quality improvements, its influence as a single plan varies based on the facility.

Behavioral Health

- Member beliefs and attitudes: Uncertainty about antidepressant medication effectiveness or unwillingness to rely on antidepressant medication at initiation of care.
- Member beliefs and attitudes: Lack of education about antidepressant medication treatment and side effects.
- Member habits: Forgetfulness (filling subsequent medications).
- Medical providers may be prescribing the majority of antidepressant medications without the tools to monitor treatment adherence.
- Education about behavioral health & address the stigma of diagnosis.
- Timely access to Admit, Discharge, and Transfer (ADT) data.
- Improve the percentage of provider notifications for members with SUD/MH diagnoses following or within 7 days of an emergency department (ED) visit.
- Education about behavioral health & address the stigma of diagnosis.
- Timeliness of referrals and follow-ups.

Member Experience/CAHPS

- All patient interaction has the potential to impact CAHPS scores.
- CAHPS results are often based on patient perception and patient recall.
- Any negative experience will stay with the member regardless of this look-back period.
- Impacts of the COVID-19 pandemic is still being seen with members' access to care:
  - Members' making up for delayed care.
  - High staff turnover rates and limited bandwidth make it hard for clinics.
  - Limited appointment availability.
- Operational issues that impact member experience/CAHPS:

- Prior authorization delays for care.
- PCP and specialist referral delays.

Provider Access and Availability Surveys

- Providers may not have sufficient tools and guidance to address member satisfaction with access.
- Providers not complying with timely appointments standard.
- Provider offices are having difficulty responding accurately to the survey calls due to the volume of providers requiring appointment availability responses, busy with patients during normal office hours.
- Health Plan to understand barriers that practices have in meeting timely access to better assist providers.
- Members do not have access to or information for urgent care services.
- Specialty access issues in certain geographies.
- Provider practices may be closed to new patients, leading to access issues.
- Ineligibility rates from PAAS.
- PAAS non-responders.
- Providers non-compliance with access standards year-over-year.

Section 3: Overall Effectiveness of QI Work Plan Initiatives

3.1. Behavioral Health

Improve Behavioral Health Measures

MHN continued providing behavioral health (BH) oversight through attendance and participation in QI/UM and Access Workgroup Meetings and submitting BH Performance Indicator Reports timely. There were no corrective actions required.

Antidepressant Medication Management (AMM)

MHN's clinical outreach team continued to support antidepressant medication management through live calls to adult members (in Kings and Madera counties) that were newly prescribed an antidepressant medication, diagnosed with major depression, and demonstrating refill gaps between 15-50 days.

For calendar year 2023, the engaged (reached) rate was 20.59% (7/34) for Kings County, and 12.50% (1/8) for Madera County. The top three reasons for not reaching members remained "leaving a voicemail," "unable to leave a voicemail," and "disconnected phone." Technical difficulties with Pharmacy data persisted into early 2023, impacting the number of members identified for outreach. Ultimately, the plan worked on three monthly lists of members and then concluded the AMM outreach in September 2023 to focus on the non-clinical PIP and to augment the PIP with MHN live outreach to CVH counties.

Results: The *AMM – Acute Phase of Treatment* rate for RY 2023 was 50.03%. *The Continuation Phase of Treatment* rate was 33.23%.

Next steps will be to continue the shift in focus to live outreach to CalViva members in Fresno and Madera counties for follow-up after mental health or substance use disorder emergency department visits.

Non-Clinical PIP Behavioral Health

CalViva Health will improve the percentage of provider notifications* for members with substance use disorders (SUD)/behavioral health/mental health diagnoses following or within 7 days of an emergency department (ED) visit in Fresno and Madera counties.

CalViva Health members in Fresno and Madera Counties who are actively enrolled during the measurement year, are ages 6 and above and had an emergency department (ED) visit with a diagnosis of behavioral health/mental health condition or are ages 13 and above who had an emergency department visit with a diagnosis of substance use disorder. (SUD).

The non-clinical PIP will be focusing on provider notifications for the 7-day follow-up of the ED visits (8 total days). The project includes Fresno and Madera Counties.

The California Department of Health Care Services (DHCS) implemented a new PIP process in 2023. Health Services Advisory Group (HSAG) provided a 2023-2026 PIP Overview Training to Managed Care Organizations on April 26, 2023. For the non-clinical PIP, the original topic was to “Improve the Percentage of referrals to Community Support Programs (Sobering Centers, Day Habilitation program) within 7 Days of visiting an Emergency Department (ED) for Members with an SUD/MH Diagnosis and seen in the ED for the Same Diagnoses in Fresno and Madera Counties for CalViva Health.” The original Module 1 was submitted on September 8, 2023. In November 2023, the decision was made to change the PIP topic from leveraging CalAIM data to “Improve the percentage of provider notifications for members with SUD/MH diagnoses following or within 7 days of an emergency department (ED) visit in Fresno and Madera Counties for CalViva Health.” In December 2023, the PIP was re-submitted, and we recently received feedback from HSAG.

Next steps include the launch of Non-Clinical PIP Workgroups and CalViva will be implementing steps 7 and 8 to highlight the planning of interventions. Interventions will start in Q1 2024.

3.2. Chronic Conditions/Chronic Disease

Improve Chronic Conditions

Chronic diseases are complex and influenced by multiple risk factors such as genetics or age which cannot be changed, and by modifiable risk factors like diet, physical activity and tobacco use that can be changed. Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities. Hypertension or high blood pressure increases the risk of heart disease and stroke. The burden of chronic disease can be reduced by focusing on strategies in primary prevention, early detection and interventions, and disease management. Implementing evidence-based approaches to prevent chronic disease can improve the quality of care. For 2023, the multi-gap HEDIS calls identified 33,534 CalViva members for the outreach, with 22,983 total attempts made and 5,476 CalViva members reached. Live outreach to close multiple gaps in care including those with controlling blood pressure and diabetes care gap yielded a reach rate of 23.8%. Project Extension for Community Healthcare Outcomes (ECHO) Diabetes is a tele-mentoring program launched in February 2023 to support primary care providers in targeted rural counties of California with high rates of diabetes to improve provider self-efficacy and knowledge, patient care, and outcomes. The one-year, 12-session Project ECHO utilized virtual communities of practice, including specialists and PCPs to address clinical inertia and health disparities. There were 19 providers that serviced CalViva areas of the total 36 registered for the program. Those who participated in Project ECHO Diabetes reported

satisfaction and increased confidence in diabetes management. Next steps include ways to better identify CalViva members with undiagnosed hypertension and/or uncontrolled diabetes, address and improve medication adherence, and promote self-management skills.

3.3. Member Engagement and Experience

Improve Satisfaction with Quality of Care/Service

Member CAHPS Survey

CalViva participated in the regulatory CAHPS survey, and it launched successfully in Q1 2023. Root cause analysis on appeals and grievances data is conducted quarterly to identify trends in member pain points and areas for improvement. Findings are shared with appropriate internal stakeholders and teams. The CAHPS Team continues to meet regularly with departments to track progress of the various activities around CAHPS performance and general member experience. These meeting spaces are also a platform to brainstorm any new ideas or projects to address any member issues that come up during the year.

A few CAHPS related improvement activities in 2023 include:

- CAHPS Provider Training Series via Sullivan Group:
  - Provider Communication/Engagement – Provider: CAHPS – Physician lead webinar trainings; topics focus on improving provider communication and access (3 topics, 6 sessions total). CAHPS PPG Webinar:
- CAHPS Annual Webinar:
  - Provider Communication/Engagement – Provider: CAHPS – Annual Webinar reviewing CAHPS program and initiatives to help build CAHPS awareness and offer Best Practices. The webinar covers recommendations and best practices on how provider/provider staff can improve patient satisfaction throughout all patient interactions and the importance of CAHPS.
- CAHPS Best Practice Core Measure:
  - Provider Communication/Engagement – Provider Outreach: CAHPS Created a one Page Best Practice Core Measure for Provider Engagement Facing Teams.
- CAHPS Playbook:
  - Provider Communication/Engagement – Provider Outreach: highlights the importance of CAHPS and best practices around CAHPS provider influenced key measures.

Opportunities for 2024 include:

The CAHPS Team continues to connect regularly with stakeholder teams and departments to track progress of improvement initiatives that may impact CAHPS and member experience.

- CAHPS and member experience awareness and education continue to be a focus since there are multiple stakeholder teams that are member-facing and have the potential to impact CAHPS scores.
- The CAHPS Team will continue to educate and collaborate with multiple stakeholder teams to socialize CAHPS.
  - All patient interaction has the potential to impact CAHPS scores.
  - CAHPS results are often based on patient perception and patient recall.
  - Any negative experience will stay with the member regardless of a look-back period.

3.4. Hospital Quality/Patient Safety

Improve Hospital Quality/Patient Safety

Our hospital quality initiatives focused on raising awareness among hospitals about performance expectations for specific metrics and connecting facilities with the organizations and QI resources that they may need to drive improvements.

These programs include considerable collaboration with external organizations that report outcomes and/or support those QI efforts, including Cal Hospital Compare and its sister organization Cynosure Health, a participant in the CMS-funded Hospital Quality Improvement Contract (HQIC) program; The Leapfrog Group; the California Health Care Foundation; and the California Maternal Quality Care Collaborative (CMQCC).

One of CVH's hospitals, identified as a repeat poor performer, received enhanced outreach to convey expectations and identify opportunities to connect the hospital with QI guidance and tools.

While CVH hospitals overall showed either appropriate performance, improvement or continued avoidance of outlier performance for most hospital-acquired infection metrics, improvement is still needed. CLABSI was an outlier at one facility and directional improvement on MRSA and SSI-Colon was not achieved among the hospitals with reportable data. Continued progress is needed to reduce the risk to patients of preventable complications. C-section performance has improved but most hospitals did not meet the goal. Continued engagement to drive excellence and to raise performance among network facilities is called for, as well as collaboration across stakeholders to support those goals.

3.5. Pediatric/Children's Health Program

Improve Pediatric/Children's Health

<u>Clinical PIP: Well-Child Visits in the First 30 Months of Life – 0 – 15 months – Six or More Well-Child Visits (W30-6+)</u>

Target Population: Black or African American members in Fresno County.

The California Department of Health Care Services (DHCS) implemented a new PIP process in 2023. Health Services Advisory Group (HSAG) provided a 2023-2026 PIP Overview Training to Managed Care Organizations on April 26, 2023. CalViva Health identified 244 Black or African American members in the W30-6+ denominator in MY 2021 with a rate of 31.56%. This target population was approved by HSAG/DHCS as having an adequate denominator for the PIP.

Steps 1 – 6 of the PIP process were submitted to HSAG/DHCS on September 8, 2023 and minor revisions were resubmitted on November 30, 2023. CalViva received 100% validation in January 2024.

The PIP has two AIM statements:

- Do targeted interventions lead to statistically significant improvement in the percentage of Black or African American children 15 months of age in Fresno County that had six or more well-child visits during the remeasurement year.
- Do targeted interventions lead to statistically significant improvement in the percentage of Black or African American children who complete three or more infant well-care visits within 120 days of life in Fresno County during the remeasurement year.

CalViva completed Key Informant Interviews with providers and Community Based Organizations that serve Black residents in Fresno County. A focus group and additional Black resident key informant interviews provided additional feedback. CalViva has drafted a key driver diagram and started a process map of health plan outreaches to pregnant and parenting Black members with infants up to 15 months of age. The next steps are to identify interventions based on failures in the process and key drivers and begin implementation in 2024.

Strength, Weaknesses, Opportunities, and Threats (SWOT)

CalViva Health implemented a SWOT analysis and strategy implementation targeting CIS-10 and W30 in Fresno and Kings Counties. CalViva Health implemented three strategies to improve CIS-10 and W30 rates in Fresno and Kings Counties. CalViva Health submitted the final progress report to DHCS on November 30, 2023. The three strategies and outcomes were:

1. Retrieve the Hep B immunization data for the vaccine given to newborns in three high volume delivery hospitals. Two of the three hospitals are submitting Hep B data through a Health Information Exchange Manifest. CalViva continues to work with the third hospital to include vaccine data in the data already being submitted to Manifest.
2. Increase the conversion of sick visits to well-care visits for children under 30 months of age. Two FQHCs attempted to convert sick to well-care visits. One FQHC abandoned converting sick to well-care visits and the other FQHC continues to schedule follow-up to sick visits as well-care visits. Both FQHCs added weekend hours dedicated to well-care visits in order to improve access to well care visits for all ages.
3. Implement a process in pediatric provider offices to vaccinate children under the age of two years at every visit, not just well-care visits. Both FQHCs have standing orders for vaccines and are working to maximize nurse only visits for vaccines. Nurse only visits are also available at the weekend well care clinics.

3.6. Perinatal Health/Reproductive Health

Improve Perinatal Health/ Reproductive Health

CalViva Health is performing well in the perinatal and reproductive health measures. All CalViva Health Counties are exceeding the 50th percentile for timely prenatal care (PPC-pre), postpartum care (PPC-post) and Chlamydia screening (CHL). Fresno, Kings and Madera Counties exceeded the 90th percentile for PPC-post. And Fresno and Madera Counties exceeded the 75th percentile for PPC-pre. Despite the overall good performance for PPC, a disparity exists for Black or African American pregnant and postpartum members. CalViva may attempt to improve postpartum visits among the Black population as well as infant well-care visits for Black infants as part of the clinical W30-6+ PIP.

CalViva Health implemented a Confirmation of Pregnancy provider incentive targeting primary care providers. However, no Confirmation of Pregnancy forms were received from CalViva PCPs. The Confirmation of Pregnancy has not yet been built into Cozeva, due to competing priorities and the challenges of building a provider incentive in Cozeva without an established denominator.

The Population Health team began postpartum outreach calls in 2023 with offers to assist members in scheduling a postpartum visit, an early infant well care visit and enroll members in the First Year of Life Program. The team reached an average of 49% members. Of those reached, 35% self-report to have already scheduled a postpartum visit, 46% self-report to have already scheduled an infant well-care visit and 96% of members reached enrolled in the First

Year of Life program.

3.7. Pharmacy

Improve Pharmacy Measures

Asthma Medication Ratio (AMR) is a new MCAS measure for MY 2023. In 2023, members who had an AMR gap were outreached to address barriers to asthma medication adherence and encouraged to discuss action plans with their providers. In 2024, assessment of the effectiveness of these strategies will be made as well as modifications/additions to address the desired outcomes.

3.8. Preventive Health/Cancer Prevention

Improving Preventive Health/Cancer Screenings

Cancer screening interventions/programs aim to improve the quality of cancer screening services leading to an increase in the number of members screened. Cancer screening program strategies included increasing both member and provider education/awareness, reducing structural barriers, and facilitating provider trainings and clinic process assessments.

Interventions and projects to improve preventive health screening performance in 2023 included multi-gap member outreaches, mobile mammography screenings and incentives, and provider education and action planning.

CalViva members who had multiple gaps were outreached to schedule their appointments and address other barriers related to closing both breast and cervical cancer screening care gaps. Tip sheets for both cervical cancer and chlamydia screenings were posted on the Provider Library. Provider Engagement action plans were completed for both cervical cancer and chlamydia screenings statewide to understand provider barriers and to provide recommendations and best practices.

Two mobile mammography vendors, Alinea and Pacific Coast, were contracted to partner with providers in removing access as a barrier to care for CalViva members. There were 20 Pacific Coasts mobile mammography events that were completed for CalViva. A Mammography Incentive Program was also offered, and in 2023, eight provider groups opted into the radiology incentive program.

Opportunities for 2024 include:

- Evaluate current trackers and reports to identify opportunities for data reporting enhancement and segmentation to allow for appropriate member-level as well as line of business attribution.
- Gather disaggregated Asian American member data for the multi-gap call outreach which will help identify the unique barriers within this population.

3.9. Provider Engagement

<u>Quality EDGE</u>
Quality EDGE continued to focus on the children's health domain throughout 2023 to align with DHCS' bold goal of achieving the 50th percentile for all pediatric MCAS measures by 2025.

Provider Engagement developed action plans to improve the pediatric measure rates for priority providers in Fresno, Kings and Madera Counties.

Quality EDGE was the mechanism to identify providers to target for one-stop clinics, mobile mammography, and the distribution of point of care member incentives. CalViva also implemented member outreach through the Family Unit HEDIS outreach calls. The team prioritized interventions along the strategic tracks of Data Analytics & Technology, Member and Community Engagement, Direct Care Interventions, Physician/PPG Engagement and Compliance and Operations to support goal achievement.

3.10. Continuity/Coordination of Care (Behavioral and Nonbehavioral)

Improving continuity and coordination of care

Continuity and coordination of care between medical care and behavioral health care is an important aspect of care requiring focused and proactive assessment. A patient with a medical or surgical condition may have a behavioral complication or comorbidity. Similarly, a patient with a behavioral disorder may have a medical comorbidity or there may be a medical implication. The delivery system may or may not have a mechanism to ensure the seamless transfer of information between medical and behavioral care. This lack of structure, commonly found in the industry today, can cause members to experience discontinuity. The goals of the monitoring and evaluation process are to promote seamless, continuous, and appropriate care to members.

The CalViva Health Quality Improvement/Utilization Management (QI/UM) Committee is to provide oversight and guidance for CalViva Health's QI, Utilization Management (UM), and Credentialing Programs. The QI/UM Committee monitors the quality and safety of care and services rendered to members, identified clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, and institutes needed actions.

Coordination of Care (Non-Medical):

CalViva uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. CalViva utilizes NCQA as a roadmap for improvement and how an organization can deliver high-quality care. Organizations use NCQA standards to perform a care gap analysis and align improvement activities with areas that are most important to the State and employers. It provides a framework for implementing best practices to apply a QI process to improve key operational areas and is reported on every two years for accreditation.

Opportunities for improvement are along providing enhanced member and provider education on engaging both and utilizing available resources, such as digital communications to reach more members.

3.11. Access, Availability, and Service and Satisfaction

Improve Provider Access, Availability, Satisfaction and Service

CalViva Health is required to follow and monitor timely access standards set by regulators. The DMHC developed the Provider Appointment Availability Survey (PAAS) Methodology and survey tools set for each measurement year. For MY 2022, CalViva Health administered the DMHC PAAS to randomly selected sample of in-network PCPs, Specialists, and Ancillary providers. Adopted DMHC's regulatory compliance goals for Urgent and Non-Urgent

Appointment Availability at 70% to allow for consistency within the health care industry to align performance goals for Provider Appointment Availability Survey (PAAS) goals for all appointment measures. For MY 2023, the new survey vendor, QMetrics administered DMHC PAAS surveys between August through December for CalViva Health. After-hours access is evaluated annually through telephonic Provider After-Hours Access Surveys (PAHAS) with performance goals remaining at 90%. Sutherland Global conducted the MY 2022 surveys last year. Results indicated a need for improvement in several areas. The DMHC PAAS was also administered to Managed Health Network (MHNs) psychiatrists and non-physician mental health providers who provided behavioral health services to CalViva members. The surveys were conducted via fax, telephone, and/or email between August through December 2022. Additionally, CalViva Health administered a separate Provider Appointment Availability Survey to capture appointment access among a wider group of PCPs and specialists, to monitor appointment access standards and fulfill reporting requirements (NCQA).

Corrective Action Plan (CAP) - For MY 2022 deficiencies were identified through analysis of the survey results and Corrective Action Plan (CAP) and educational packets were issued to PPGs and providers who failed in one or more of the timely access or after-hours measures. PPGs that received CAP are required to complete an Improvement Plan (IP), submit a signed non-compliant providers notification attestation, and attend a Timely Access webinar. Ten (10) PPGs and eleven (11) Direct Network providers received CAP packets. Twelve (12) PPGs and forty-two (42) direct network providers received educational packets. PPGs that received CAP have submitted Improvement Plans and signed attestations as well as other supporting documentation. All CAP Improvement Plan (IP) reviews were complete and were closed.

- For 2023, the Access & Availability team have conducted fifteen (15) provider training webinars from May to November. A total of 873 participants attended, including 190 who identified themselves with CalViva affiliation. This year, there were enhanced webinar training materials emphasizing timely access standards, CAP processes, survey guidelines and timelines, and clarifications on some DMHC methodology and requirements regarding survey standards based on provider inquiries. We have answered over 125 questions and shared copy of the presentation and Q&As to all attendees.

Opportunities for 2024 include:

- Incentivize providers to improve and maintain access standards.

Section 4: QI Reporting

4.1 Safety Monitoring of Potential Quality Issues (PQIs) (Work Plan Section IV Crosswalk -QI Activity)

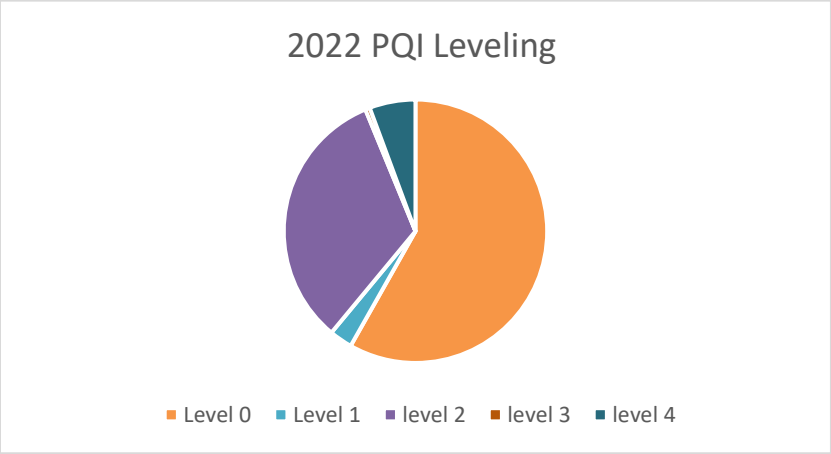
In 2023, CalViva received and closed 372 PQIs. All cases were completed within the 90-day turnaround time to maintain compliance with regulatory requirements. The following table shows the breakdown of leveling for cases. The plan used four severity levels for all PQIs:

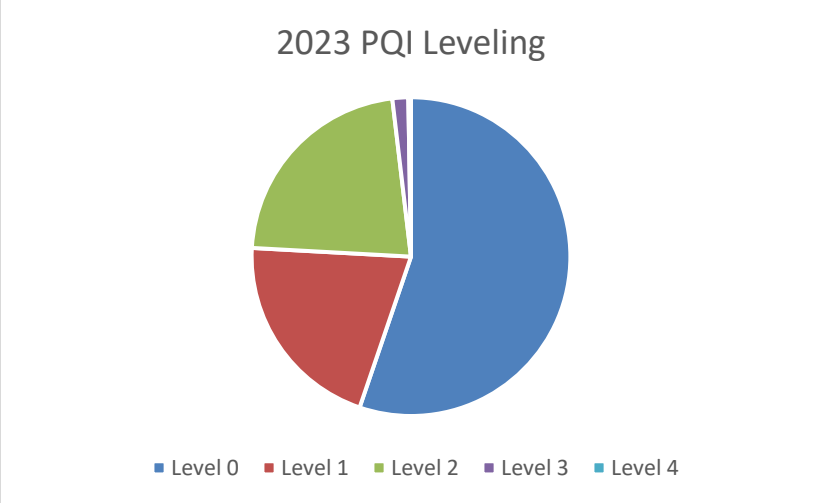
- Level 0 – Investigation indicates no quality of care issue has occurred.
- Level 1 – Investigation indicates that a particular case demonstrated a no potential for serious adverse effects.

- Level 2 – Investigation indicates that a particular case demonstrated a minimal potential for serious adverse effects.
- Level 3 – Investigation indicates that a particular case has demonstrated a moderate potential for serious adverse effects.
- Level 4 – Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects.

Table 4.1 2022-2023 PQI Cases

PQI Level	2022	2023
Level 0	103	206
Level 1	5	77
Level 2	58	83
Level 3	1	5
Level 4	10	1
Total Cases	**177**	**372**





4.2 Vendor Oversight

The Vendor Oversight team ensured delegated vendors supporting the plan were compliant with

contractual and regulatory requirements. This was accomplished via ongoing monitoring and auditing.

2023 Delegated Vendor Auditing and Monitoring Activities

- Scorecard evaluations were conducted on ASH, TurningPoint, NIA and MHN in which determination notifications provided to members were reviewed.
- Annual audits were conducted for MHN, NIA, Envolve Vision, TurningPoint, ModivCare and ASH.
- Joint Oversight Committees (JOCs) were held quarterly in which performance metrics for all delegated vendor services were reviewed.
- Quarterly scorecard evaluations of ModivCare were conducted which included reviews of provider enrollment, PCS form and minor consent processes and verification that appropriate transportation level of service was provided.
- Vendor Oversight Committee (VOC) monthly meetings were held to analyze transportation data and trends to identify opportunities to improve member satisfaction and compliance.

Delegated Vendor Auditing and Monitoring Summary

- Delegated Utilization Management (UM) – American Specialty Health (ASH), TurningPoint, National Imaging Associates (NIA) and MHN were delegated for UM.
  - The TurningPoint annual audit resulted in a corrective action for UM - Same State Licensed Reviewer, Pend Process, Denial Letter Template, Postmark Requirements, Peer to Peer rights and Translation requirements. The NIA and MHN annual audit demonstrated compliance/no findings. The ASH annual audit has not been finalized.
- Delegated Credentialing – American Specialty Health (ASH), Envolve Vision (ENV) and MHN were delegated for Credentialing.
  - The ENV and MHN audit demonstrated compliance/no findings. The ASH audit has not been finalized. See below for transportation program.
- Delegated Specialty Services – The ENV audit demonstrated compliance with no findings. The remaining annual audits have not been finalized.
- Transportation Program – The quarterly scorecard evaluations of ModivCare resulted in non-compliance with the PCS form process. ModivCare has an existing corrective action for this requirement and an active remediation plan. The annual audit has not been finalized.

<u>2024 Delegated Vendor Auditing and Monitoring Plan</u>

For 2024, the plan continues to perform monitoring via scorecard evaluations, quarterly JOCs, monthly ModivCare VOCs and perform annual audits of delegated services.

Delegated Vendor	Description of Services	Proposed Audit & Monitoring Schedule
National Imaging Associates (NIA)	Advanced Radiology Services	Annual Audit: July Scorecard reviews (UM): January & May
American Specialty Health (ASH)	Acupuncture & Chiropractic Network	Annual Audit: June Scorecard review (UM): February
ModivCare	Transportation Services: Non-Medical & Non-Emergency (NMT & NEMT)	Annual Audit: June Scorecard reviews January, April, July & October

TurningPoint Healthcare Solutions	Musculoskeletal Surgical, Cardiac Procedures and Ear Nose and Throat Utilization Management	Annual Audit: May Scorecard reviews (UM): February & October
MHN	Outpatient behavioral/mental health programs	Annual Audit: May
Envolve Benefit Options (Envolve Vision)	Vision Benefits Manager (Optometry & Ophthalmology)	Annual Audit: April

Section 5: Summary of Key Accomplishments

The 2023 reporting year was a productive year for CalViva's Quality Improvement Program. The following is a brief summary of some the key QI interventions and accomplishments for this period.

Quality Indicators and Ratings

- Fresno, Kings and Madera Counties all met 100% of the Adult Chronic Care measures MPL – 50th percentile.
- Kings and Madera Counties met 100% of the Adult Preventive Care/Cancer Prevention Measures MPL - 50th percentile.
- Madera County met 100% of the Children's Health Measures MPL – 50th percentile.
- Fresno, Kings and Madera Counties all met 100% of the Perinatal/Reproductive Care measures MPL – 50th percentile.
- Kings and Madera counties met 100% of the Pharmacy measure MPL - 50th percentile.
- CalViva scored 100% for Provider After-Hours Survey, PAAS Access to Ancillary measures, and BH PAAS by Risk Rating measures.

Regulatory Requirements and Submissions

- High Volume Physical Accessibility Review Survey (PARS) report was submitted to DHCS in January 2023.
- Annual DHCS Blood Lead Screening report was submitted.
- The BCS Health Equity PIP exceeded its SMART Aim goal with final submission to HSAG in Q2 2023.
- The CIS-10 PIP exceeded its SMART Aim goal with the final submission to HSAG in Q2 2023.
- The Clinical Improving Infant Well-Child Visits (W30-6+) Among Black or African American Infants in Fresno County PIP Steps 1-6 were submitted to HSAG in Q3 2023. Received a final validation score of 100%.
- The Non-Clinical Behavioral Health PIP SUD/SMH Steps 1-6 were submitted to HSAG in Q4 2023; currently awaiting final validation.
- CVH SWOT was submitted to DHCS on 11/30/2023 and was closed by DHCS.

Quality Improvement Initiatives

- Completed Medi-Cal DHCS regulatory Reports: two Performance Improvement Projects (PIPs).
- Began pilot of tracking high volume, low performing providers for Initial Health Appointments (IHA) with Provider Engagement team.
- Working with CalViva leadership to track performance of three high volume, low performing providers.

- Partnered with Fresno County Department of Public Health's Lead Poisoning Prevention Program to provide training to high volume LSC Providers in Fresno County.
- Provided 8 POC lead analyzers and one year supply of test strips to provider offices in the CalViva Health service area.
- Completed 44 PARS in Fresno, Kings, and Madera counties.
- Results from annual Member Access Survey (2022 results): YOY rate increase for the following measures: *Got routine care as soon as needed*; *Ease of getting care/test/treatment*.
- Successfully prepared and coordinated all needed requirements for CalViva to launch regulatory CAHPS in Q1 2023.
- Conducted a total of 15 provider Timely Access webinars sessions with a total of 190 identified CalViva provider participants.

Quality Improvement Department and Program

- Implemented Quality EDGE through Provider Engagement and Medical Affairs targeting priority providers and PPGs in Fresno, Kings, and Madera Counties.
- Quality EDGE funding supported 87 activities to close care gaps in CalViva counties in 2023. Activities include member outreach call campaigns, equipment for providers, educational materials, lead screening resources, technology support, direct care services (one-stops and mobile mammography), member and provider staff incentives.

Section 6: Annual QI Program Changes

Based on this evaluation, the QI Program effectively meets safe clinical practice goals, has adequate resources, and a strong QI Committee structure, which includes productive practitioner participation and effective leadership. The Medi-Cal Health Education Team, as well as the PARS Team moved under the Medi-Cal Quality Improvement Director to align Medi-Cal strategies and create focused synergies to drive member access and outcomes. At the end of 2022, team Program and Drivers (PODs) were established in order to gain efficiency across various teams, to streamline operations, and reduce duplication within and across teams and programs. The purpose of the team PODs is to improve the design and group of programs to achieve strategic outcomes and goals, foster collaboration and align teams, and create more opportunities for innovation and growth. Quality Management will continue as a centralized department, serving multiple business functions, and will continue to leverage Corporate Centene materials, activities, and reporting along with its internal processes through the relationship with Health Net.

In 2023, resources were further assessed to identify improved ways to deliver quality and health education programs and projects. With regulatory requirements changing and the plan preparing for accreditation, new approaches were warranted. One QI Manager has oversight on the PARS team and is the Health Education lead. The Quality Improvement Department's Directors, Senior Managers, Managers, Program Managers, and Specialists were all responsible for integrating Health Education initiatives, programs, and compliance activities into their projects. In 2024, the health education system will be supported by the development of a health education POD that will address collateral and digital promotion strategies and oversee all operations related to health education and wellness.

Appendix

Table A-1. Performance Goals

Standard	Goal
DHCS Managed Care Accountability Set (MCAS) HEDIS Measures	NCQA QC National 50th Percentile
Behavioral Health MCAS HEDIS Measures	NCQA QC National 50th Percentile
Hospital Care/Patient Safety	YOY Directional improvement for % network hospitals meeting Hospital-Acquired Infections and Nulliparous, Term, Singleton, Vertex C-section rate targets
CAHPS	YOY Improvement and/or NCQA QC National 25th Percentile (stretch goal)
Provider Access and Availability and Satisfaction Surveys	70 or 90 Percentage Rate (%) or directional YOY improvement.

Table A-2. MY 2022 MCAS Measures Above 50th Percentile by County

CalViva Counties	Fresno	47%	**Overall 64%**
	Kings	60%	
	Madera	87%	

Table A-3. Summary of RY 2023 Outcomes by Category

Category	Medi-Cal	
	N	Rate %
Adult Chronic Care	6/6	100%
Adult Preventive Care/Cancer Prevention	5/6	83.33%
Adult Survey (CAHPS)^	5/8	62.5%
Behavioral Health	0/6	0%
Children's Health	7/18	38.88%
Hospital Care/Patient Safety	10/12	83%
Member Access Survey	2/4	50%
Pharmacy*	1/3	33%
Provider Access and Availability and Satisfaction Surveys	60/124	48.39%
Reproductive Health	9/9	100%
Total	**105/196**	**53.57%**

*^ The CalViva DHCS CAHPS Survey is completed every two years and thus, annual rate updates will not be available. * Outcome summary is based on MY2023 and Quality Compass MY 2022 25th Percentile.* In 2023, the annual Regulatory CAHPS survey was conducted for CalViva for the first time.

Table A-4. Summary of Opportunities

Based on results, the following performance measures are areas of focus for improvement for CalViva.

Adult Health Opportunities	Reproductive Health Opportunities
Chronic Care: • N/A **Pharmacy:** • Asthma Medication Ratio **Preventive Health/Cancer Prevention:** • Cervical Cancer Screening	• N/A
	Children's Health Opportunities
	• Childhood Immunization Status - Combo 10 • Immunizations for Adolescents - Combo 2 • Well-Child Visits in the First 30 Months of Life - 0 to 15 Months • Well-Child Visits in the First 30 Months of Life - 15 to 30 Months • Child and Adolescent Well-Care Visits • Lead Screening in Children
Behavioral Health Opportunities	
• Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) New opportunities identified by DHCS: • Depression Remission or Response for Adolescents and Adults (DRR-E) • Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	
Hospital Care/Patient Safety Opportunities	
• Hospital performance on HAI: Surgical Site Infection – Colon	
Member Experience – CAHPS Opportunities	
CAHPS Measures: • Access to Care Composite • Customer Service Composite • Doctor Communication Composite • Care Coordination • Overall Rating Measures (Health Plan, Health Care Quality, Provider, Specialist) **Member Access Survey Measures:** • Got urgent care as soon as needed • Ease to get specialist appointment.	

Provider Survey Opportunities

PAAS Survey Measures:

- Access to PCPs,
- Access to Specialists,
- Access to Psychiatry and Non-Physician Mental Health
- Telephone Access: Provider call-back for non-urgent issues during normal business hours

PAHAS Survey Measures:

- N/A

Provider Satisfaction Survey:

- All Provider Satisfaction Survey Access Measures
- Behavioral Health Practitioners Survey Access Measures: Routine Care, Urgent Care, Non-Life-Threatening Emergent Care, and Coordination of appointments with an interpreter Standards.
- All BH Experience of Care and Health Outcomes (ECHO) measures

Table A-5. County Level MCAS HEDIS Outcomes for MY 2021 – MY 2022

Fresno	HEDIS Measure	MY 2021 (%)	MY 2022 (%)	^ Rate Trend	*QC 2022 Nat'l 50th Percentile	Outcome Met (Y/N)
Adult Chronic Care						
CBP	Controlling High Blood Pressure	56.83%	61.73%	↑	59.85%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control (>9.0%) **(inverted)**	42.64%	37.47%	↑	39.90%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	49.11%	52.14%	↑	50.95%	Y
CCS	Cervical Cancer Screening	63.04%	57.08%	↓	57.64%	N
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	35.04%	27.49%	↓	34.79%	N
IMA-2	Immunizations for Adolescents - Combo 2	37.23%	39.17%	↑	35.04%	Y
LSC	Lead Screening in Children	N/R	49.88%	N/T	63.99%	N
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	48.80%	50.01%	↑	55.72%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	61.86%	62.69%	↑	65.83%	N
WCV	Child and Adolescent Well-Care Visits	46.30%	48.14%	↑	48.93%	N

Pharmacy						
AMR*	Asthma Medication Ratio	64.44%	62.15%	↓	64.26%	N
Reproductive Health						
CHL	Chlamydia Screening in Women	59.88%	58.86%	↓	55.32%	Y
PPC	Prenatal and Postpartum Care – Postpartum Care	81.60%	84.23%	↑	77.37%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	86.11%	89.62%	↑	85.40%	Y
Kings	**HEDIS Measure**	**MY 2021 (%)**	**MY 2022 (%)**	**^ Rate Trend**	***QC 2022 Nat'l 50th Percentile**	**Outcome Met (Y/N)**
Adult Chronic Care						
CBP	Controlling High Blood Pressure	65.10%	71.81%	↑	59.85%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%) **(inverted)**	34.04%	30.05%	↑	39.90%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	56.64%	58.61%	↑	50.95%	Y
CCS	Cervical Cancer Screening	64.17%	58.95%	↓	57.64%	Y
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	31.87%	23.84%	↓	34.79%	N
IMA-2	Immunizations for Adolescents - Combo 2	32.12%	29.68%	↓	35.04%	N
LSC	Lead Screening in Children	N/R	53.77%	N/T	63.99%	N
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	55.56%	53.48%	↓	55.72%	N
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	54.43%	55.59%	↑	65.83%	N
WCV	Child and Adolescent Well-Care Visits	38.80%	39.56%	↑	49.93%	N
Pharmacy						
AMR*	Asthma Medication Ratio	64.76%	64.37%	↓	64.26	Y
Reproductive Health						
CHL	Chlamydia Screening in Women	55.98%	62.15%	↑	55.32%	Y

PPC	Prenatal and Postpartum Care - Postpartum Care	87.34%	84.18%	↓	77.37%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	91.70%	87.76%	↓	85.40%	Y
Madera	**HEDIS Measure**	**MY 2021 (%)**	**MY 2022 (%)**	**^ Rate Trend**	***QC 2022 Nat'l 50th Percentile**	**Outcome Met (Y/N)**
CBP	Controlling High Blood Pressure	67.29%	67.49%	↑	59.85%	Y
CDC/ HBD	Hemoglobin A1c Control for Patients With Diabetes - HbA1c Poor Control (>9.0%) **(inverted)**	40.45%	35.93%	↑	39.90%	Y
Adult Preventive Care/Cancer Prevention						
BCS	Breast Cancer Screening	56.63%	61.03%	↑	50.95%	Y
CCS	Cervical Cancer Screening	64.42%	61.58%	↓	57.64%	Y
Children's Health						
CIS-10	Childhood Immunization Status - Combo 10	49.64%	48.42%	↓	34.79%	Y
IMA-2	Immunizations for Adolescents - Combo 2	50.49%	53.53%	↑	35.04%	Y
LSC	Lead Screening in Children	N/R	66.42%	N/T	63.99%	Y
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 to 15 Months	65.06%	56.71%	↓	55.72%	Y
W30-2+	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months	73.23%	75.65%	↑	65.83%	Y
WCV	Child and Adolescent Well-Care Visits	55.52%	57.71%	↑	48.93%	Y
Pharmacy						
AMR*	Asthma Medication Ratio	71.80%	72.93%	↑	64.26%	Y
Reproductive Health						
CHL	Chlamydia Screening in Women	63.15%	59.38%	↓	55.32%	Y
PPC	Prenatal and Postpartum Care - Postpartum Care	80.00%	87.04%	↑	77.37%	Y
PPC	Prenatal and Postpartum Care - Timeliness of Prenatal Care	88.15%	90.37%	↑	85.40%	Y

*Percentile based on Quality Compass (QC) 2022 National HMO benchmarks for MY 2022 MCAS. Outcomes met for regional performance is based on the DHCS MPL at the 50th percentile.
^ rate trend based on directional changes to rates year over year.
NTNot trendable year over year due to significant differences in NCQA technical specifications.
N/RNot reported.
^Administrative rate only

*These measures are not current MY 2023 MCAS measures but are upcoming MY 2023 MCAS measures.

Table A-6. Progress to MY 2022 Goals – Behavioral Health Outcomes (HEDIS)

Fresno	HEDIS Measure	MY 2021 (%)	MY 2022 (%)	^ Rate Trend	*QC 2022 Nat'l 50 Percentile Rate	Outcome Met (Y/N)
AMM-Acute	Antidepressant medication management – Acute Phase Treatment	48.69%	50.00%	↑	60.44%	N
AMM-Acute	Antidepressant medication management – Continuation Phase Treatment	31.55%	33.55%	↑	42.96%	N
Kings	**HEDIS Measure**	**MY 2021 (%)**	**MY 2022 (%)**	**^ Rate Trend**	***QC 2022 Nat'l 50 Percentile Rate**	**Outcome Met (Y/N)**
AMM-Acute	Antidepressant medication management – Acute Phase Treatment	44.19%	46.97%	↑	60.44%	N
AMM-Acute	Antidepressant medication management – Continuation Phase Treatment	28.24%	27.95%	↓	42.96%	N
Madera	**HEDIS Measure**	**MY 2021 (%)**	**MY 2022 (%)**	**^ Rate Trend**	***QC 2022 Nat'l 50 Percentile Rate**	**Outcome Met (Y/N)**
AMM-Acute	Antidepressant medication management – Acute Phase Treatment	53.31%	54.15%	↑	60.44%	N
AMM-Acute	Antidepressant medication management – Continuation Phase Treatment	33.09%	36.82%	↑	42.96%	N

*Percentile based on Quality Compass (QC) 2022 National HMO benchmarks for MY 2022 MCAS. Outcomes met for regional performance is based on the DHCS MPL at the 50th percentile.
^ rate trend based on directional changes to rates year over year.
[NT]Not trendable year over year due to significant differences in NCQA technical specifications.
[N/R]Not reported.
^Administrative rate only

Table A-7. Regulatory CAHPS Survey CAHPS Measures	MY 2022 (%)	^ Rate Trend	Baseline Source (Source: For 2022 - Quality Compass MY 2022 25th Percentile)	*Outcomes Met (Y/N)
Getting Needed Care	76.7%	N/A	79.2%	N
Getting Care Quickly	81.8%	N/A	77.2%	Y
How Well Doctors Communicate	93.5%	N/A	90.8%	Y
Customer Service	86.3%	N/A	86.7%	N
Rating of All Health Care	53.2%	N/A	52.9%	Y
Rating of Personal Doctor	64.8%	N/A	64.3%	Y
Rating of Health Plan	55.4%	N/A	58.6%	N
Rating of Specialist	69.6%	N/A	64.7%	Y

^ Rate trend N/A and Not Trendable – In 2023, the annual Regulatory CAHPS survey was conducted for CalViva for the first time
in February 2023, with final results available in August 2023.
* Outcome met Y/N based on Quality Compass MY 2022 25th Percentile.

Measure rates captured above for both the DHCS CAHPS Survey (Table A-7) and the CalViva Member Access Survey (Appendix Table A-8) represent rates based on the percentage of members who chose “Always/Usually” as their response.

Table A-8. Annual Member Access Survey Summary

Member Access Measures	MY 2020 (%)	MY 2021 (%)	Rate Trend	Baseline Value (Source: Previous Year CalViva Access Survey: MY 2019 Rate)	Outcomes Met (Y/N)
Got urgent care as soon as needed	77%	75%	↓	77%	N
Got routine care as soon as needed	62%	64%	↑	62%	Y
Ease to get specialist appointment	65%	47%	↓	65%	N
Ease of getting care/test/treatment	69%	71%	↑	69%	Y

Provider Appointment Availability Survey (PAAS)

Table A-9. PAAS (DMHC PAAS + Non-DMHC Medi-Cal Questions) – Access to PCPs

PAAS (DMHC + Non-DMHC Medi-Cal)										
Access Measure and Standard (Performance Goal = 70%)										
County	Urgent Care Appointment within 48 hours of request (PCP)		Non-Urgent Appointment within 10 business days of request (PCP)		Access to Preventive Health Check-Up/Well-Child Appointment within 10 business days of request (PCP)		Access to Physical Exams and Wellness Checks within 30 calendar days of request (PCP)		Access to First Prenatal Appointment within 2 weeks of request (PCP)	
	(Rate %)									
	MY 2021	MY 2022	MY 2021	MY 2022	MY 2021	MY 2022	MY 2021	MY 2022	MY 2021	MY 2022
Fresno	49.5	50.2↑	65.9	76.8↑	70.4	62.9	88.5	81.7	100.0	71.9
Kings	57.1	62.7	87.5	77.2	66.7*	69.8	100.0*	84.6	66.7	82.1
Madera	52.4	60.0	90.9	73.2↓	0.0*	68.6	0.0*	84.8↑	N/A	90.0
Telehealth	N/A	42.2	N/A	70.3	N/A	56.7	N/A	76.0	N/A	66.7
Overall	**50.9%**	**49.0%↓**	**71.4%**	**74.4%**	**67.7%**	**61.8%**	**86.7%**	**80.3%**	**92.3%**	**72.6%**

N – Total number respondents to the question.
Rate - Percent of total number of respondents surveyed who met the access standard.
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05).
* - Denominator less than 10,
^ Low response rates compared to MY 2021 and
therefore comparisons should be made with caution

Table A-10. PAAS (DMHC + CalViva) – Access to Specialists (All)

PAAS (DMHC + CALVIVA PAAS)						
Access Measure and Standard (Performance Goal = 70%)						
County	Urgent Care Appointment within 96 hours of request (Specialists)		Non-Urgent Appointment within 15 business days of request (Specialists)		Access to First Prenatal Appointment within 2 weeks of request (Specialists)	
	(Rate %)					
	MY 2021	MY 2022	MY 2021	MY 2022	MY 2021	MY 2022
Fresno	39.6	39.3	64.3↓	60.1	78.1	63.9
Kings	50.0	47.1	76.9	82.4	100.0*	100.0*
Madera	39.0	32.3	62.9↓↟	48.6↓	100.0*	N/A
Telehealth	N/A	34.6	N/A	42.9	N/A	N/A
Overall	**40.2**	**37.6**	**64.8**	**56.1↓**	**80.80**	**67.4↓**
County	Urgent Care Appointment		Non-Urgent Appointment			

	within 96 hours of request (Specialists - Oncology)		within 15 business days of request (Specialists - Oncology)	
	(Rate%)			
	MY 2021	MY 2022	MY 2021	MY 2022
Fresno	70	25↓	83	86
Kings	0	33*	0	67*
Madera	60	50*	70	75*
Overall	**65.0**	**35**	**79**	**82**

N – Total number respondents to the question
Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-11 PAAS (DMHC ONLY)–SCPs (Cardiologists, Gastroenterologists, Endocrinologists)

PAAS (DMHC)				
Access Measure and Standard (Performance Goal = 90%)				
	Urgent Care Appointment within 96 hours of request (Specialists)		Non-Urgent Appointment within 15 business days of request (Specialists)	
	(Rate %)			
County	MY 2021	MY 2022	MY 2021	MY 2022
Fresno	44.1	40.9	60.0	50.0
Kings	60.0*	50.0	100.0*	100.0
Madera	33.3	26.3	53.1	42.2
Telehealth	N/A	34.6	N/A	42.9
Overall	**42.0**	**35.4**	**59.4**	**46.3**

N – Total number respondents to the question
Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant
difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

Table A-12. PAAS (DMHC) – Access to Ancillary

PAAS (DMHC)			
Access Measure and Standard		Non-Urgent Services within 15 business days of request (Ancillary)	
County	Performance Goal	MY 2021 (%)	MY 2022 (%)
Fresno	70%	92.3	92.3
Kings	70%	100.0*	100.0*
Madera	70%	100.0*	75.0*
Overall	**70%**	**94.1%**	**89.5%**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses

* - Denominator less than 10

Table A-13. PAAS (DMHC) – Access to Psychiatry and Non-Physician Mental Health

PAAS (DMHC)								
Access Measure and Standard (Performance Goal = 70%)								
County	Urgent Care services within 96 hours of request (Psychiatrist)		Non-Urgent Appointment within 15 business days of request (Psychiatrist)		Urgent Care services within 96 hours of request (NPMH)		Non-Urgent Appointment within 10 business days of request (NPMH)	
	(Rate %)							
	MY 2021	MY 2022	MY 2021	MY 2022	MY 2021	MY 2022	MY 2021	MY 2022
Fresno	75.0*	38.5	55.6*	50.0	59.4	50.0	77.3	77.1
Kings	0.0	0.0*	N/A	0.0*	50.0*	33.3*	77.8*	66.7*
Madera	N/A	N/A	N/A	N/A	54.5	75.0*	66.7	100.0*
Telehealth	N/A	25.0*	83.3*	50.0*	40.0	37.8	59.5	60.5
Overall	**46.2%**	**33.3**	**66.7**	**47.4**	**54.2**	**47.4**	**72.6**	**73.4**

Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)
N/A – No available responses
* - Denominator less than 10

CalViva Telephone Access Survey

Table A-14. CalViva Telephone Access Survey

Access Measure	Standard	Goal	County	MY 2021 (%)	MY 2022 (%)
Telephone Answer Time	Within 60 seconds	90%	Fresno	100	100
			Kings	100	100
			Madera	100	92.0
			Total	**100**	**99.0**
Provider Call-back for non-urgent issues during normal business hours	Within one business day	90%	Fresno	100	86.0
			Kings	100	87.0
			Madera	100	88.0
			Total	**100**	**87.0**

N - Total number of respondents to the survey question

Provider Satisfaction Survey - Satisfaction with Timely Access Regulations

Medical/Non-Behavioral Health

Table A-15. CalViva Provider Satisfaction Survey (PSS) Survey (% Satisfied/Very Satisfied) – Overall Results

Metric	MY 2021 (%)	MY 2022 (%)
Access and Availability (Composite)	70.3	69.7
Referral and/or prior authorization process necessary for your patients to access covered services	72.9	65.5
Access to Urgent Care	68.0	71.7

Access to non-urgent primary care	70.5	73.9
Access to non-urgent specialty services	72.1	68.0
Access to non-urgent ancillary diagnostic and treatment services	72.4	70.0
Access to current and accurate provider directory data	65.9	68.8

Table A-16. CalViva PSS Survey Results (% Satisfied/Very Satisfied) – by County

Access Measure	Source	Fresno		Kings		Madera	
		MY 2021 (%)	MY 2022 (%)	MY 2021 (%)	MY 2022 (%)	MY 2021 (%)	MY 2022 (%)
Referral and/or prior authorization process	CalViva Provider Satisfaction Survey	77	61	50*	50*	63	90
Access to urgent care		73	73	50*	50*	50	75
Access to non-urgent primary care		75	72	75*	100*	50	80
Access to non-urgent specialty services		74	68	60*	50*	69	71
Access to non-urgent ancillary diagnostic & treatment services		75	71	50*	50*	70	71
Access to current and accurate provider directory data		71	67	40*	100*	53	71

* Rates calculated with small denominator size (≤30), and therefore comparisons and conclusions should be made with caution.
N/A – Not Applicable for measurement year

CalViva Provider After-Hours Availability Survey (PAHAS)

Table A-17. Provider After-Hours Survey Results

		Appropriate After-Hours Emergency Instructions		Ability to contact on-call physician after-hours within 30 minutes	
County	Performance Goal	MY 2021 (%)	MY 2022 (%)	MY 2021 (%)	MY 2022 (%)
Fresno	90%	99	97.8	80	90.1
Kings	90%	100	100	89	94.3
Madera	90%	100	100	93	100
Overall	**90%**	**100%**	**98.3%**	**82%**	**91.6%**

N – Total number respondents to the question
Rate - Percent of total number of respondents surveyed who met the access standard
↑↓ Statistically significant difference between MY 2021 PAAS vs MY 2022 PAAS (p<0.05)

Table A-18. CalViva PSS for Behavioral Health Practitioners Survey Results

Access Measure	Source	MY 2021 (%)	MY 2022 (%)
Perspective on or concerns with compliance with the Routine Care standard (% No)	Behavioral Health Provider Satisfaction Survey (PSS)	60.9	58.6
Perspective on or concerns with compliance with the Urgent Care standard (% No)		57.1	60.7
Perspective on or concerns with compliance with the Non-Life-Threatening Emergent Care standard (% No)		80.0	70.4
Perspective on or concerns with the coordination of appointments with an interpreter? (% No)		100.0	84.0
Perspective on or concerns with the availability of an appropriate range of interpreters? (% No)		100.0	95.8
Perspective on or concerns with compliance with the training and competency of available interpreters? (% No)		100.0	91.7

Table A-19. CalViva Health Experience of Care and Health Outcomes (ECHO)

Access Measure	Performance Goal	Source	FRESNO		KINGS		MADERA	
			MY 2021 N (%)	MY 2022 N (%)	MY 2021 N (%)	MY 2022 N (%)	MY 2021 N (%)	MY 2022 N (%)
Non-urgent initial appointment with a psychiatrist within 15 days of request	90%	Experience of Care and Health Outcomes (ECHO)	60 (56.7)	61 (59.0)	3 (100)	7 (42.9)*	6 (50.0)	6 (66.7)*
Non-urgent initial appointment with psychiatrist within 10 days of request	90%		N/A	61 (37.7)	N/A	7 (42.9)*	N/A	6 (33.3*)
Non-urgent follow-up appointment with psychiatrist within 30 days of request	90%		75 (82.7)	89 (79.8)	5 (80.0)	7 (71.4)*	8 (75.0)	5 (80.0)*
Non-urgent initial appointment with a non- physician within 10 days of request	90%		79 (51.9)	75 (45.3)	8 (62.5)	8 (25.0)*	6 (50.0)	11 (36.4)
Non-urgent follow-up appointment with non-physician behavioral health care provider within 10 days of request	90%		N/A)	94 (51.1)	N/A	11 (27.3)	N/A	9 (44.4)*

Access Measure	Performance Goal	Source	FRESNO		KINGS		MADERA	
			MY 2021 N (%)	MY 2022 N (%)	MY 2021 N (%)	MY 2022 N (%)	MY 2021 N (%)	MY 2022 N (%)
Non-urgent follow-up appointment with non-physician behavioral health care provider within 30 days of request	90%		94 (87.2)	94 (84.0)	10 (70.0)	11 (45.5)	9 (77.8)	9 (100.0*)

* Rates calculated with small denominator size (≤30), and therefore comparisons and conclusions should be made with caution.
N - Represents the number of respondents who populated a response to that particular Access Measure

Table A-20. MHN BH Appointment Availability Results by Risk Rating

Access Measure	Performance Goal	Source	MY 2021 (%)	MY 2022 (%)
Access to Urgent care within 48 hours	90%	Behavioral Health Case Management System	100	100
Access to NLTE care within 6 hours			N/A	100

CalViva Health
Quality Improvement
Year-End Work Plan Evaluation
2023

1/29/2024

TABLE OF CONTENTS

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

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 2023. The development of this document requires resources of multiple departments.

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances
A&I:	Audits and Investigation
ADA:	American Diabetes Association
AH:	After Hours
AWC:	Adolescent Well-Care
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CalAIM:	California Advancing and Innovating Medi-Cal
CAP:	Corrective Action Plan
CCAC:	Central California Asthma Collaborative
CCHRI:	California Cooperative Healthcare Reporting Initiative
CCM:	Chronic Conditions Management
CDC:	Comprehensive Diabetes Care
CM:	Care Management
CMQCC:	California Maternity Quality Care Collaborative
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
HAIs:	Hospital acquired infections
HE:	Health Education
HEDIS®:	Healthcare Effectiveness Data and Information Set
HPL:	High Performance Level
HN:	Health Net
HSAG:	Health Services Advisory Group
HQPP:	Hospital Quality Performance Program
IHA:	Initial Health Assessment
ICE:	Industry Collaborative Effort
IP:	Improvement Plan
IVR:	Interactive Voice Response
MCAS:	Managed Care Accountability Sets
MCL:	Medi-Cal
MH:	Mental Health
MMCD:	Medi-Cal Managed Care Division
MPL:	Minimum Performance Level
NCQA:	National Committee on Quality Assurance
PCP:	Primary Care Physician
PDSA:	Plan, Do, Study, Act
PIP:	Performance Improvement Project
POD:	Program Owners and Drivers
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
PNM:	Provider Network Management
PRR:	Provider Relations Representative
PTMPY:	Per Thousand Members Per Year
QC:	Quality Compass
QI:	Quality Improvement
SMART:	Specific, Measurable, Achievable, Relevant, and Time-Bound
SPD:	Seniors and Persons with Disabilities
SWOT:	Strengths, Weaknesses, Opportunities, and Threats
UM:	Utilization Management

I. BEHAVIORAL HEALTH

1.1 Behavioral Health	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Linda Ciotoli, Program Manager III, Quality Improvement Rhonda Dick, Sr. QI Specialist Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL (FUA-30 and FUM-30). **Rationale:** According to the National Committee on Quality Assurance, HEDIS Volume 1 Narrative, substance use disorders are a prevalent and serious public health issue and, if left untreated, can lead to damaging effects on an individual's health, finances and overall well-being. Individuals who are seen in the Emergency Department (ED) due to substance misuse are at high-risk of subsequent adverse events, especially within the year following their ED visit. These measures focused on ensuring care coordination for members who are discharged from the ED following high-risk substance use events, since those individuals may be particularly vulnerable to losing contact with the health care system.

	Additionally, many individuals are affected by a serious mental illness (SMI). Although ED visits are common among patients suffering from mental illness, many may be avoidable. In 2007, approximately 12 million ED visits were related to mental health or substance abuse—1 out of 8 (12.5%) of all ED visits. More than 7.6 million were related to mental health conditions only. Two million (28.9%) of mental health-related ED visits listed a mental health disorder as the primary diagnosis.
Program Objectives	Meet directional improvement of 1-5% from prior year or exceed DHCS MPLs Quality Compass (QC) 50th percentile benchmarks for DHCS required metric (non-clinical PIP): • FUA-30 • FUM-30 **Prior rate (MY 2021)** (%, ratio)**:** • FUA-30: 0%, 0/3 • FUM-30: 0%, 0/3 **Final rate (MY 2022)** (%, ratio)**:** • FUA-30: 33%, 1/3 • FUM-30: 33%, 1/3 Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023

Objectives Met (ratio, %):	2/6, 33.33% The final FUA-30 rates for MY 2022 show Fresno County (10.84%) and Madera County (11.54%) fell below the MPL of (21.24%); while Kings County (21.85%) exceeded the MPL. The final FUM-30 rate for MY 2022 show Fresno County (14.98%) and Madera County (36.80%) fell below the MPL of (54.51%).
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 3/3, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Will leverage CalAIM data to track county referrals. The referrals will need to be to a community support agency or facility within seven days of an ED visit for both SUD and SMH. • SUD/SMH denominator will be calculated by determining the number of current eligible members referred to a community support agency or facility. • Completion of barrier analysis is in progress using HEDIS data to assess why members are not getting community support services. Next steps: Combine barrier analysis data and CalAIM data. • Begin PIP workgroups. • Leverage barrier analysis results to identify SMART aim goal.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year;*	*Completed at (ratio, %):* 9/10, 90% ☐ *Off track (<75%)* ☒ *On track (=>75%)*

(Percent Completed)	*Updates:* • Non-clinical PIP Steps 1-6 were submitted to HSAG on December 15, 2023. Currently awaiting feedback. • Updated Key Driver Diagram to reflect new SMART Aim. • Starting to complete Steps 7 and 8 of the PIP which includes process flows, reviewing the key driver diagram, and key informant interviews. • First intervention to start in Q1 2024. • Twenty-two FUA FUM Provider Surveys were completed and analyzed. • Change to SUD/SMH indicators for 2024.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Behavioral health staff at the hospital may be unaware that people who have an emergency department visit need to have a follow-up within 7 days. • Providers may not be receiving timely notifications from the hospital regarding patients' ER visits. • Social and economic limitations: food, or housing insecurity (e.g., homelessness). • Lack of patient and provider education on mental health referral information and member transportation support information. • Discrimination, such as concerns with treatment, low patient empowerment, and stigma. • Access to health care, transportation, lack of support from family members. *Lesson Learned:* • If members do not have follow-up care within 7 days, the vast majority do not have a visit within 60 days of the ED visit. • Increase staff training and education to help providers learn about mental health referral information and member transportation request information • Implement motivational interviewing. • Empathy and support from providers to address members' fear and anxiety.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

II. CHRONIC CONDITIONS

2.1 Heart Health/ Blood Pressure	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Gigi Mathew, Program Manager III, Medicare, QI Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL. • CBP **Rationale:** High blood pressure affects more than half of people over age 50 and more than 75% of those older than 65. Findings have shown that both high systolic and high diastolic pressure can predict the risk of heart attack or stroke. Focusing on initiatives for prevention of age-related increase in blood pressure in addition to managing existing hypertension is imperative to reducing the large burden of blood-pressure related cardiovascular disease and microvascular complications.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS MPL measure:

	• CBP **Prior rate (MY 2021)** (%, ratio)**:** 100%, (3/3) **Final rate (MY 2022)** (%, ratio)**:** 100%, (3/3) Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	3/3, 100% Overall, all CalViva counties exceeded the MPL of 59.85% and Fresno and Kings Counties met at least 1% year-over-year directional improvement for CBP.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 2/2, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Multigap HEDIS calls for members with care gaps including controlling blood pressure started in May. As of 8/4/23, the overall reach rate for Medi-Cal is 13.59%, with an attempted rate of 51.17%. The actual number of members reached was 2,868 (of the 21,102 attempted), and this had been progressively increasing since the beginning of the multigap HEDIS call. • Final remediated CBP provider tip sheets were available June 2023 and posted to the provider library. CalViva data on the number of CBP provider tip sheets downloaded is not available. Currently, provider tip sheets are being moved from the provider library to a new section of the portal landing page (https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/hedis-measure-specifications.html).

Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 2/2, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • For 2023, the multi-gap HEDIS calls identified 33,534 CalViva members for the outreach, with 22,983 total attempts made and 5,476 CalViva members reached. Live outreach to close multiple gaps in care including those with CBP care gap yielded a reach rate of 23.8%, slightly higher than the overall multi-gap reach rate of 22.6%.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Outdated or inaccurate contact information makes it difficult for multigap HEDIS calls to effectively outreach to members. *Lesson Learned:* • Exploring phone validation options to ensure accurate and up-to-date contact information is available for personalized, telephonic outreaches. • Exploring opportunity to supplement care gap closure via member-reported BP and providing guidance on how digital BP monitors could be obtained as durable medical equipment.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

2.2 Diabetes	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Gigi Mathew, Program Manager III, Quality Improvement Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance of measures included in the DHCS MCAS measures held to MPL. • CDC >9 **Rationale:** Diabetes is a chronic disease that places high demands on the health system, both regarding the care processes and associated expenditures. Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities. Social factors such as income, education, race, ethnicity, and built environment play a crucial role in determining the incidence and severity of diabetes and need to work to eliminate the disparities they cause. Diabetes control is achieved through effective comprehensive diabetes care and management, and clinical preventive care.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS MPL measure: • CDC >9

	Prior rate (MY 2021) (%, ratio): 100%, (3/3) **Final rate (MY 2022)** (% ratio)**:** 100%, (3/3) Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	3/3, 100% There was directional improvement on CDC >9 from MY 2021 to MY 2022 across all CalViva counties. All CalViva counties for CDC –poor A1c control were held to the 50th percentile MPL at 39.9% for MY 2022, with lower rates indicating better performance.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 4/4, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Multigap HEDIS calls for members with care gaps including A1c control started in May. As of 8/4/23, the overall reach rate is 13.59%, with an attempted rate of 51.17%. The actual number of members reached was 2,868 (of the 21,102 attempted), and this has been progressively increasing since the beginning of the multigap HEDIS call. • Final remediated diabetes provider tip sheets were available February 2023, and posted to the provider library. There were 7 downloads of the CalViva provider tip sheet on HbA1c control for patients with diabetes from February to July 2023. Currently, provider tip sheets are being moved from the provider library to a new section of the portal landing page where CalViva branded provider tipsheets are available. (https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/hedis-

	measure-specifications.html). • Social media post "Healthy Vision Month" posted on 4/29/2023 directed members to ADA video https://youtu.be/IcTtkYGsAw4 with a 2% engagement rate on Facebook and Instagram, respectively. • Project Extension for Community Healthcare Outcomes (ECHO) tele-mentoring program to support primary care providers in targeted rural counties of California with high rates of diabetes to improve provider self-efficacy and knowledge, patient care, and outcomes launched in February 2023. The one-year, 12-session Project ECHO utilizes virtual communities of practice, including specialists and PCPs to address clinical inertia and health disparities. As of 6/16/23, there were 27 registered PCPs, and attendance varied per session. Ongoing efforts to improve attendance included outreach by Weitzman Institute (vendor) and HN provider engagement team via phone text to encourage participation of registered PCP, nurse practitioners, and physician assistants, and asking attendees to help promote the ECHO program. Additionally, there are currently 19 registered providers in Project ECHO that supports the CalViva service areas.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 4/4, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • For 2023, the multi-gap HEDIS calls identified 33,534 CalViva members for the outreach, with 22,983 total attempts made and 5,476 CalViva members reached. Live outreach to close multiple gaps in care including those with Diabetes care gap yielded a reach rate of 23.8%, slightly higher than the overall multi-gap reach rate of 22.6%. • Project ECHO began on 2/17/23 and concludes in January 2024. Of the 36 total providers registered for the program, 27 were PCPs including nurse practitioners, physician assistants and other health care providers. By year end, of those registered, 19 were providers supporting CalViva service areas. The average session attendance is 23. Higher patient load to maintain access to care in North and Central Valley and competing priorities during Project ECHO sessions

	attributed to variance in attendance.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Outdated or inaccurate contact information makes it difficult for multigap HEDIS calls to effectively outreach to members. *Lesson Learned:* • Exploring phone validation options to ensure accurate and up-to-date contact information is available for personalized, telephonic outreaches. • Project ECHO participants overall were satisfied with the program, and offering incentives (i.e., sign-on bonus and lunch vouchers) maintained engagement. Will submit evaluation request to QIRA to examine impact of participating providers in Project ECHO to care gap closure on HbA1c testing and control. • Exploring opportunity to increase care gap closure via promotion and utilization of continuous glucose monitoring (CGMs) since updated HEDIS® specifications allow for inclusion of glucose management indicator (GMI) data.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

III. MATERNAL/WOMEN'S HEALTH

3.1 Perinatal Care	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Juli Coulthurst, Program Manager III, Quality Improvement Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Improve maternal health by ensuring all pregnant members have timely prenatal care and postpartum care. **Rationale:** To align activities with DHCS MCAS measures.
Program Objectives	• Achieve directional improvement in the number of reporting units that meet the 75th percentile for Medi-Cal MCAS perinatal measures: PPC-pre and PPC-post. • Reduce disparities in African-American (A-A) members in timely prenatal care and postpartum care. Target rate to reduce disparity by 50%: ○ PPC-pre: 84% ▪ MY 2021 overall CalViva PPC-pre rate for A-A: 81.30%; Hispanic: 86.49%; White: 82.49%; and Asian: 83.16%. There was a 5.19 percentage points difference between A-

	A and the highest performer, Hispanic. ○ PPC-post: 70% ▪ MY 2021 overall CalViva PPC-post rate for A-A: 64.31%; Hispanic: 73.98%; White: 68.79%; and Asian: 76.66%. There was a 12.35 percentage points difference between A-A and the highest performer, Asian. **Prior rate (MY 2021)** (%, ratio)**:** • MCAS rates: 66.67%, 4/6 • PPC-pre A-A: 82% • PPC-post A-A: 64% **Final rate (MY 2022)** (%, ratio)**:** • MCAS rates: 83.33%, 5/6 • PPC-pre A-A: 83.49% • PPC-post A-A: 54.74% Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	MCAS: 5/6, 83% Fresno, Kings and Madera exceeded the 50th percentile for timely prenatal care and postpartum care. Fresno, Kings and Madera exceeded the 90th percentile for postpartum care. Fresno and Madera exceeded the 75th percentile for timely prenatal care.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/*	*Completed at (ratio, %):* 1/5, 20% ☒ *Off track (<75%)* ☐ *On track (=>75%)*

Mid-Year Activities Planned; (Percent Completed)	*Updates:* • Perinatal training of Provider Engagement completed. The training included a review of the HEDIS® technical specifications for each MCAS measure and best practices to improve rates. • The *CalViva Health Pregnancy Program* is an ongoing program. Referrals of African-American/Black pregnant members in Fresno County to the CalViva Health Pregnancy Program started in May 2023 and will continue monthly. • Planning for a Confirmation of Pregnancy provider incentive for PCPs to launch Q3 2023.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 4/5, 80% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Confirmation of Pregnancy provider incentive for PCPs launched August 2023. No Confirmation of Pregnancy Forms received from CalViva Health PCPs. • Population Health began postpartum outreach calls in July 2023. Population Health offers to assist members who very recently delivered a baby in scheduling a postpartum visit, an early infant well care visit and enroll members in the First Year of Life Program. Population Health has reached approximately 49% of members. Of those, 35% of members reached self-report to have already scheduled a postpartum visit, 46% of members reached self-report to have already scheduled an infant well care visit, and 96% of members reached enrolled in the First Year of Life program.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • No Confirmation of Pregnancies received from PCPs. • Confirmation of Pregnancy provider incentive has not been built in Cozeva. Competing priorities of the Cozeva team and challenges of building a provider incentive in Cozeva without an established denominator, since members do not make it into the timely prenatal care

	denominator until a live birth occurs. *Lessons Learned:* • Fresno, Kings and Madera are high performers in timely prenatal care and postpartum care. Disparities in timely prenatal care and postpartum care exist for the Black population. Postpartum care could get addressed along with infant well care for the Black population in the clinical PIP targeting W30-6+, infant well care in Black families.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

IV. MEMBER ENGAGEMENT AND EXPERIENCE

4.1 Initial Health Appointments (IHA)	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☒ Member Experience ☐ Other:
Responsible Person	Miriam Rosales, Program Manager III, QI Tanya Demirjian, Manager, QI Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Increase number of members who receive their IHA within 120 days of enrolling as a new member and increase the compliance of outreaching new members 3 times within 120 days of enrolling as a new member. **Rationale:** To meet DHCS APL 22-030 requirements.
Program Objectives	Meet year over year performance improvement of (1-5%) for MY 2023 rates. **Prior rate (MY 2021)** (%, ratio)**:** 56.78% **Final rate (MY 2022)** (%, ratio)**:** 59.82%

	Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	1/1, 100% The IHA year rate improved by 3% from MY 2021 of 56.78% to 59.82% for MY 2022.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 5/5, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Updated provider materials in accordance with APL 22-030. Materials updated included a provider tip sheet, IHA non-compliance provider notices, IHA trainings, provider portal website, Medi-Cal Operations Guide, a provider update with the listed APL changes, welcome packet, member handbook, IHA call scripts, and CalViva IHA policy. • Ongoing IHA quarterly reporting: Reported quarterly on plan outreach and IHA compliance. • Ongoing IHA provider notice: Providers who were found non-compliant during FSR/MRR audits were sent IHA provider notices on IHA requirements. • By 6/30/2023 PE conducted 509 outreaches to providers regarding IHA and IHA trainings. Outreaches included in-person meetings, online meetings, phone, and email. PE outreaches and trainings included training providers on how to access and use new member reports on the provider portal to determine which members are due for an IHA, documentation and coding of IHA, and handoff of supporting materials (process flow, provider tip sheet, and Step Guide). Providers also had access to an online training on IHA. • Providers with low performance were offered training and additional interventions to resolve barriers to IHA completion.

Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 5/5, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Updated provider materials in accordance with APL 22-030. Materials updated included a provider tip sheet, IHA non-compliance provider notices, IHA trainings, provider portal website, Medi-Cal Operations Guide, a provider update with the listed APL changes, welcome packet, member handbook, IHA call scripts, and CalViva IHA policy. • Ongoing IHA quarterly reporting: Reported quarterly on plan outreach and IHA compliance. • Ongoing IHA provider notice: Providers who were found non-compliant during FSR/MRR audits were sent IHA provider notices on IHA requirements. • Conducted Action Plan Focus training to PE team regarding IHA and IHA trainings. Providers also had access to an online training on IHA. • Providers with low performance were offered training and additional interventions to resolve barriers to IHA completion.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Invalid member contact information makes it difficult to schedule member to complete their initial PCP visit to complete IHA wit in turn-around time. • Multiple departments collect enrollment and outreach data on member, each possibly utilizing different metrics. *Lesson Learned:* • Incorporated DHCS MCAS measures into our IHA reporting. Utilizing DHCS MCAS measures as proxy for IHA completion expands on the current criteria for IHA which can lead to increased completion rates. • If a multi-member household enrolls with the plan, they are issued a household ID and only one enrollment packet is mailed to the household.

	• Household ID's have been incorporated into routine data analysis to account for multi-member households. • Including household ID's in the routine data analysis will include members who reside in a multi-member household who did not receive an enrollment packet addressed to them.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☒ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

4.2 CAHPS Improvement	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☐ Quality of Care ☒ Quality of Service ☐ Safety ☒ Member Experience ☐ Other:
Responsible Person	Frances Arce, Program Manager III, CAHPS Team Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Implement initiatives and partner with operational stakeholders to improve CAHPS survey results and overall member experience. **Rationale:** The regulatory CAHPS Survey will launch to CalViva members in Q1 2023. The CAHPS survey captures

	member experience on various topics including: • Access to Care Composite • Customer Service Composite • Doctor Communication Composite • Care Coordination • Overall Rating Measures (Health Plan, Health Care Quality, Provider, Specialist) Survey results will help guide where improvement efforts should be focused on. Final results will be analyzed by the CAHPS Team and cascaded out to appropriate stakeholders.
Program Objectives	• Meet directional rate improvement of 1-5% by MY 2023 for the following measures: o Access to Care Composite o Customer Service Composite o Doctor Communication Composite o Care Coordination o Overall Rating Measures (Health Plan, Health Care Quality, Provider, Specialist) YOY improvement on all measures. Please refer to internal CAHPS tracker. **Prior rate (MY 2021)** (%, ratio)**:** RY 2022 Access Survey Measures YOY Improvement: 50%, (2/4) **Final rate (MY 2022)** (%, ratio)**:** MY 2022 Regulatory CAHPS Survey: N/A This was the first year CalViva participated in the Regulatory CAHPS Survey. Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023

Objectives Met (ratio, %):	N/A
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 1/1, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • The Regulatory CAHPS Survey for CalViva members launched on-time in Q1 2023.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need a higher level of attention are being escalated in a timely manner.

Year End Activities Update: *(Populate at year end)*
 	
Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)
	Completed at (ratio, %): 9/9, 100%
	☐ *Off track (<75%)*
	☒ *On track (=>75%)*
	
	Updates:
	• CalViva Provider Newsletter CAHPS Article:
	  ○ Provider Communication/Engagement - Provider Outreach: Information about CAHPS and Measure Rates provided.
	• CAHPS Survey Demographic Analysis:
	  ○ Provider Communication/Engagement: - CAHPS Survey Results Demographic Analysis for Health Equity Accreditation Report underway for Member and Internal process.
	• CAHPS Provider Training Series via Sullivan Group:
	  ○ Provider Communication/Engagement - Provider: CAHPS - Physician lead webinar trainings; topics focus on improving provider communication and access (3 topics, 6 sessions total).
	• CAHPS CME Provider Training Pilot:
	  ○ Provider Communication/Engagement - Provider: CAHPS Continuing Medical Education (CME) Credit offered to licensed health care professionals after attending CAHPS Provider Training Series.
	• CAHPS Playbook:

	○ Provider Communication/Engagement - Health Plan: CAHPS - Best Practices and Measure information captured in one resource. • CAHPS PPG Webinar: ○ Provider Communication/Engagement - Provider: Annual Webinar reviewing CAHPS program and initiatives to help build CAHPS awareness and offer Best Practices. The webinar covers recommendations and best practices on how provider/provider staff can improve patient satisfaction throughout all patient interactions and the importance of CAHPS. • CAHPS Results and Goals YOY Analysis: ○ Provider Communication/Engagement - Health Plan: CAHPS Results and Goals YOY Analysis for Internal process. • CAHPS Flu Campaign 2023: ○ Provider Communication/Engagement - Health Plan/Preventative Care: Flu Outreach to provider groups in collaboration with Clinical Program Managers (CPM). • CAHPS Best Practice Core Measure: ○ Provider Communication/Engagement - Provider Outreach: CAHPS Created a one Page Best Practice Core Measure for Provider Engagement Facing Teams.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • All patient interaction has the potential to impact CAHPS scores. • CAHPS results are often based on patient perception and patient recall. • Any negative experience will stay with the member regardless of this look-back period. <u>Member Experience/CAHPS</u> • Impacts of the Covid-19 pandemic is still being seen with members' access to care: ○ Members' making up for delayed care. ○ High staff turnover rates and limited bandwidth make it hard for clinics. ○ Limited appointment availability. • Operational issues that impact member experience/CAHPS: ○ Prior authorization delays for care. ○ PCP and specialist referral delays. *Lesson Learned:* • CAHPS and member experience awareness and education continue to be a focus since there are multiple stakeholder teams that are member-facing and have the potential to impact CAHPS

	scores. • The CAHPS Team will continue to educate and collaborate with multiple stakeholder teams to ensure improved member satisfaction.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☒ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

V. Hospital Quality/ Patient Safety

5.1 Hospital Quality/ Patient Safety	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☒ Safety ☐ Member Experience ☐ Other:
Responsible Person	Barbara Wentworth, Program Manager III, Quality Improvement Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** High quality hospital networks should be designed and managed in ways that account for facility quality. Patient safety and C-section performance are the primary focus, with particular emphasis on poor performing facilities. **Rationale:** Work to ensure contracted hospitals are providing appropriate, safe care to patients that avoids preventable harm, and provide guidance to members about informed choice that accounts for quality performance when selecting a site for care.
Program Objectives	• Engage hospitals with poor performance on priority metrics: Obtain quality updates from targeted hospitals either verbally or in writing. • Hospitals with reportable data: Directional improvement, based on appropriate scores (Standardized Infection Ratio (SIR)=<1.0) or outliers (SIR>2) for target hospital acquired infections (HAIs) (Catheter-

	associated urinary tract infections (CAUTI), central line-associated bloodstream infection (CLABSI), Clostridioides difficile (C.Diff), Methicillin-resistant Staphylococcus aureus (MRSA), and Surgical Site Infection following Colorectal Surgeries (SSI-Colon), if baseline is <90% (appropriate) / >5% (outlier). Otherwise, maintain =>90%/<5% status. • Maternity hospitals with reportable data: Directional improvement for the proportion of hospitals meeting the national standard (=<23.6%) for all-payer NTSV C-section rates. **Prior rate (MY 2021)** (%, ratio)**:** For MY 1/1/21 to 12/31/21, all CVH network hospitals with sufficient data to produce a Scorecard (Revised to reflect CVH network only): • CAUTI: ○ SIR=<1.0: 25% ○ SIR>2.0: 0% • CLABSI: ○ SIR=<1.0: 0% ○ SIR>2: 0% • C.Diff: ○ SIR=<1.0: 100% ○ SIR>2: 0% • MRSA: ○ SIR=<1.0: 50% ○ SIR>2: 0% • SSI-Colon: ○ SIR=<1.0: 50% ○ SIR>2: 0% • NTSV C-sections (MY ’21): ○ Rate of =<23.6%: 0% **Final rate (MY 2022)** (%, ratio)**:** For Measurement period 10/1/2021 to 9/30/2022, all CVH hospitals with sufficient data to produce a Scorecard • CAUTI:

	○ SIR=<1.0: 50% ○ SIR>2.0: 0% • CLABSI: ○ SIR=<1.0: 25% ○ SIR>2: 25% • C.Diff: ○ SIR=<1.0: 100% ○ SIR>2: 0% • MRSA: ○ SIR=<1.0: 50% ○ SIR>2: 0% • SSI-Colon: ○ SIR=<1.0: 50% ○ SIR>2: 0% • NTSV C-sections (MY '22): ○ Rate of =<23.6%: 20% Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	9/12, 75% We successfully engaged the hospital identified as a repeat poor performer and obtained a detailed update about the status of their performance and quality improvement efforts, as described below. CVH network hospitals with reportable data (a total of 5 facilities) achieved directional improvement for those meeting a SIR of 1.0 or lower for CAUTI (25% to 50%) and CLABSI (0% to 25%). Those meeting the C.Diff target remained at 5 out of 5, or 100%. The percentage of hospitals meeting the SIR of 1.0 or lower target for MRSA and SSI-Colon was unchanged at 50% and did not meet the goal of directional

	improvement. CVH hospitals continued to achieve 0% outliers for all HAI's except CLABSI, which increased from 0% to 25% (1 out of 4 hospitals with reportable data). CVH hospitals did improve the percentage of hospitals meeting the NTSV C-section rate target of 23.6%, from 0% to 20% (1 out of 5 hospitals).
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 15/16, 93.75% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* Hospital Quality activities: C-section overuse: • Launched initiative to promote new Medi-Cal doula benefit. Collaborated with Health Equity Officer to send letter to all maternity hospitals in Medi-Cal about doula care and the new doula benefit. (Note these included CalViva's 5 maternity hospitals, although the mailings were not branded as such.) In consultation with Doula Workgroup, developed member letter on doula benefit and C-section overuse, as well as preeclampsia prevention and warning signs that urgent medical care is needed. Currently in DHCS review. Monthly mailings to pregnant members planned for launch once materials receive full approval from all parties (will be submitted for CalViva review to confirm permission to conduct this outreach to CalViva members). • Mailed outreach was conducted to all maternity hospitals across LOBs about C-section overuse; the opportunity to engage with California Maternity Quality Care Collaborative (CMQCC); California Health Care Foundation implicit racial bias training resources; and maternal health/birth equity reporting and assessment. (Included CalViva maternity hospitals. Future mailings will be submitted for CalViva review and branded as CalViva for these hospitals.) • Collaborated with the California Quality Care Collaborative (CMQCC) to support maternal health quality improvement among network hospitals, primarily on C-section rates, including individual hospital engagement, and maternal health/birth equity initiatives. Patient Safety: • Served as co-chair of the Leapfrog Group's Partners Advisory Committee. Chaired both quarterly meetings, including in-person DC meeting and attended related events. Participated in Data Users

	Group meetings and activities. • Collaborations with Cal Hospital Compare and Cynosure Health support quality improvement among hospitals through promotion of Honor Rolls, use of Poor Performer report, coordination/consultation with staff about specific hospitals' performance, and promotion of QI resources to address patient safety metrics. • Conducted outreach to network hospitals that did not earn a place on the Patient Safety Honor Roll list. Included promotion of Leapfrog Hospital Survey and forthcoming Sepsis Care Honor Roll from Cal Hospital Compare. Administrative delay prevented Q2 distribution, but letters went out the first week of August. • Social media outreach promoting informed hospital choice based on quality performance was conducted on Facebook in April, May and June. April and May posts generated over 350,000 impressions. The June post generated over 100,000 impressions. Overall Quality and Poor Performer: • Conducted follow-up with repeat poor performers, based on end of year performance on Hospital Scorecard metrics and other key indicators. Phone outreach sought to obtain status updates about poor performing metrics that were highlighted in end-of-year mailed outreach to the hospitals. Two CalViva network hospitals were included in this initiative.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 36/36, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* Hospital Quality activities: C-section overuse: • Conducted mailed outreach to all network maternity hospitals that failed to make the Maternity Care Honor Roll list. Included content about appropriate doula protocols, including an insert on the topic from the California Maternity Quality Care Collaborative's (CMQCC's) *Toolkit to Support*

	Vaginal Birth and Reduce Primary Cesareans. Promoted engagement with CMQCC and use of their tools to stratify rates by race/ethnicity. Urged compliance with implicit racial bias training requirements and identified free courses sponsored by the California Health Care Foundation (CHCF) and others. • Ongoing collaborations with CMQCC and CHCF on hospital outreach content, quality improvement resources available to hospitals, and hospital engagement strategy. Patient Safety: • Conducted mailed outreach to all network hospitals about patient safety. Urged participation in Cal Hospital Compare's Opioid Care Honor Roll in early 2024, and reminded hospitals about upcoming new Sepsis Care Honor Roll. Encouraged hospitals to take advantage of Cynosure Health's online learning platform and pointed them to a course on sepsis care among others. Urged focus on high priority measures including hospital-acquired infections and Leapfrog's recently-updated Hospital Safety Grade. Provided information about a new Leapfrog program recognizing excellence in care for patients with diabetes. • Ongoing collaborations with Cal Hospital Compare, Cynosure Health, and Leapfrog on hospital performance, engagement strategies, and quality improvement resources. • Chaired in-person Leapfrog Partners Advisory Committee meeting in Washington, DC. Health Net's hospital quality lead was featured as a speaker at Leapfrog's Annual Meeting on a panel that addressed patient safety expectations among key stakeholders. Poor Performers: • One hospital in CalViva's network was identified as a repeat poor performer in 2022 and 2021. (This is a correction to the mid-year report, which noted that there were two. Two of Health Net's poorest performers are in the CalViva network but only one was a repeat poor performer.) Health Net conducted extensive outreach to connect with the hospital's new Quality Director and to obtain an update on the status of lower performing measures at this hospital. The hospital provided a thorough 5-page update detailing: current trends across priority metrics; quality improvement programs in place designed to raise performance by metric; and relevant facility-specific context for these factors. The Quality Director demonstrated encouraging engagement and identified meaningful improvements for multiple metrics, including lower Standardized Infection Ratios for multiple priority hospital-acquired infections; improvement on the Leapfrog Safety Grade, which improved from a D to a C; and the hospital's low-risk, first-birth C-section rate, which is now less than 1% away from the national target. The hospital is also working to address disparities in maternal health as a participant in the first cohort of CMQCC's new equity-

	focused collaborative. Overall performance: • Quality data for the Hospital Scorecard program was updated for all network hospitals with sufficient available data on featured categories. Updated Scorecards will be published internally for use by contracting in early January 2024.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • The process to develop member-facing doula outreach was protracted and delayed at the State level. The decision was made to not conduct outreach to CVH members at this time. Currently in process of developing member-facing webpage featuring maternal health resources , and which will include streamlined doula-related content that aims to facilitate access and utilization. • Quite difficult to engage poorest performing hospitals. Connecting with the repeat poor performer described above required mailed outreach; multiple telephonic attempts; and collaboration through our contracting staff. Once we did connect with the correct (new) staff, we were encouraged by the hospital's engagement and report. *Lesson Learned:* • While CVH hospitals overall showed either appropriate performance, improvement or continued avoidance of outlier performance for most hospital-acquired infection metrics, improvement is still needed. CLABSI was an outlier at one facility and directional improvement on MRSA and SSI-Colon was not achieved among the 5 hospitals with reportable data. Continued progress is needed to reduce the risk to patients of preventable complications. C-section performance has improved but progress has been limited. Continued engagement to drive excellence and to raise performance among network facilities is called for, as well as collaboration across stakeholders to convey mutual expectations to hospitals and to help connect them to the resources and guidance they may need to improve. We have been a leader among health plans in this area and will continue to spearhead this work with our collaborative partners.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

VI. PEDIATRIC

6.1 Performance Improvement Project – Infant Well-Child Visits (W30-6+)	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Tanya Demirjian, Manager Juli Coulthurst, Program Manager III Naomi Lam, Sr. QI Specialist Meena Dhonchak, Sr. QI Specialist Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Improve pediatric health by ensuring all infants under 15 months of age complete timely well-child visits and all appropriate immunizations and screenings. **Rationale:** To align activities with DHCS required PIP.
Program Objectives	Meet or exceed DHCS MPLs at QC 50th percentile benchmarks for DHCS required W30 -6+ measure. (PIP)

	Prior rate (MY 2021) (%, ratio)**:** 33%, 1/3 **Final rate (MY 2022)** (%, ratio)**:** 33%, 1/3 Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	1/3, 33.33% Madera was the only county to meet the 50th percentile for W30-6+ in MY 2022/RY 2023.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 0/1, 0% ☒ *Off track (<75%)* ☐ *On track (=>75%)* *Updates:* • First clinical PIP (W30-6+ targeting African-American/Black members) submission on track for due date on 9/8/2023. • Attended HSAG training for new 2023-2026 PIP requirements on April 26, 2023.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 1/1, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Submitted first clinical PIP on 9/8/2023. Made minor revisions and resubmitted PIP on 11/30/2023. Awaiting validation findings from HSAG.

	○ Conducted provider and community-based organization key informant interviews. Also completed individual community member key informant interviews (KII) and a focus group with four community members (Black or African American residents with children under 2 years of age). Summary of results of key informant interviews and focus groups will be completed by January 2024. ○ Drafted a key driver diagram based on literature review, data and key informant interviews and focus groups. ○ Currently developing a process map of health plan outreach activities to the pregnant and parenting of infants up to age 15 months.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Disparate W30-6+ rates in the Black or African American population have existed for years, and it may take years to reduce the disparities with multiple interventions/systems changes. • Systems changes that HSAG and DHCS are looking for take time to test, especially changes that target one specific race/ethnicity. • Challenges in coordinating with Community Based Organizations that serve the Black or African American population in Fresno County. *Lessons Learned:* • Black or African American parents of young children prefer consistency with their infants' medical provider and culturally appropriate health information from a trusted messenger. • Collaboration with CBOs that serve the Black or African American population are critical to engage community members. Incentives for the community members and CBOs help with engagement in the collaboration. • Providers would not take the time to schedule key informant interviews, but preferred to complete KII surveys via email.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☒ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

6.2 Pediatric SWOT: CIS-10 and W30	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Tanya Demirjian, Manager, QI Juli Coulthurst, Program Manager III Meena Dhonchak, Sr. QI Specialist Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Improve pediatric health by ensuring all infants under 2 years of age complete timely well-child visits and all appropriate immunizations and screenings (CIS-10, W30-6+). **Rationale:** To align activities with DHCS required SWOT.
Program Objectives	Meet or exceed DHCS MPLs at QC 50th percentile benchmarks for DHCS required W30/CIS-10 measure. (SWOT). **Prior rate (MY 2021)** (%, ratio)**:** 33%, 2/6 **Final rate (MY 2022)** (%, ratio)**:** 33%, 2/6

	Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	2/6, 33.33% Madera exceeded the 75th percentile in CIS-10 and W30-2+. Madera exceeded 50th percentile in W30-6+. Fresno and Kings County did not meet the 50th percentile for CIS-10, W30-6+ or W30-2+.
Mid-Year Activities Update: *(Populate at mid-year)* *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 1/1, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • SWOT was submitted to DHCS on 7/17/23. Next submission is due 11/30/23. • The top three delivery hospitals were identified in Fresno and Kings Counties. Contact has been made with all hospitals and a process has been established to receive the Hep B data from each hospital. • Two FQHCs identified to participate with CalViva on converting sick to well-care visits for children under the age of 30 months and vaccinate children under the age of two years any time they are in the clinic. Providers have been trained for converting sick to well-care visits and provided the CDC handout on communicating with parents about vaccines.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Year End Activities Update: *(Populate at year end)*	*Completed at (ratio, %):* 1/1, 100% ☐ *Off track (<75%)*

Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)	☒ *On track (=>75%)*
	
	Updates:
	• Final SWOT submission submitted 11/30/2023 and accepted by DHCS.
	  ○ Two of the three highest volume delivery hospitals are submitting Hep B data through Manifest. Work continues with the hospital not currently sending vaccine data (including Hep B) to add vaccine data to the data submitted to Manifest.
	  ○ Two FQHCs attempted to convert sick to well-care visits. One FQHC abandoned converting sick to well-care visits and the other FQHC continues to schedule follow-up to sick visits as well-care visits. Both FQHCs also added weekend wellness events or Saturday clinics in order to improve access to well care visits for all ages.
	  ○ Both FQHCs engaged in data reconciliation for W30-6+, which will be an ongoing activity for both FQHCs.
	  ○ Both FQHCs have standing orders for vaccines and will vaccinate at any visit to the clinic. Both FQHCs are working to maximize nurse only visits for vaccines, especially for children who are behind in vaccines. Both FQHCs offer nurse only vaccine visits at weekend clinics.

Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • One hospital not including vaccine data in the data they send to Manifest. • Data gaps identified for W30-6+ measure, requiring data reconciliation by providers and CalViva Health. • Access to well care visits. FQHCs had to offer expanded hours dedicated to well care visits to accommodate access. • Parent refusals for vaccines increased in measurement year 2022 and continued in 2023. *Lessons Learned:* • Converting sick to well care visits through scheduling creates access issues to well care by pushing well-care appointments out several months. Most providers will have to expand hours dedicated to well care or have dedicated hours for well care during regular business hours.
Initiative Continuation *(Populate at year end)*	☒ *Closed* ☐ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

VII. PHARMACY

7.1 Respiratory Health	
Type of activity/program	☒ New activity ☐ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Alicia Bednar, Program Manager III, Medicare QI Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL. • AMR **Rationale:** Treating asthma early may prevent long-term lung damage and help keep the condition from getting worse over time. Asthma medications are long-term controllers used to achieve and maintain control and quick-reliever medications used to treat acute symptoms and exacerbations. Appropriate ratios for these medications improve symptomatic control.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile national benchmark for the following measure: • AMR

	Prior rate (MY 2021) (%, ratio)**:** 100%, 3/3 **Final rate (MY 2022)** (%, ratio)**:** 66%, 2/3 Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	2/3, 66.67% Only Kings and Madera County met program objectives by meeting the 50th percentile for MY 2022.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 3/4, (75%) ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Live outreach calls to close multiple gaps in care including those with AMR care gaps initiated in May. • Provider update on asthma education was postponed from April to July due to compliance review delay. • Social media on asthma awareness of triggers posted in April. There was a 1% engagement rate with 66 reactions, 4 shares and 1 post comment. • CCAC In-Home Asthma Support Program finished in June. Reporting and evaluation to follow.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.

Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 4/4, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Live outreach calls to close multiple gaps in care including those with AMR care gaps concluded in December. Overall reach rate for CalViva members was 24%. • CCAC In-Home Asthma Support Program reporting and evaluation will be available in 2024. • Enrolled 48 members in smoking cessation program.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Additional clinical pharmacy support was needed to conduct member outreach in CalViva counties as calls were limited. • Accurate member phone numbers/contact info. *Lesson Learned:* • Explore targeted provider outreach to educate and engage utilizing Asthma Remediation services in 2024. Environmental asthma-trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

VIII. PREVENTIVE HEALTH

8.1 Cancer Screenings	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Ravneet Gill, Program Manager III, Quality Improvement Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Implement activities to improve performance in measures included in the DHCS MCAS measures held to MPL (BCS, CCS, CHL). **Rationale:** It is important for members to stay up to date on the recommended screening schedules to stay healthy and detect diseases early when they are easier to treat.
Program Objectives	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measures: • BCS • CCS • CHL

	Prior rate (MY 2021) (%, ratio)**:** • BCS: 33.3%, 1/3 • CCS: 66.7%, 2/3 • CHL: 33.3%, 1/3 **Final rate (MY 2022)** (%, ratio)**:** • BCS: 100%, 3/3 • CCS: 66.67%, 2/3 • CHL: 100%, 3/3 Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	8/9, 88.89% Objectives were met for CCS and BCS in all counties. CCS did not meet the MPL in Fresno County but did meet the MPL in both Kings and Madera.
Mid-Year Performance goal update and improvement opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)*	*Completed at (ratio, %):* 5/5, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* BCS: 3/3 • Alinea Mobile Mammography: As of 6/30, there were 36 Alinea mobile mammography events

	scheduled in collaboration with PPGs/Provider clinics statewide, out of which 2 were canceled, 14 were completed and 20 are scheduled to be completed through 9/9/2023. • CalViva held 19 mobile mammography events with Pacific Coast. Nine of those were in Fresno. Two additional dates with Pacific Coast are planned for Dec 8th and 9th. Mammography Incentive Program – Information was shared with Clinical Program Managers. In the process of receiving opt-in documents from PPGs/radiology facilities. • BCS Action Plans: Completed 256 BCS action plans for Provider Engagement statewide. CCS and CHL: 2/2 • Tip sheets for both CCS and CHL. Both posted on the provider library at the link below: https://providerlibrary.healthnetcalifornia.com/medi-cal/materials.html#c. • PE action plans completed for both CCS and CHL statewide.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. No issues were found at this time.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 8/8, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Multi-Gap Calls: As of 12/21/2023, 4,223 CalViva members were reached via the multi-gap call outreach. • Alinea Mobile Mammography: As of 12/31/2023, there were 43 Alinea mobile mammography events scheduled in collaboration with PPGs/Provider clinics statewide, out of which 2 were canceled. • CalViva had 21 mobile mammography events with Pacific Coast, 1 was canceled resulting in 20 events held in Fresno County. • Mammography Incentive Program – 8 provider groups opted into the radiology incentive program.
Year-end barriers/ lessons learned	*Barriers:*

(Populate at year end)	• There were barriers in receiving and collecting CalViva level data on programs such as the Alinea mobile mammography events. Additionally, for the Mammography Incentive Program, the outcomes trackers did not specify CalViva specific impact. *Lesson Learned:* • Evaluate current trackers and reports to identify opportunity for data reporting enhancement and segmentation to allow for appropriate member-level as well as line of business attribution.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

8.2 Childhood Blood Lead Screenings	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☒ Member Experience ☐ Other:
Responsible Person	Juli Coulthurst, Program Manager III Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):**

	Increase overall rates of childhood blood lead screening and anticipatory guidance year over year for Medi-Cal. **Rationale:** To meet DHCS APL-18-017 AND APL 20-016 requirements.
Program Objectives	• Conduct quarterly monitoring of HEDIS® Lead Screening for Children (LSC) administrative rate and anticipatory guidance. • Update member education materials including lead screening flyer and preventative service guidelines (PSGs). • Update provider training and education materials including the Medi-Cal operations manual and HEDIS provider tools on Lead Screening for Children. • Conduct Medical Records Reviews for lead screening during Facility Site Reviews and report to DHCS twice a year. **Prior rate (MY 2021)** (%, ratio)**:** N/A **Final rate (MY 2022)** (%, ratio)**:** 52.09% Refer to Quality Initiatives Tracking System (QITS) log for program activities (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	4/4, 100% All objectives were met by completing all quarterly reports, updating provider and member education materials, and reporting to DHCS.
Mid-Year Activities Update: *(Populate at mid-year*) *Number of Activities Completed at Mid-Year/*	*Completed at (ratio, %):* 3/4, 75% ☐ *Off track (<75%)* ☒ *On track (=>75%)*

Mid-Year Activities Planned; (Percent Completed)	*Updates:* • Ongoing quarterly monitoring of HEDIS LSC administrative rate and anticipatory guidance. • Updated provider trainings and education materials including the Medi-Cal operations manual and HEDIS provider tools on LSC. • Three providers were trained by the Fresno County Lead Poisoning Prevention Program Nurse. • Completed annual blood lead level screening DHCS submission. CalViva identified lower rates in the mid-age group. CalViva is currently investigating the lower rates in the mid-age group. • Updated P&Ps to reflect anticipatory guidance documentation. • Identified high volume providers to assess their process for lead screening to identify providers not currently offering point of care capillary lead screening. Developed process to purchase Lead Care II analyzers and one kit of 48 individual tests for offices.
Mid-Year Performance Goal Update and Improvement Opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely. The California Department of Public Health issued a letter in January 2023 indicating that filter paper would no longer be an acceptable blood lead screening method. The Health Net Vice President, Medical Director escalated this issue to the DHCS hosted health plan medical directors meeting on January 26, 2023 and to CDPH, followed by an email to CDPH. CDPH sent an email response on February 3, 2023 indicating that filter paper lead testing will no longer be accepted. Lead Care II point of care testing is an acceptable lead screening method. CalViva had been promoting MedTox, a newer filter paper for lead screening to providers. CalViva discontinued the promotion of MedTox filter paper and is now identifying providers not currently offering point of care capillary lead screening to receive Lead Care II point of care analyzers.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 4/4, 100% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • Ongoing quarterly monitoring of HEDIS LSC administrative rate and anticipatory guidance. • Collaborated with provider engagement to provide funding to providers who submitted a QI EDGE

	request for POC lead analyzers. • Weekly monitoring of QI EDGE fund requests for POC lead analyzers. • Monthly tracking of providers who received a POC lead analyzers by using PPP report. • Initiated vendor onboarding to purchase POC lead analyzers from contracted vendor.
Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers*: • Providers do not see the return on investment of the equipment. • Providers do not have enough staff to do mandatory blood lead level reporting required by the California Department of Public Health (CPDH). • Initiated vendor onboarding with Merdian Bioscience the manufacturer for the LeadCare II analyzer but once the contracting process began the manufacturer deferred to the distributer McKesson. *Lessons Learned:* • Effective July 1, 2023 CDPH and California Lead Poisoning Prevention Program (CLPPP) is requiring all blood lead level results to be reported. Results ≥ 3.5µg/dL must report within 3 working days of analysis and results ≤ 3.5µg/dL must report within 30 calendar days of analysis. • Anticipatory guidance can be documented using CPT code 83655 along with one of the following codes: 99401, 99402, 99403, 99404. • Obtaining a lead analyzer in the office requires the additional responsibility of creating an Electronic Blood Lead Reporting (EBLR) system account and with reporting all blood lead level screenings to CDPH. • If patients are referred to a lab for blood lead level screenings it is the labs responsibility to report the blood lead level results within the appropriate time frame.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

IX. PROVIDER ENGAGEMENT

9.1 Quality Evaluating Data to Generate Excellence (EDGE)	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☐ Quality of Service ☐ Safety ☐ Member Experience ☐ Other:
Responsible Person	Suvas Patel, Sr. Quality Program Development Manager, Quality Improvement Amy Wittig, Director, QI Tanya Demirjian, Manager, QI Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Have incremental performance improvement (greater than 10%) in EDGE key performance indicator (KPI) categories for CalViva, relative to previous measurement year. **Rationale:** CalViva Health relies on its provider network to improve the quality of care CalViva members receive. Quality EDGE, a collaborative approach between three teams, QI + Dyad (Provider Engagement + Medical Affairs), to help network providers overcome barriers to improving care and HEDIS performance.
Program Objectives	• Incrementally improve quality metrics performance across for high impact priority providers, through

	the Dyad + QI partnership and implementation of Quality EDGE. <u>EDGE KPI Categories Performance for MCAL CalViva (Year-end MY 2022), N=112 Priority Providers:</u> • Priority provider measure performance, MY 2022: final MY 2022 data are pending. ○ Preliminary MY 2022 final, care gap data through April 2023: 13% (Target=65%). • Cozeva adoption for priority providers, YTD 2023*: 97% (Target= 75%). • Priority provider (PE) action planning - adult measures, YTD 2023*: 12% (Target=80%). • Priority provider (PE) action planning - pediatric measures, YTD 2023*: 12% (Target=80%). *Sources: MCAL EDGE KPI Report, 202303 Footnotes: • Cozeva data thru 2/27/23, from Cozeva Practice Mapping File, reflecting adoption rates for MY 2022 priority providers. • Action planning data thru 4/14/23 for action plans with start and end date in MY 2022. • Action planning targets and volume of priority providers are subject to change for MY 2023. Refer to Quality Improvement EDGE Fund activities log (See attachment).
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	Baseline Year, see above KPIs and EDGE Fund activities log. KPI: 1/3, 33.33% Priority provider performance and action planning activities did not meet target. Cozeva adoption for priority providers met target. Q-EDGE: 1/1, 100% The 2023 Quality EDGE requests (87) surpassed the 2022 Quality EDGE requests received (78) goal of 10%.
Mid-Year Progress Update:	*Completed at (ratio, %):* N/A at mid-year.

(Populate at mid-year) *Number of Requests at Mid-Year*	☐ *Off track (<10% increase towards KPI target)* ☐ *On track (=>10% increase towards KPI target)* ☐ *Off track (<10% increase in Quality EDGE requests from prior year)* ☐ *On track (=>10% increase in Quality EDGE requests from prior year)* *Updates:* Number of Quality EDGE funding requests (baseline MY 2023 YTD): Medi-Cal: 50 The strategy this year for Quality EDGE was updated, therefore progress is N/A at mid-year. The same strategy will be used for 2024 and will be able to compare requests volume and KPI data in 2024.
Mid-Year Performance goal update and improvement opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need a higher level of attention are being escalated timely. To support the Quality EDGE process, some of the action plans provider-facing teams (Provider Engagement and Medical Affairs) created in partnership with providers and provider groups needed support to reach jointly agreed upon action plan goals. From January-June 2023, Quality EDGE supported 50 action plans financially. The top three categories of support given are: Mobile Mammography Events, Member Incentives, and Material Support. The total funds granted to providers for January-June 2023 is $227,502.00. Support to providers was also given by provider-facing teams in the form of HEDIS measure trainings, barrier analysis identification, and implementing change management processes to achieve action plan goals.

Year End Progress Update: *(Populate at year end)* *Number of Requests at Year End*	*Completed at (ratio, %):* KPI: 1/3, 33.33%; Q-EDGE: 1/1, 100% ☒ *Off track (<10% increase towards KPI target)* ☐ *On track (=>10% increase towards KPI target)* ☐ *Off track (<10% increase in Quality EDGE requests from prior year)* ☒ *On track (=>10% increase in Quality EDGE requests from prior year)* *Updates:* **<u>EDGE KPI Categories Performance for MCAL CalViva (Year-end MY 2022), N=112 Priority Providers:</u>** • Priority provider measure performance, MY 2022: final MY 2022 data are pending. ○ Preliminary MY 2022 final, care gap data through November 2023: 33% (Target=65%). • Cozeva adoption for priority providers, YTD 2023*: 100% (Target= 75%). • Priority provider (PE) action planning – Focus Measures, YTD 2023*: 45% (Target=80%). <u>Number of Quality EDGE funding requests (baseline MY 2023 YTD):</u> Medi-Cal: 87 Funding Amount for 2023: $467,660 Performance of each measure continues to be monitored biweekly. Improvement opportunities are being tracked and issues that need a higher level of attention are being escalated timely. To support the Quality EDGE process, some of the action plans provider-facing teams (Provider Engagement and Medical Affairs) created in partnership with providers and provider groups needed support to reach jointly agreed upon action plan goals. From January-December 2023, Quality EDGE supported 87 action plans financially. The top three categories of support given are: Equipment/Supplies (implemented strategy to support Lead Screening for Children (LCS) by sponsoring lead screening equipment and supplies for providers); Member Incentives; and Mobile Mammography. The total funds granted to providers for January-December 2023 is $467,660.00 Support to providers was also given by provider-facing teams in the form of HEDIS measure trainings, barrier analysis identification, and implementing change management processes to achieve action plan goals.

	*Footnotes: • Cozeva data thru 11/30/23, from Cozeva Practice Mapping File, reflecting adoption rates for MY 2023 priority providers. • Action planning data thru 11/30/2023 for action plans with start and end date in MY 2022.
Year-end barriers/ lessons learned *(Populate at year end)*	Barriers: • Documentation of updated program processes in current SharePoint site. ○ The Quality EDGE request process will be updated in 2024 when the new SharePoint site is implemented to reflect the programmatic changes of 2023. Lesson Learned: • Coordinated provider action plans that are quality-focused in collaboration with the health plan provider-facing teams is essential to the success of the Quality EDGE program.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☒ *Continue Initiative Unchanged* ☐ *Continue Initiative with Modifications*

9.2 Provider Access, Availability, and Service	
Type of activity/program	☐ New activity ☒ Ongoing activity - (monitoring of previously identified activity) Type of activity/program: ☒ Quality of Care ☒ Quality of Service ☐ Safety

	☐ Member Experience ☒ Other: Provider Experience
Responsible Person	Paul Fuentes, Provider Relations Specialist II Amy R. Schneider, RN Director Medical Management
Program/Indicator Performance Goal	**Goal(s):** Improve access to care: Timely appointments to primary care physicians, specialists, ancillary providers and after-hours access. **Rationale:** Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. The Provider Appointment Access Survey (PAAS) and Provider After-Hours Availability Survey (PAHAS) assess practitioner compliance with access standards and surveying members allows the identification of areas for improvement. • Timely appointment access for primary care physicians and specialists are monitored using the DMHC PAAS Tool and the CalViva PAAS Tool. • Timely appointment access for ancillary providers is monitored using the DMHC PAAS Tool. • After-hours (AH) access is evaluated through an annual telephonic Provider After-Hours Access Survey (PAHAS).
Program Objectives	To meet performance goal for Provider Appointment Access Survey (PAAS) at 70%. To meet performance goal for Provider After-Hours Access Survey (PAHAS) at 90%. **Prior rate (MY 2021)** (%)**:** PAAS: • PCP Urgent: 50.9% • PCP Non-Urgent: 71.4% • Specialists (All) Urgent: 40.2% • Specialists (All) Non-Urgent: 64.8% • Ancillary Non-Urgent: 94.1% PAHAS: • Appropriate Emergency Instructions: 100.0%

	• Ability to Contact On-Call Physicians: 82.0% **Final rate (MY 2022)** (%)**:** PAAS: • PCP Urgent: 49.0% • PCP Non-Urgent: 74.4% • Specialists (All) Urgent: 37.6% • Specialists (All) Non-Urgent: 56.1% • Ancillary Non-Urgent: 89.5% PAHAS: • Appropriate Emergency Instructions: 98.3% • Ability to Contact On-Call Physicians: 91.6% Supporting activities: • By year-end (Q3-Q4 2023), the Plan is working with a new survey vendor to ensure provider barriers to survey responses are addressed for MY 2023 to obtain accurate responses on the survey. • By year-end, implement the annual 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. • By year-end, implement the annual Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability. • By year-end, based on the Provider Appointment Availability and After-Hours Survey results, the Plan implements a Corrective Action Plan (CAP) for providers. On 7/12/23, CAP packets were sent to 10 PPGs and 11 direct network providers. Educational packets were sent to 12 PPGs and 42 direct network providers. CAP review process continues until the end of the year. As of 8/18/23, there were 3 completed CAP reviews. Consecutive Non-compliant PPGs, Groups/Clinics and Direct Network Providers receive the CAP and are also encouraged to attend the Provider Training Webinar and complete an attestation of participation/attendance. • Develop and distribute the annual Provider Updates, with alerts of upcoming appointment and after-hours surveys (in 3rd quarter of every year), and with results of surveys (by 3rd quarter of every year), will include recommendations, tips and tools for improving after-hours access. CalViva will be publishing the provider update and the MY 2022 Provider Appointment Availability

	Survey Excellence Letter and Certificate. • By year end, the Plan's Provider Engagement field staff will annually outreach to providers (PCP offices only) that were found to be non-compliant on Non-Urgent timely access standards year-over-year to understand/discuss barriers and determine next steps for improvement. • The Plan and MHNS reminds all PAAS eligible providers on an annual basis the importance and obligation to respond to the PAAS. • Annually by year-end, the Plan will recognize providers that met both Urgent and Non-Urgent appointment standards for MY 2022. • CalViva Health utilizes a dashboard to address several access reporting metrics at the delegated group level. The dashboard results are discussed at quarterly Management Oversight Meetings (MOM) to address deficiencies and key activities for improvement.
Activities Completion Due Date:	**Mid-Year:** 06/30/2023 **Year-End:** 12/31/2023
Objectives Met (ratio, %):	PAAS measures: (2/5), 40% met the 70% performance goal. PAHAS measures: (2/2), 100% met the 90% performance goal.

Mid-Year Activities Update:
(Populate at mid-year)
 	
Number of Activities Completed at Mid-Year/ Mid-Year Activities Planned; (Percent Completed)
	Completed at (ratio, %): 3/3, 100%
	☐ *Off track (<75%)*
	☒ *On track (=>75%)*
	
	Updates:
	• The MHN reminder outreach was completed in Q2 2023. Additional outreach planned for Q3 2023.
	• The PPG Dashboard was presented to MOM Committee.
	  ○ Q4 2022 update was reported in February 2023.
	  ○ Q3 2023 update was reported in November 2023.

Mid-Year Performance goal update and improvement opportunities:	Performance of each measure is being monitored biweekly. Improvement opportunities are being tracked and issues that need higher level attention are being escalated timely.

	Based on MY 2022 Provider Appointment Availability and After-Hours Survey results, the Plan implements CAPs for providers. Non-compliant PPGs, group/clinics and direct network providers receive the CAPs and are encouraged to attend the provider training webinars. Nonresponsive issues are escalated to Provider Network Management and have open dialogue with providers. For MY 2023, the Plan is working with a new survey vendor to ensure provider barriers to survey response are addressed.
Year End Activities Update: *(Populate at year end)* *Number of Total Activities Completed at Year End/Total Activities Planned for Year; (Percent Completed)*	*Completed at (ratio, %):* 10/12, 83.33% ☐ *Off track (<75%)* ☒ *On track (=>75%)* *Updates:* • The new survey vendor, QMetrics, conducted the DMHC PAAS survey in 2023 which began in August and ended by first week of December 2023. There were trending improvement in compliance rates compared to last year. • The 2023 PAAS and PAHAS surveys were conducted from August through December, and survey results are reflected under MY 2022 final rates in the program objectives. Quarterly outreach was not conducted specific to DHCS EQRO survey due to Provider Engagement (Tier 1 engagement) resource availability. • As of December 2023, all PPGs and direct network providers that received CAP packets have submitted the Improvement Plans and supporting documentation. CAP reviews were completed and all CAPs were closed. As of November 2023**,** the Access and Availability team have conducted 15 provider training webinars with 873 total participants/attendees. Webinar completion certificates were collected and tracked. • Provider updates for MY 2022 PAAS and PAHAS surveys results were distributed in September 2023. The provider update for MY 2023 PAAS survey preparation was released in August 2023. The communications included recommendations, tips and tools for improving compliance with PAAS and PAHAS measures. • Access to Care Champion certificates of recognition for providers who met both urgent and non-urgent appointment standards were sent out to providers in November 2023. • Q3 2023 MOM PPG Dashboard was presented during the MOM Committee meeting in November 2023. Additionally, two activities, the Medi-Cal Appointment Access Survey, and the outreach to providers who were non-compliant on Non-Urgent Timely Access standards, were cancelled due to Provider Engagement priorities and resource availabilities.

Year-end barriers/ lessons learned *(Populate at year end)*	*Barriers:* • Providers may not have sufficient tools and guidance to address member satisfaction with access. • Providers not complying with timely appointments standards. • Members do not have access to or information for urgent care services. • Specialty access issues in certain geographic locations. • Provider practice may be closed to new patients, leading to access issues. • PAAS non-responders. • Providers non-compliance with access standards year-over-year. *Lesson Learned:* • Provider office having difficulty responding accurately to the survey calls due to volume of providers requiring appointment availability responses, busy with patients during normal office hours. Specialty access issues in certain geographic locations. Increase use of telehealth as an alternative service offered by provider offices.
Initiative Continuation *(Populate at year end)*	☐ *Closed* ☐ *Continue Initiative Unchanged* ☒ *Continue Initiative with Modifications*

X. ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Completion Date	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.	B. Head, Sr. Health Education Specialist J. Felix , Sr. Health Education Specialist	Ongoing. December 2023	Ongoing. Information on PSGs are distributed via the annual member newsletters and the new member welcome packets.	☒	12/31/2023	New members receive the PSG guidelines in the new member welcome packet, and are also distributed via the annual members newsletter, which was mailed 9/2023. The Preventive Screening Guidelines was submitted to the November 16th, 2023 QIUM Committee meeting.
2. Adopt and disseminate Medical Clinical Practice Guidelines (CPG).	CalViva Health/HN J. Serratore Director, Clinical Programs	Ongoing. December 2023	CPG grid was updated in May 2023. Provider Communication update planned for July and providers are directed to the healthnet.com site to view the CPG grid.	☒	July 2023	Provider Communication update was completed in July and the CPG grid was posted on the website. The Clinical Practice and Preventive Health Guidelines 2023 was submitted the the QIUM Committee on October 19th, 2023.
3. Monitor CalViva Health Pregnancy Program and identify high risk members via Care Management.	C. Patnuade, Director, Care Management	Ongoing. December 2023	On target.	☐		Year-end metrics are not available yet. Expecting by end of January 2024. Numbers are reported in Case

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
						Management quarterly reports.
4. Maintain compliance with childhood blood lead level screening requirements in accordance with DHCS APL 18-017 and APL 20-016.	T. Demirjian, Manager, Quality Improvement A. Jayme, Quality Improvement Specialist	Ongoing. December 2023	On target. QI is in the process of onboarding Meridian Bioscience as a vendor for the Leadcare II Analyzer machine. Provider-facing team members will be able to request funding to purchase Leadcare II Analyzer machines through Quality EDGE to support the updated LSC strategy.	☐	Q1 2024	QI will develop a Statement of Work with McKesson to purchase Leadcare II Analyzers and supplies. Provider-facing team members will request the Leadcare II Analyzer and equipment through Quality EDGE to support the LSC strategy.
CONTINUITY OF CARE						
1. Monitor opportunities and interventions for NCQA Standards QI.3 & QI.4 Coordination of Care (COC) requirements (non-BH and BH reports).	L. Ciotoli/ M. Rosales Program Manager III, Quality Improvement	Ongoing. December 2023	QI.3 report on track for Q3 reporting. QI.4 report on track for Q3 reporting.	☒	December 2023	First year report submitted on 12/27/23 for consultant review.
DISEASE/CHRONIC CONDITIONS MANAGEMENT						
1. Monitor Chronic Conditions (Disease) Management Program for appropriate	Vanessa Valdivia, Clinical Accounts	Ongoing. December 2023	Ongoing. June 2023	☐	January 2024	Redesign was approved and will launch in

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
member outreach.	Manager; Mark Schweyer, Director, Telehealth Services					January 2024.
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE						
1. Health Equity Report: Analyze and report on Cultural and Linguistics.	D. Fang, Manager, Health Equity	Q2, Q3 2023.	Language Assistance Program End of Year Report and Annual Work Plan Evaluation were completed in Q2 2023.	☒	May 2, 2023	The 2023 Language Assistance Program Mid-Year Evaluation Report and Mid-Year Work Plan Evaluation were completed in Q3 2023.
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s).	P. Fuentes, PR Specialist, Access & Availability	Ongoing. December 2023	PAAS, PAHAS and Telephone Access surveys are conducted in Q3 – Q4.	☒	December 31, 2023	Switched survey vendor to QMetrics and have conducted DMHC PAAS survey and expected to conclude by first week of December 2023. Trending improvement in compliance rates compared to last year.
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date.	P. Fuentes, PR Specialist, Access & Availability	March 2023	MY 2022 DMHC TAR filing completed timely 5/8/23. DMHC revised due date from 3/31/23 to 5/8/23.	☒	5/08/23	Filing was completed.
4. ACCESS SURVEY RESULTS: Monitor appropriate timely appointment and after-hours access and identify noncompliant PPGs and providers.	P. Fuentes, PR Specialist, Access & Availability	Ongoing. December 2023	CAPs for MY 2022 scheduled to be distributed Q3-Q4.	☒	7/12/23	CAP packets were sent to 10 PPGs and 11 Direct Network providers. Acknowledgement of

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
						CAP receipt due within 10 days of notice. CAP Improvement Plan (IP) was due to the health plan August 12, 2023.
5. ACCESS PROVIDER TRAINING: Conduct quarterly webinars.	P. Fuentes, PR Specialist, Access & Availability	Q1, Q2, Q3, Q4 2023.	Provider Training webinars were held in Q2 & July to October (13 more) In Q3: 940 registered 459 attended 166 CalViva Webinar completion certificate required to validate attendance.	☒	5/17/23 5/31/23 6/14/23 6/28/23 7/12/23 7/19/23 7/26/23 8/9/23 8/23/23 9/13/23 9/27/23 10/11/23 10/25/23 11/15/23 11/29/23	The Access & Availability team has Conducted a total of 15 Provider Training Webinars. A total of 873 participants have attended and submitted webinar completion certificate. Answered over 125 questions and shared copy of presentation and Q&As to all attendees for informational only.
6. TELEPHONE ACCESS SURVEY: Conduct quarterly surveys and issue CAPs to noncompliant providers.	P. Fuentes, PR Specialist, Access & Availability	Q1, Q2, Q3, Q4 2023.	Sutherland (3rd party vendor) conducted telephone access survey Q3-Q4 2022. CAP and Educational Packets will be issued to non-compliant providers during Q1-Q2 2023.	☒	12/31/23	Telephone Access survey conducted in Q4 2023 and will end in December with final report generation at the end of January 2024.
7. DHCS MEDI-CAL MANAGED CARE TIMELY ACCESS REPORT SURVEY:	P. Fuentes, PR Specialist, Access &	Q1, Q2, Q3, Q4 2023.	CAPs and educational	☒	9/01/23	Quarterly outreach not conducted specific to

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
Conduct quarterly education outreach to noncompliant providers identified by this survey.	Availability		packets issued to non-compliant providers in Q1 & Q2. Provider training webinars held throughout the year to educate providers on timely access.			DHCS EQRO survey due to Provider Engagement (Tier 1 engagement) resource availability. Year over year PAAS non-compliant providers and DHCS non-compliant providers analyzed for PE activity. Six providers deemed non-compliant in both PAAS and DHCS EQRO were reached out by Provider Engagement.
8. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances review.	D. Saldarriaga; Manager, A&G	Ongoing. December 2023.	On track. Ongoing.	☒	12/31/23	CalViva Health will continue with the process. A&G worked with providers and internal departments to include tracking any potential trends through various committees and workgroups to help resolve member appeals and grievances, as needed.
9. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement. Analyze and inform Provider Network Management of areas needing	D. Fang, Manager, Health Equity	Q3 2023.	Geo Access report will be completed in Q3.	☒	Q3 2023	Geo Access report was completed in Q3.

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
increased contracting with a particular provider to improve availability.						
10. Maintain compliance with DHCS Initial Health Appointment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report.	T. Demirjian, Manager, Quality Improvement	Ongoing. December 2023.	On track.	☒	Q1-Q4 2023	Quarterly IHA reporting completed for 2023.
12. Engage with CalViva provider offices to complete MY 2022 MCAS training focused on best practices for closing care gaps.	A. Wittig, Director, Quality Improvement Jose Gonzalez, Manager, Provider Engagement	Ongoing. December 2023.	On track. From January thru June, there were 520 CalViva providers who received HEDIS trainings.	☒	12/31/2023	CVH providers received MCAS training January-December 2023. The total number of providers trained were 1,698.
13. In collaboration with Provider Engagement, engage with Quality EDGE priority provider offices to complete interventions addressing systemic barriers to HEDIS performance.	A. Wittig, Director, Quality Improvement/ Provider Engagement	Ongoing. December 2023.	On track. Please refer to the Quality Edge initiative in Section 8 as well as the attachment provided.	☒	12/31/2023	Completed for MY 2023. The Quality strategy will continue for MY 2024.
QUALITY AND SAFETY OF CARE						
1. Integrated Care Management (ICM) • Implement PHM pyramid as the predictive modeling tool to identify high-risk members for referral to ICM. • Evaluate the ICM Program based on the following measures: ○ Readmission rates ○ ED utilization ○ Overall health care costs ○ Member Satisfaction	C. Patnaude, Director, Care Management	PHM pyramid: 01/09/2023 ICM: Q1, Q2, Q3, Q4 2023.	On target.	☐		Not complete. Year-end metrics not available. Expecting by end of January 2024. Numbers are reported in Case Management quarterly reports.
CREDENTIALING / RECREDENTIALING						

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
1. Credentialing/Recredentialing Practitioners/Providers: Achieve and maintain a 100% timely compliance and 100% accuracy score.	M. Catello, Manager, Credentialing	Ongoing. December 2023.	On track.	☒	12/31/23	All credentialing and recredentialing activities were completed for 2023. There were no outliers.
2. PPG Delegates Credentialing/Recredentialing oversight achieve and maintain audit scores between 90 -100% compliance for annual review.	M. Catello, Manager Credentialing; K. Bowling, Sr. Manager Delegation Oversight	Ongoing. December 2023.	For the 2023 mid-year, activity remains on track for monitoring the PPGs' delegated activities. Correction Action Plans are issued as applicable. Report findings and ongoing monitoring are reported to CalViva quarterly, annually, and as applicable.	☒	12/20/23	For the 2023 year-end, completed activity for monitoring the PPGs' delegated activities. Correction Action Plans are issued as applicable. Report findings and ongoing monitoring are reported to CalViva quarterly, annually, and as applicable.
Delegation OVERSIGHT/ BEHAVIORAL HEALTH						
1. Conduct oversight of Behavioral Health (BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	M. Cashman, Sr. Director, QI MHN	Ongoing. December 2023.	On track: MHN QI has presented required performance tracking reports and has initiated the annual surveys (member	☒	12/26/23	MHN Services presented the remaining 2023 Performance Indicator Reports to the CalViva QI/UM and Access Workgroups; no corrective actions were necessary in 2023.

Activity	Activity Leader	Completion Date	Mid-Year Update	Year End (YE)		
				Complete?	Date	YE Update or Explanation *(if not complete)*
			satisfaction, provider satisfaction and PAAS). There were no instances of non-compliance to correct.			The member satisfaction survey results review and discussion led to two provider- facing interventions intended to improve the member experience receiving and understanding clinical information provided by their BH provider.
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 APL 22-107 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 and 15-023.	P. Carpenter, Director, Quality Improvement	Ongoing. December 2023.	On track.	☒	12/31/23	Completed.
2. Complete all potential quality issues (PQIs) received within 90 day TAT to maintain compliance with regulatory requirements.	P. Carpenter, Director, Quality Improvement	Ongoing. December 2023.	To date, all cases were completed within TAT.	☒	12/31/23	Completed.
3. Evaluation of the QI program of the previous year. Complete QI Work Plan evaluation annually.	A. Wittig, Director; T. Demirjian, Manager; Quality Improvement	Q1 2023.	Completed in Q1.	☒	2/8/2023	Completed.

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

Item #10
Attachment 10.A-10.B

2023 Annual Utilization Management
Case Management Workplan Evaluation

- Executive Summary
- Year End Evaluation

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO:	CalViva Health QI/UM Committee Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Patrick Marabella, MD, Chief Medical Officer Amy Schneider, RN, Director Medical Management
COMMITTEE DATE:	February 15, 2024
SUBJECT:	2023 CalViva Utilization Management/Care Management Work Plan End of Year Evaluation Executive Summary

Summary:

On an annual basis, CalViva Medical Management assesses the overall effectiveness of the Utilization Management Care Management Program by evaluating the structures, consistency, timeliness, adequacy, and availability of the programs and services offered to our members. CalViva Health (CalViva) has delegated responsibilities for utilization management and care management (UM/CM) activities to Health Net Community Solutions, Inc. (Health Net), but CalViva oversees the UM/CM Programs. CalViva's UM/CM activities are handled by qualified staff at Health Net including physicians, nurses, behavioral health practitioners, data analysts, and other administrative staff.

Utilization Management (UM) processes have been consistent, and evaluation/monitoring of UM metrics continue to be a priority. Both Care Management and Disease Management continue to monitor the effectiveness of programs to identify opportunities to enhance services.

The annual work plan includes a variety of metrics (see attached full work plan evaluation) in order to perform this global assessment with clearly stated, quantifiable measures. All measures, except the two metrics listed below were identified to meet objectives for the year-end evaluation reporting period:

- 1.4 Periodic Audits for Compliance with Regulatory Standards
- 3.3 PPG Profile

Purpose of Activity:

The purpose of this activity is to determine if the UMCM Program remains current and appropriate, therefore at a minimum, CalViva annually evaluates the:

- Program structure.
- Program scope, processes, information sources used to determine benefit coverage and medical necessity.
- Level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program.
- Member and practitioner experience data when updating the program.

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

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

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

Analysis/Findings/Outcomes:

1. **UMCM Committee Structure**

In 2023, CalViva's UMCM Program was successfully supported by the CalViva QI/UM Committee which met seven times. The committee supervised the UMCM Program, provided feedback, decision support, and recommendations for the UMCM program throughout the year. The QI/UM Committee reported to the CalViva RHA Commission six times in 2023. CalViva's QIUM Committee structure is supported by the HNCS Committee structure as noted in the Annual Program Description.

The QI/UM Workgroup supports the efforts of the QI/UM Committee by scheduling, receiving, reviewing, editing, and approving reports for presentation at the QI/UM Committee. QI Workgroup aids in the identification and pursuit of opportunities to improve health outcomes, safety, access and member and provider satisfaction. Significant findings and follow-up were reported to the QIUM Committee and RHA Commission.

The QI/UM Workgroup met thirty-four (34) times in 2023 and was chaired by CalViva's Chief Medical Officer. Members of the Workgroup consisted of CalViva staff including Director of Medical Management (who is a Registered Nurse) and a Manager of Medical Management Services; and Health Net staff from Utilization and Care Management, Quality Improvement, Appeals and Grievances, Health Equity, Pharmacy, Credentialing, Customer Contact Center, Population Health Management, Provider Network Management, and Provider Relations. The Workgroup conducted review of UMCM routine and special reports and discussions of monitoring of UMCM activities, findings, barriers, and interventions to develop and implement actions.

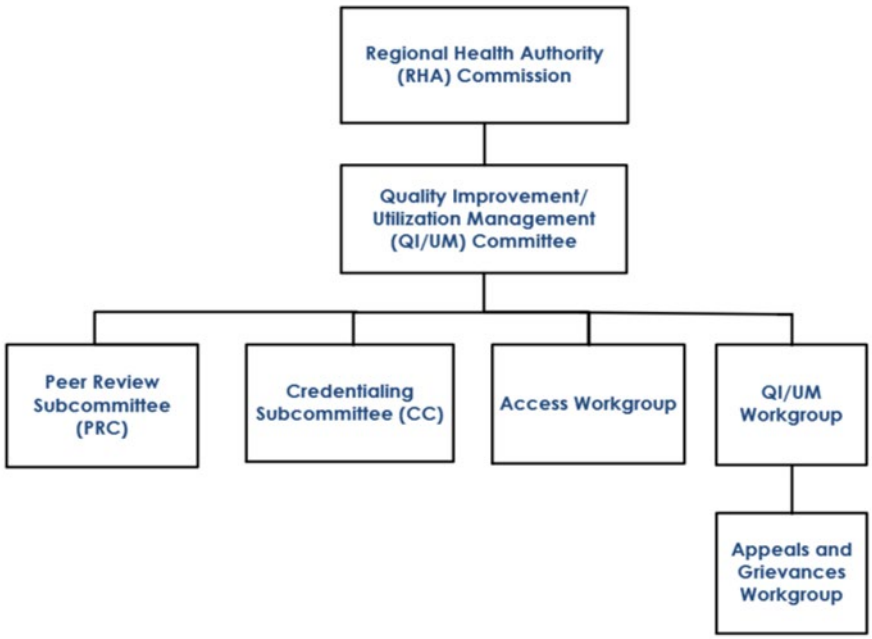
The Appeal and Grievance Workgroup reports to the QI/UM Workgroup and supports the UMCM program through the review and analysis of appeal and grievance data. The Workgroup processed, tracked and trended member grievances and appeals for 2023 at the provider and plan level evaluating for type, severity, volumes, rates, and the identification of opportunities for improvement. The Workgroup submitted reports to the QI/UM Workgroup and Peer Review Subcommittee to review, act, and follow-up on identified significant events or trends. The Appeals and Grievances Workgroup met nine times in 2023.

The CalViva Health Access Workgroup reports directly to the QI/UM Committee through quarterly reports and committee minutes. This access focused Workgroup included representatives from CalViva Health and Health Net departments with access and network adequacy related functions. The Workgroup reviewed findings from ongoing monitoring of access to plan services, identified gaps, and developed and evaluated activities that addressed those gaps in access to care. The Workgroup submitted issues that required escalation to the Management Oversight Meeting ("MOM"), QI/UM Committee and/or RHA Commission for final decision and approval of recommended actions. CalViva's Access Workgroup met seven times in 2023.

CalViva's Credentialing and Peer-Review Subcommittees also successfully supported CalViva's UMCM Program, as demonstrated in the organizational chart below. The subcommittees met 4 times each in 2023.

Please refer to the 2023 Utilization Management and Care Management Program Descriptions for more information on the committees and sub-committees.

CalViva's Quality Improvement Utilization Management Committee Organizational Chart



2. Compliance with Regulatory & Accreditation Requirements

All Compliance activities met objectives for this end of year evaluation with no barriers identified with the exception of work plan activity 1.4 Periodic Audits for Compliance with Regulatory Standards.

3. Periodic Audits for Compliance with Regulatory Standards (work plan activity 1.4)

Compliance with the following letter requirements were not met in all periods in 2023: clear and concise, criteria guideline used, Plan name reference, and incorrect font size.

Additionally, a required statement in the A&G letter template was not verbatim with DMHC requirement which resulted in a CAP in Q4-2023.

Barriers included:

- Use of clinical verbiage resulted in failure to consistently meet clear and concise letter requirements.
- The correct process for adding out of network providers to TruCare (clinical documentation system) was not followed. This resulted in inaccurate provider information in the letters.
- There was no standard guidance from management to MD's on how to reference Concert Genetics guidelines.

Actions taken:

- Quarterly additional training and individual coaching were completed in 2023 regarding use of clear and concise language.

- Referral Specialists were coached and retrained on process for provider additions in TruCare.
- The Plan incorporated sample cases for denial letter language in 2023 in group meetings with UM Medical Directors to critique denial verbiage used and provided job aids to streamline the process.

- Revised job aids and Work Processes on how to populate the referring provider within the letter, how to meet clear and concise language standards, as well as, how to address Concert Genetic specific criteria within a letter.

- The A&G letter template correction was submitted to compliance for approval and subsequently moved to production in January 2024. Teams will work to ensure CAP closure.

Additional activities conducted:

a. Annually review, approve, and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making.

   All clinical policies were reviewed and updated annually. Policies are posted on the healthnet.com site and providers are notified of changes quarterly via fax and web. No barriers were identified.

   A summary of the annual review and edits of the UMCM Policies and Procedures was presented and approved at the November 16, 2023, CalViva QI/UM Committee. A complete redline version of all new policies and policies with substantial changes was presented and reviewed at this meeting.

b. Evaluate inclusion of new technologies and new application of existing technologies in applicable benefit packages including medical, behavioral procedures, pharmaceuticals, devices, and new application of existing technologies.

   Clinical policies are developed for new technology and new uses of established technology as needed and brought to the monthly Medical Advisory Council for review and approval. No barriers were identified.

4. Monitoring the Utilization Management Process

UM Process Monitoring activities met objectives for this end of year evaluation.

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

The Plan monitored TAT as planned throughout 2023 and met all goals of 95% or better. TAT was met with 99% or better in all areas and quarters with the exception of Pre-Service Routine Deferrals; there was one deficiency in January 2023 resulting in a 96.85% TAT for the quarter.

Barriers identified:

PA Deferral Turn Around times was impacted in January by the following:

1. Staff not calculating deferral pend timeframe correctly, and
2. not selecting all recipients for Deferral Letters.

Action taken:

- As a result of the preservice deferral TAT failures, retraining was provided to staff members and staff work was monitored.

Additional activities conducted:

a. Review annual member and practitioner surveys to assess satisfaction with UM process and to address areas of dissatisfaction.

b. CalViva utilizes Health Net's provider network who participate in an annual provider survey coordinated by Centene. The 2022 survey results were evaluated, and highlights and trends presented to the QIUM Committee at their September 2023 meeting. The 2023 annual survey was completed in 2023. Results will be assessed and presented in Q1 2024.

c. Regulatory CAHPS member satisfaction surveys were completed in 2022. Results were reviewed and analyzed. Trends and highlights were presented at the CalViva QIUM Committee at the September 2023 meeting. Regulatory CAHPS member satisfaction surveys were completed in 2023. Results were reviewed and analyzed with trends and highlights presented at the HN CAHPS work group in Q4. Results will be provided to CalViva in Q1 2024.

d. Member grievances were monitored to address findings of dissatisfaction.

No barriers were identified.

5. Monitoring Utilization Metrics

All Monitoring Utilization Metrics activities met objectives for this end of year evaluation with the exception of work plan activity 3.3. PPG Profile.

a. Improve Medi-Cal shared risk and FFS UM acute in-patient performance (work plan activity 3.1)

Acute inpatient performance met the target of a 2% reduction in bed days, average length of stay (ALOS) and readmission rates. SNF facility staffing was a challenge which created barriers to finding placement in SNFs for some higher acuity patients leaving the acute hospital.

Metric	2022	2023 Q1-Q2	% Change
Bed Days Acute PTMPY	239.9	218.8	-9%
Admits PTMPY	63.9	62.8	-2%
ALOS Acute	5.2	5.1	-2%
Readmit 30 Day	9.9%	9.4%	-6%

b. Over/under utilization (work plan activity 3.2)

Activities met objectives however barriers include:

- Sante's quality director position remains open.
- Paper-based charts and slow Cozeva adoption remain barriers.
- Cultural, linguistic and health equity concerns in serving diverse populations with unique needs and beliefs in accessing care.
- Change in MSO for some PPGs (CVMP, LaSalle) has posed challenges in reporting.
- MMN (Meritage) membership transitioning to direct network in beginning of 2024.
- Workforce development and succession planning challenges
- Aging technology infrastructure and need for upgrades.
- Reluctance among small practices to take advantage of state funding (Equity & Practice Transformation)
- Limited adoption of registries (e.g. Cozeva) and virtual consults to drive improvements in quality and access.

- Substance use limited behavioral health access and social drivers of health remain major drivers of utilization.

c. PPG Profile (workplan activity 3.3)

Activities related to PPG Profile performance did not meet objectives. Annual audit reviews resulted in corrective action plans (CAPs) for PPGs due to falling below turnaround time targets, denials, access to staff, appropriate professionals and delegation. CAPs identified during the annual audits were monitored and followed-up by HN Delegation Oversight and reported to CalViva.

Barriers identified:

- Specialty access continues to be a challenge for PPGs.
- Specialists' inconsistent use of auth number while submitting claims is a barrier to accurately tracking time to closure.
- Lack of closed loop referral between auth and claims processing systems
- LaSalle has by far the largest volume of specialty referrals and 'service date not reported'. It is skewing the 'service date not reported' rate.
- MSO transition (CVMP, LaSalle) is exacerbating timely processing of specialty referrals.
- Meritage reported issues with denial criteria hierarchy and letter date.
- Adventist barriers were related to system issues, call scripts and staff training.
- Sante Urgent TAT was below 95% in Q1 due to office closure on holidays.
- Sante experienced high OON authorizations in Q1 due to transition from Community Health.

Actions taken:

- Methodology updated to include Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance.
- We have partnered with provider network management to address delays in access.
- Partnered with new MSO and CVMP on opportunities for improvement and implementation of corrections were made and improvement seen in denial letter files post actions.
- Promoted use of eConsults for non-procedural specialty referrals
- MSO and Provider Engagement (PE) will educate specialist network to consistently use auth number while submitting claims.
- Meritage has issued staff training regarding their hierarchy and is working with their software vendor to resolve their denial letter issue.
- IMG issued additional timeliness and plain language training.
- Sante was educated on 72-hour TAT requirements and added provisions to address future holidays.
- As of 09/01/2023, Sante has tightened UM reviews of OON specialty requests. Improvements are reflected in their internal reporting. It will take a few quarters for this to be reflected in health plan reporting.

6. Monitoring Coordination with Other Programs and Vendor Oversight

All activities related to monitoring coordination with other programs and vendor oversight met objectives for this end of year evaluation.

a. Care Management (CM) Program (workplan activity 4.1)

Activities met objectives however barriers identified include:

- Fewer than expected number of satisfaction surveys completed. Care Managers encourage members to take surveys and gain preferred contact method by member for survey.

- Decreased referrals from Concurrent Review to some programs due to restructuring of Transition of Care program. As a result, the teams utilized additional reports for outreach.

b. Behavioral Health Case Management Program (workplan activity 4.3)

Activities met objectives however the following barrier was identified:

- Reduced referrals from MHN and County partners as all referrals are now handled according to the DHCS-mandated screening and referral process as outlined in APL22-028. This process resulted in increased referrals from MHN to the County behavioral health departments. The members referred tend to be of higher acuity and often receive case management and comprehensive services through the Counties. MHN continues to refer members that need additional follow up.

Actions taken:

- Increased referrals from ADT reports. Utilized post discharge report for referral source.

c. Behavioral Health Performance Measures (workplan activity 4.7)

Activities met objectives, however barriers identified include there were 35 non-ABA reviews in Q1 2023 and 34 were compliant with timeliness standards. Even though non-ABA authorization timeliness did not meet the 100% target, it exceeded the threshold for action of 95%.

7. Monitoring Activities for Special Populations

All monitoring activities for special populations met objectives for this end of year evaluation and no barriers were identified.

8. Adequacy of UMCM Program Resources

Based upon the results of the 2023 monitoring activities noted above and within the attached full Work Plan, CalViva has determined that program resources met the needs of CalViva membership and providers. Timeliness standards were consistently met, and Care Management volumes have increased throughout the year without a decrease in satisfaction or quality. Utilization metrics met the goal of a 2% decrease in bed days, acute admissions, length of stay and readmissions. A new Long-Term Services and Supports Liaison position was created and filled for the CalViva region as the state moved responsibility for Long Term Care to the Medi-Cal Managed Care Plans in 2023. Satisfaction data reports noted a number of results consistent with previous years with some improvements and some opportunities for improvement identified. Improvement in timeliness of referrals was identified as an opportunity and determined to be consistent with grievance data when analysis was performed.

9. Program Scope, Processes, Information Sources

The scope of services offered to CalViva members meets the state of California requirements for Medi-Cal Managed Care Plans. Evidence of this is provided by CalViva's most recent annual DHCS survey (2023) which had only one deficiency identified. Ongoing out-reach efforts to CalViva membership demonstrates a commitment to informing and engaging members in the programs and services available to them. From prenatal services to Behavioral Health Case Management, to Enhanced Care Management and Community Supports services and many more, appropriate benefits and services are available for all members. Identification of opportunities to improve processes, care, and service is something that CalViva and HNCS continually work on together. Ongoing monitoring of interventions is essential for all areas to ensure appropriate actions are being taken to meet goals.

Clinical criteria involved in UM decision-making must be reviewed by appropriate individuals at a minimum annually. Centene's Corporate Clinical Policy Committee and HN California's Medical Advisory Council (MAC) review and

approve policies on clinical criteria annually. Clinical practice guidelines are reviewed and approved at least every two years. UM clinical criteria, medical policies and clinical practice guidelines need to be available to providers.

In 2023, Health Net of California's Medical Advisory Council (MAC) in conjunction with Centene's Corporate Clinical Policy Committee reviewed, updated as necessary, and approved policies for clinical criteria for UM decision making. These updated clinical criteria and clinical practice guidelines were presented to and adopted by the CalViva QI/UM Committee at the October 19th, 2023, committee meeting. Medical policies were reviewed and adopted by the CalViva QI/UM Committee at least quarterly in 2023.

UM clinical criteria and UM clinical practice guidelines are made available to practitioners via the healthnet.com site and practitioners are notified of new policies and changes via the Quarterly Medical Policy provider fax. are available to providers upon request; Change Healthcare, Inc.'s InterQual criteria are also available to providers upon request.

10. Practitioner Participation and Leadership Involvement in the UM Program

The CalViva committee structure ensured that external and internal physicians with various specialties participated in the oversight, monitoring, evaluation, and improvement of the UMCM Program. Six external providers were participants in the QI/UM Committee and both the Credentialing and Peer Review Sub-Committees with specialties in Pediatrics, Family Medicine, behavioral health, Internal Medicine, Obstetrics and Gynecology, and general surgery. CalViva's Chief Medical Officer chaired the committees and invited external practitioners to participate. The behavioral health provider (psychologist) has attended all meetings since her appointment to the QI/UM Committee in June 2023. She actively participates in the review, discussion, and decision making for reports, data, and performance improvement activities related to behavioral health.

Practitioner involvement in 2023 included: reviewing and approving the 2022 UMCM Work Plan Annual Evaluation, and the 2023 UMCM Work Plan and 2024 Program Descriptions for both Utilization Management and Case Management. Practitioners discussed monitoring results of performance. Practitioners were also involved in discussions regarding opportunities for improvement based upon findings and experience.

CalViva's Chief Medical Officer and Director of Medical Management RN participate in weekly Multi-disciplinary Care Rounds with the Health Net Concurrent Review team to assess adequacy of care and address barriers to discharge for high-risk members.

Health Net ensures senior physician involvement in the planning, design, implementation, and review of the UMCM program. This includes the behavioral health aspects of the UM Program. MHN was the HN behavioral health affiliate who provided mental health services to CalViva membership in 2023. MHN's leadership and staff provided reports, participated in improvement activities, and attended monthly meetings with CalViva's Medical Management Team, and appropriate QI/UM Workgroup meetings in 2023. See attached full Work Plan Annual Evaluation for more information.

CalViva Health
2023
Utilization Management (UM)/ Case Management (CM)
Work Plan
End of Year Evaluation

Last updated: February 8, 2024

TABLE OF CONTENTS

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 Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide minimum 4 clinical continuing education opportunities to staff. Conduct Population Health and Clinical Operations (PHCO) Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Ongoing As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in the first half of 2023: **January:** Post Partum Depression **February:** Covid and the immunocompromised **March:** Palliative Care **May:** Riding the Waves of Change New hire overview training is offered monthly for all new hires. Medical management onboarding classes are offered and completion is monitored through our online learning management system. Ongoing process are in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform).	None identified	None	Ongoing

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	The following monthly clinical education (CE) and Quality Improvement (QI) in-services were offered to all nurse and MD reviewers in 2023. **January:** Post Partum Depression **February:** Covid and the immunocompromised **March:** Palliative Care **May:** Riding the Waves of Change Courses offering clinical continuing education units (CEUs) are available to team members through the Plan's online learning management system. Reimbursement is offered to staff for CEU courses provided outside of the Plan. Clinical courses that include CEUs are also offered to the external Provider community and internal staff are able to attend. New hire overview training was offered monthly for all new hires. Medical management onboarding classes were offered and completion was monitored through our online learning management system. Training materials were reviewed and revised as needed. Ongoing process in place to monitor and ensure continued licensure for qualified health professionals via WorkDay (human resource platform). IRR training and testing was completed.	None identified	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to PHCO processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Reviewed new legislation and regulations, received from the Compliance Department and/or the Regulatory and Legislative Implementation committee. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Reviewed new legislation and regulations, either through e-mail or department presentation. Participated in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participated in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	None identified	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and reminded annually thereafter. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire. Annual reminders will be distributed in Q3-2023. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' upon hire and are reminded annually thereafter. Annual reminders were distributed to all staff in August 2023. No MIP Goals created that benefit MDs or Nurse reviewers based on any potential to deny care.	None	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing January 2023, April 2023, July 2023, October 2023

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Ongoing monthly regulatory standard auditing continues of 30 sample size per metric. When a variance from compliance standards is identified, sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented Program Metrics Reporting (PMR) meeting.	None identified	None	Ongoing
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Ongoing monthly regulatory standard auditing continues. When a variance from compliance standards is identified sample size is increased to 50 as well as a CAP submission and staff education completed as evidenced by CAP tracking within the Compliance and Auditing departments. Auditing results presented to the Program Metrics Reporting (PMR) meeting and with CalViva Health. Compliance with the following letter requirements were not met in all periods in 2023: clear and concise, criteria guideline used, Plan name reference and incorrect font size. Required statement in the A&G letter template was not verbatim with DMHC requirement which resulted in a CAP in Q4-2023.	Use of clinical verbiage resulted in failure to consistently meet clear and concise letter requirements. The process of adding out of network providers to TruCare was not followed. This resulted in inaccurate provider information in the letters. There was no standard guidance from management to MD's on how to reference Concert Genetics guidelines.	Quarterly additional training and individual coaching were completed in 2023 regarding use of clear and concise language. Referral Specialists were coached and retrained on process for provider additions in TruCare. The Plan incorporated sample cases reviewed of denial letter language in 2023 in group meetings with UM Medical Directors to critique denial verbiage used and provided job aids to streamline the process. Revised job aids and Work Process on how to populate referring provider within the letter, to meet clear and concise as well as incorporate how to address Concert Genetic specific criteria. The A&G letter template correction was submitted to compliance for approval and subsequently moved to production in January 2024. Teams will work to ensure CAP closure.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2023. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for the first two quarters in the year.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Monthly and quarterly reports to CalViva and Medical Director and Chief Medical Officer continue. Health Net Medical Directors and the CalViva Chief Medical Officer participated in the DHCS Medi-Cal Managed Care Division's Medical Directors meetings for all quarters in the year.	None identified	None	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 as needed and 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 PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2023 UM and CM Program Descriptions. Write and receive CalViva approval of 2022 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2023 UMCM Work Plan. Write and receive CalViva approval of 2023 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2023 Q 1 2023 Q 1 2023 Q 3 2023 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	The 2022 Year End UM/CM Work Plan Evaluation, 2023 UM/CM Work Plan, 2022 UM Program Description and the 2023 CM Program Description were submitted and approved in Q1 2023. Continued assessment of needs to review and revise the program materials or policies and procedures based on DHCS, DMHC and other regulatory requirements is ongoing.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	The 2022 Year End UM/CM Work Plan Evaluation, 2023 UMCM Work Plan, 2023 UM Program Description and the 2023 CM Program Description were submitted and approved in Q1-2023. The 2023 UMCM Work Plan Mid-Year Evaluation was submitted and approved in Q3-2023. CalViva continues to monitor and revise policies and procedures based on DHCS, DMHC and other regulatory requirements.	None	Senior Physician involvement is ensured, including behavioral health aspects of the UM Program.	Ongoing

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Turnaround times (TAT) • Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. Increase staff to prepare for the long-term care benefit carve in and ensure continuity of care.	Ongoing

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

☒ ACTIVITY ON TARGET

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

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

A Long-Term Care (LTC) Specialist Social Worker based in Fresno was onboarded in 2023 to support the transition to Skilled Nursing Facility (SNF). The LTC Specialist attends clinical rounds, engages with SNFs and supports acute hospitals with challenging discharges.

<table>
<tr><th></th><th colspan="3">Authorization Volume</th></tr>
<tr><th>Months</th><th>Approved</th><th>Denied</th><th>Modified</th></tr>
<tr><td>January</td><td>5171</td><td>810</td><td>53</td></tr>
<tr><td>February</td><td>4662</td><td>483</td><td>32</td></tr>
<tr><td>March</td><td>5719</td><td>941</td><td>42</td></tr>
<tr><td>April</td><td>4667</td><td>521</td><td>73</td></tr>
<tr><td>May</td><td>5284</td><td>535</td><td>66</td></tr>
<tr><td>June</td><td>6005</td><td>1035</td><td>72</td></tr>
<tr><td>Totals</td><td>31508</td><td>4325</td><td>338</td></tr>
</table>
</td>
<td>None identified</td>
<td>Q3-Q4: Contract, educate and train 49 Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) homes on how to work with the health plan in preparation for carve-in on 1/1/24.</td>
<td>Ongoing</td>
</tr>
</table>

Annual Evaluation

☒ **MET OBJECTIVES**

☒ **CONTINUE ACTIVITY IN 2024**

The Health Net leadership team meets daily to review reports to track turn-around times (TAT), current inventory and staffing resources. Daily goals, action plans, barriers are discussed and staffing adjustments are made in order to meet TAT goals.

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

	Authorization Volume		
Months	**Approved**	**Denied**	**Modified**
January	5171	810	53
February	4662	483	32
March	5719	941	42
April	4667	521	73
May	5284	535	66
June	6005	1035	72
July	11615	3203	60
August	15496	5262	67
September	5845	1061	61
October	4930	669	85
November	4741	587	70
December	4070	480	63
2023 Totals	**78205**	**15587**	**744**

Prior year for comparison:

2022 Totals	**67869**	**12443**	**681**
2021 Totals	**76,001**	**12,236**	**463**
2020 Totals	**71,516**	**12,236**	**369**

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

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<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The plan met all TAT goals of 95% or better in the first half of the year.

<table>
<tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th></tr>
<tr><td>Pre-Service Routine</td><td>100%</td><td>100%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>96.85%</td><td>100%</td></tr>
<tr><td>Pre-Service Expedited</td><td>100%</td><td>99.09%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service with Extension/Deferral</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Concurrent</td><td>100%</td><td>100%</td></tr>
</table>
</td>
<td>None</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2024</td>
<td>The Plan monitored TAT as planned throughout 2023 and met all goals of 95% or better. TAT was met with 99% or better in all areas and quarters with the exception of Pre-Service Routine Deferrals; there was one deficiency in January 2023.

<table>
<tr><th>Authorization TAT</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Pre-Service Routine</td><td>100%</td><td>100%</td><td>100%</td><td>99%</td></tr>
<tr><td>Pre-Service Routine with Extension/Deferral</td><td>96.85%</td><td>100%</td><td>98.88%</td><td>100%</td></tr>
<tr><td>Pre-Service Expedited</td><td>100%</td><td>99.09%</td><td>100%</td><td>99%</td></tr>
<tr><td>Pre-Service Expedited with Extension/Deferral</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Post Service</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Concurrent</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
</td>
<td>PA Deferral Turn Around times was impacted in January by the following:

1. Staff not calculating deferral pend timeframe correctly, and
2. not selecting all recipients for Deferral Letters.</td>
<td>As a result of the preservice deferral TAT failures retraining was provided to staff members and staff work was monitored.</td>
<td>Ongoing</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	PHCO Learning and Development annually administers Change Healthcare InterQual® IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews The minimum passing score is 90% on each InterQual® IRR test	Provide training to leadership focused on IRR testing CAP documentation and monitoring. Administer the Change HealthCare InterQual IRR test in Q3-Q4 2023 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews.	Q1-2023 Q3-4 2023

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Training focused on IRR testing CAP documentation and monitoring provided to leadership Q1-2023. IRR testing and training will be held Q3-4 2023	None identified	Repeat training to leadership regarding CAP documentation and monitoring in for IRR testing in Q3-2023.	12/31/2023
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Training focused on IRR testing CAP documentation and monitoring provided to leadership Q1-2023 and Q4-2023. 2023 InterQual Annual Summary of Changes and Road to Successful IRR training was provided. Annual InterQual IRR testing followed and was completed in Q3-Q4 2023. The Optum (formerly Change HealthCare) InterQual IRR testing was administered to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews requiring a minimum score of 90% to pass. Final Pass Rate for InterQual IRR 2023 was 97%	None identified	None	12/31/2023

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. 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. 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. 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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<tr>
<td>Mid-Year Report

☒ ACTIVITY ON TARGET

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

Not medically necessary (184) and Balance Billing (2) appeals remain two top trends during the review period. The top two subclassifications were diagnostic – MRI (46) and Surgical - Arthroscopy with 26.

Same specialty matched physicians were engaged when appropriate.

Turnaround Time Compliance for resolved expedited and standard appeals was 100% for all 189 cases.
<table>
<tr><th colspan="3">2023 Semi-Annual Count of Appeal Type</th></tr>
<tr><th>Appeal Type</th><th>Case Count</th><th>Percentage</th></tr>
<tr><td>Overturn</td><td>107</td><td>56.61%</td></tr>
<tr><td>Uphold</td><td>77</td><td>40.74%</td></tr>
<tr><td>Partial Uphold</td><td>4</td><td>2.12%</td></tr>
<tr><td>Withdrawal</td><td>1</td><td>0.53%</td></tr>
<tr><td>Case Total</td><td>189</td><td>100%</td></tr>
</table>
</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2024</td>
<td>Appeals data is a consistent component of UM/QI and is tracked on a routine and ongoing basis. Activity will be ongoing to ensure quality outcomes are met.

Appeals of UM Appeal determinations for time frame January – December 2023 Turnaround Time Compliance for Appeals = 99.72% or 360 out of 361 cases.

Not medically necessary (351) and Services Available in Network (3) appeals remain two top case types during the review period. The top two subclassifications were diagnostic – MRI (90) and Other - Self Injectable Medication (45).</td>
<td>None identified</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

2023 Annual Count of Appeal Type		
Appeal Type	Case Count	Percentage
Overturn	203	56.23%
Uphold	147	40.72%
Partial Uphold	10	2.77%
Withdrawal	1	0.28%
Case Total	361	

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 PHCO manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days	Establish 2023 utilization goals once 2022 outcomes are available. Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. Leverage Member Connections to support on-site bed side enrollment of members into programs such as MedZed, CalAim, Complex Care Management and Community Supports. Explore areas for on-site support (clinical or non).	Q1-2023 Ongoing

<table>
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☐ TOO SOON TO TELL</td>
<td>The Plan continued care management initiatives for all members. Interdisciplinary meetings occur weekly with CalViva Health and Daily with Case Management and Public Programs teams.

Member Connections support of on-site bed side enrollment to be executed in Q4.
2023 Utilization goals established as:
• ALOS: 2% overall decrease
• Bed day per 1K: 2% overall decrease
• Readmission: 2% overall decrease

Key Indicator Report thru 6/30/2023:
<table>
<tr><th>Metric</th><th>2022</th><th>2023 Q1-Q2</th><th>% Change</th></tr>
<tr><td>Bed Days Acute PTMPY</td><td>238.2</td><td>216.3</td><td>-9%</td></tr>
<tr><td>Admits PTMPY</td><td>63.7</td><td>63.2</td><td>-1%</td></tr>
<tr><td>ALOS Acute</td><td>5.3</td><td>5.1</td><td>-4%</td></tr>
<tr><td>Readmit 30 Day</td><td>9.8%</td><td>9.2%</td><td>-6%</td></tr>
</table>
</td>
<td>SNF facility staffing continues to be a challenge which creates barriers to finding placement in SNF for some higher acuity patients leaving the acute hospital.</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

<table>
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☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2024</td>
<td>The Plan continued telephonic care management activities for members including involvement with the medical directors and interdisciplinary teams throughout 2023 including daily UM huddles and weekly huddles with key hospitals.

2023 Utilization goals established as:
• ALOS: 2% overall decrease
• Bed day per 1K: 2% overall decrease
• Readmission: 2% overall decrease

Based on data through November 2023, results of our goals to acute bed days, ALOS and readmission utilization by 2%, are on target to be met.

<table>
<tr><th>Metric</th><th>2022</th><th>2023 Jan-Nov</th><th>% Change</th></tr>
<tr><td>Bed Days Acute PTMPY</td><td>239.9</td><td>218.8</td><td>-9%</td></tr>
<tr><td>Admits PTMPY</td><td>63.9</td><td>62.8</td><td>-2%</td></tr>
<tr><td>ALOS Acute</td><td>5.2</td><td>5.1</td><td>-2%</td></tr>
<tr><td>Readmit 30 Day</td><td>9.9%</td><td>9.4%</td><td>-6%</td></tr>
</table>
</td>
<td>SNF facility staffing was a challenge which created barriers to finding placement in SNF for some higher acuity patients leaving the acute hospital.</td>
<td>None</td>
<td>Ongoing</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. Specialty referrals for target specialties PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis.	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 2023 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPG's with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Reevaluate appropriate metrics to be included in the PPG dashboard. Specialties and PPG's identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional 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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<td>Mid-Year Report

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Quarterly PPG UM data presented at CalViva Management Oversight Meetings.
Shifts in utilization were reviewed in quarterly JOMs with PPGs.

Q4 2022 – Q1-2023 Utilization (Q2 not yet available)
<table>
<tr><th>Metric</th><th>Q</th><th>Admits/ K</th><th>Bed Days/K</th><th>ALOS</th><th>% 30-Day Readmit</th><th>ER/K</th></tr>
<tr><td rowspan="2">CVMP</td><td>Q4</td><td>106.7</td><td>642</td><td>6.01</td><td>15.60%</td><td>527.7</td></tr>
<tr><td>Q1</td><td>87.9</td><td>511.1</td><td>5.81</td><td>19.7%</td><td>536.6</td></tr>
<tr><td rowspan="2">MMN</td><td>Q4</td><td>68.9</td><td>368.2</td><td>5.35</td><td>14.20%</td><td>407.9</td></tr>
<tr><td>Q1</td><td>63.3</td><td>375.9</td><td>5.9.4</td><td>13.10%</td><td>422</td></tr>
<tr><td rowspan="2">Dignity /IMG</td><td>Q4</td><td>34.6</td><td>108.6</td><td>3.14</td><td>0.00%</td><td>401.4</td></tr>
<tr><td>Q1</td><td>16.5</td><td>134</td><td>8.1</td><td>0.00%</td><td>451.8</td></tr>
<tr><td rowspan="2">LSMA</td><td>Q4</td><td>61.2</td><td>317</td><td>5.18</td><td>9.70%</td><td>426.8</td></tr>
<tr><td>Q1</td><td>63.6</td><td>331.2</td><td>5.21</td><td>12.90%</td><td>442.7</td></tr>
<tr><td rowspan="2">SCP</td><td>Q4</td><td>79.9</td><td>400.6</td><td>5.01</td><td>16.20%</td><td>479.4</td></tr>
<tr><td>Q1</td><td>79.7</td><td>461.2</td><td>5.79</td><td>14.20%</td><td>501.1</td></tr>
</table>
Specialty referral performance with utilization of top specialty by PPG is compared to regional standards in the quarterly delegation oversight dashboard.</td>
<td>• CVMP is working with a new MSO.
• LaSalle is also transitioning to new MSO on 09/01. Hiring continues to be a challenge for quality director and data positions with high staff turnover.
• Sante's quality director position is open since spring.
• Meritage cites financial difficulties in incentivizing providers for quality improvement. Paper-based charts and slow Cozeva adoption remain barriers. Cultural, linguistic and health equity concerns in serving diverse populations with unique needs and beliefs in accessing care.</td>
<td>• Working with palliative care vendor and CRMC to expand home based palliative care.
• Weitzman Diabetes ECHO series is ongoing to upskill providers in managing diabetes.
• ECM programs are improving.
• Working with providers in supporting workforce development.
• Leveraging QI EDGE funding for PPGs with funding problems.
• eConsults being leveraged to ease specialty access
• QI funding has been offered to Meritage for quality improvement initiatives with providers.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2024</td>
<td>Quarterly PPG UM data presented at CalViva Management Oversight Meetings.
Quarterly JOMs with PPGs review utilization patterns quarterly and compared with region.

Q4 2022-Q3 2023 Utilization:</td>
<td>• Sante's quality director position remains open.
• Paper-based charts and slow Cozeva adoption remain barriers.
• Cultural, linguistic and health equity concerns in serving diverse populations with unique needs and beliefs in accessing care.
• Change in MSO for some PPGs (CVMP, LaSalle) has posed challenges in reporting.</td>
<td>• Working with palliative care vendor and CRMC to expand home based palliative care.
• Weitzman Diabetes ECHO series is ongoing to upskill providers in managing diabetes.
• ECM programs are improving.
• Working with providers in supporting workforce development.</td>
<td>Ongoing</td>
</tr>
</table>

Metric	Q	Admits/ K	Bed Days/K	ALOS	% 30-Day Readmit	ER/K
CVMP	Q4	106.7	642	6.01	15.60%	527.7
	Q1	87.9	511.1	5.81	19.70%	536.6
	Q2	122.8	640	5.21	20.50%	464.5
	Q3	108.4	722.3	6.66	15.3%	519.6
MMN	Q4	68.9	368.2	5.35	14.20%	407.9
	Q1	63.3	375.9	5.9.4	13.10%	422
	Q2	63.1	337.8	5.35	14.20%	376.9
	Q3	65.5	335.2	5.12	14.3%	413.9
Dignity /IMG	Q4	34.6	108.6	3.14	0.00%	401.4
	Q1	16.5	134	8.1	0.00%	451.8
	Q2	25.2	99.6	3.95	0.00%	384.6
	Q3	28	91.5	3.26	5.0%	389.4
LSMA	Q4	61.2	317	5.18	9.70%	426.8
	Q1	63.6	331.2	5.21	12.90%	442.7
	Q2	72.3	368.1	5.09	13.60%	392.6
	Q3	64.9	312.6	4.82	11.0%	410.3
SCP	Q4	79.9	400.6	5.01	16.20%	479.4
	Q1	79.7	461.2	5.79	14.20%	501.1
	Q2	86.2	442.4	5.13	19.60%	465.3
	Q3	87.4	458.9	5.25	17.8%	534.2

Due to at risk status, we do not track AHP utilization.

- MMN membership transitioning to direct network in beginning of 2024.
- Workforce development and succession planning challenges
- Aging technology infrastructure and need for upgrades
- Reluctance among small practices to take advantage of state funding (Equity & Practice Transformation)
- Limited adoption of registries (e.g. Cozeva) and virtual consults to drive improvements in quality and access
- Substance use, limited behavioral health access and social drivers of health remain major drivers of utilization

- Leveraging QI EDGE funding for PPGs with funding problems.
- eConsults being leveraged to ease specialty access
- QI funding has been offered to Meritage for quality improvement initiatives with providers.
- Continue to share UM data at quarterly JOMs with strategies for appropriate utilization
- Request RCA and action plan to address high utilization (CVMP)
- Identify opportunities for technological upgrades among small practices
- Support Cozeva adoption by PPG (Sante)
- Upcoming high-level conversations with St. Agnes Medical Center leadership (CMO, UM) to gain EHR access and promote HN's transition of care programs
- Behavioral health utilization metrics, including units per thousand, unique members per thousand, authorization data (for ABA and psychological/neuropsychological testing), and penetration to be provided quarterly. These metrics are reviewed regularly by health plan BH UM leadership and acted upon when necessary. Behavioral health also monitors for FWA based on provider practice patterns and involves SIU when necessary.

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The 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, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☒ **TOO SOON TO TELL**	Q1 2023 PPG Profile and Narrative was provided 05/22/23 and reviewed at MOM on 07/11/23 PPG's profile reports are made available quarterly. Q2 - 8/22/23 Q3 - 11/20/23, Q4 - TBD Q1 & Q2 Annual Reviews - La Salle Medical Providers had 1 CAP for Timeliness issue. - Meritage Medical Network – Central Valley had 1 CAP for Denial issue. Pending Annual Reviews for Q3 & Q4 - Adventist Health Plan - Central Valley Medical Group - Independence Medical Group - Santé Physicians IPA Medical Corp Delegation oversight monitors CAPS to ensure actions are implemented, documented and followed to completion. Both PPGs have implemented an action plan to ensure compliance with denial letters/template. Q4 2022-Q1 2023 Prior Authorizations:	• Specialty access continues to be a challenge for PPGs. • Sante Urgent TAT was below 95% in Q1 due to office closure on holidays. • Sante experienced high OON authorizations in Q1 due to transition from Community Health.	• Methodology updated to include: Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance. • We have partnered with provider network management to address delays in access. • Sante was educated on 72 hour TAT requirements and added provisions to address future holidays. • Partnered with new MSO and CVMP on opportunities for improvement and implementation of corrections were made and improvement seen in denial letter files post actions.	Ongoing

	Q4-2022 PTMPY PPG | AHP | CVMP | MMN | Dignity | LSMA | SCP Total Auths | 1,274 | 1,714 | 525 | 528 | 900 | 106 I-Net | 1,192 | 1,669 | 510 | 520 | 895 | 77 OON | 81 | 46 | 15 | 8 | 5 | 28 TAT % Compliance Urgent | 100.0% | 99.31% | 99.51% | 100.0% | 99.69% | 98.85% Routine | 99.95% | 99.97% | 99.88% | 100.0% | 100.0% | 99.84% Q1-2023 PTMPY PPG | AHP | CVMP | MMN | Dignity | LSMA | SCP Total Auths | 1,254 | 2,950 | 548 | 565 | 1,170 | 176 I-Net | 1,169 | 2,748 | 534 | 554 | 1,162 | 101 OON | 85 | 202 | 15 | 11 | 8 | 74 TAT % Compliance Urgent | 99.74% | 95.79% | 99.88% | 98.63% | 99.66% | 93.79% Routine | 99.91% | 97.44% | 99.97% | 100.0% | 99.99% | 98.91%			
Annual Evaluation ☐ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	PPG Profile and Narrative were provided on: Q4 2022: 2/21/2023 2023 Q1, Q2 & Q3: 5/23/23, 8/28/23 & 11/21/2023. Q4-2023 is due February 2024. Annual audit reviews - La Salle Medical Providers had 1 CAP issued in March 2023 for Timeliness issue and was resolved in Q2 2023. - Meritage Medical Network – Central Valley had 1 CAP for Denial issue issued July 2023. CAP remains open. - Central Valley Medical Providers (CMVP) had 2 CAPs issued in August 2023 for denial and timeliness issues. CAPs remain open and are pending final approval. - Adventist Health Plan had 5 CAPs for timeliness, denials, access to staff, appropriate professionals and delegation issues. All CAPs were resolved in 2023 except denials which is pending approval in 2024.	• Specialty access continues to be a challenge for PPGs. • Specialists' inconsistent use of auth number while submitting claims is a barrier to accurately tracking time to closure • Lack of closed loop referral between auth and claims processing systems • LaSalle has by far the largest volume of specialty referrals and 'service date not reported'. It is skewing the 'service date not reported' rate. • MSO transition (CVMP, LaSalle) is exacerbating timely processing of specialty referrals. • Meritage reported issues with denial criteria hierarchy and letter date. • Adventist barriers were related to system issues, call scripts and staff training. • Sante Urgent TAT was below 95% in Q1 due to office closure on holidays. • Sante experienced high OON authorizations in Q1 due to transition from Community Health.	• Methodology updated to include: Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance. • We have partnered with provider network management to address delays in access. • Partnered with new MSO and CVMP on opportunities for improvement and implementation of corrections were made and improvement seen in denial letter files post actions. • Promoted use of eConsults for non-procedural specialty referrals • MSO and PE will educate specialist network to consistently use auth number while submitting claims • Meritage has issued staff training regarding their hierarchy and is working with their software vendor to resolve their denial letter issue.	Ongoing

- Independence Medical Group (IMG) had 2 CAPs for timeliness and denial issues in Sept 2023. CAP remains open.
- Sante Community Physicians had 1 CAP in Q1 for timeliness and was resolved in Q4-2023.

Prior Authorizations:

Q4-2022 PTMPY

PPG	AHP	CVMP	MMN	IMG	LSMA	SCP
Total Auths	**1,274**	**1,714**	**525**	**528**	**900**	**106**
I-Net	1,192	1,669	510	520	895	77
OON	81	46	15	8	5	28
TAT % Compliance						
Urgent	100.0%	99.31%	99.51%	100.0%	99.69%	98.85%
Routine	99.95%	99.97%	99.88%	100.0%	100.0%	99.84%

Q1-2023 PTMPY

PPG	AHP	CVMP	MMN	IMG	LSMA	SCP
Total Auths	**1,254**	**2,950**	**548**	**565**	**1,170**	**176**
I-Net	1,169	2,748	534	554	1,162	101
OON	85	202	15	11	8	74
TAT % Compliance						
Urgent	99.74%	95.79%	99.88%	98.63%	99.66%	93.79%
Routine	99.91%	97.44%	99.97%	100.0%	99.99%	98.91%

Q2-2023 PTMPY

PPG	AHP	CVMP	MMN	IMG	LSMA	SCP
Total Auths	**883**	**1,505**	**618**	**515**	**1106**	**194**
I-Net	817	1,417	598	501	1097	120
OON	66	89	20	14	9	73
TAT % Compliance						
Urgent	100.0%	94.51%	100%	100%	99.29%	99.36%
Routine	99.90%	98.09%	100%	100%	100.0%	99.20%

- IMG issued additional timeliness and plain language training
- Sante was educated on 72 hour TAT requirements and added provisions to address future holidays.
- As of 09/01/2023, Sante has tightened UM reviews of OON specialty requests. Improvements are reflected in their internal reporting. It will take a few quarters for this to be reflected in health plan reporting.

Q3-2023 PTMPY

PPG	AHP	CVMP	MMN	IMG	LSMA	SCP
Total Auths	**836**	**1,415**	**631**	**494**	**1,089**	**180**
I-Net	773	1,368	611	485	1,074	102
OON	63	47	20	9	15	78
TAT % Compliance						
Urgent	99.13%	97.51%	99.15%	100%	98.59%	99.26%
Routine	99.94%	99.08%	99.71%	100%	99.42%	99.16%

4. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.1 Care Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. 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. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of RNs, LCSWs, Program Specialists, Program Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly. Member connections team to collaborate with care management by providing in home visits to support appropriate interventions and improve member outcomes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Number of Health Information Forms (HIFs) completed in January-June by member and returned or Envolve People Care outreach was 3,751 and 541 members subsequently referred to Case Management through June. Total members managed through Q2 across physical, behavioral health, and Transitional Case Management programs was 2,529. Outcome measures include: readmission rates, Emergency Department (ED) utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Physical Health, Behavioral Health, & Transitional Case Management & 90 days after enrollment. Results reported in Q1 include members with active or closed case on or between 1/1/2023 & 3/31/2023 & remained eligible 90 days after case open date. 238 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 15.6% difference • Volume of ED claims/1000/year decreased by 1,200 • Total health care costs reduction primarily related to reduction in inpatient costs and outpatient services, and some increase in pharmacy costs • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 20 members were successfully contacted through Q2 • Care Team Satisfaction - overall members were satisfied with the help they received from the Case Management and reported the goals they worked on improved understanding of their health	Fewer than expected number of satisfaction surveys completed.	CM's to encourage members to take survey, gain preferred contact method by member for survey.	Ongoing
Annual Evaluation	Number of HIFs completed in January – December 2023 by member and returned or EPC outreach was 7,042; 1,021 members subsequently referred to CM.	Fewer than expected number of satisfaction surveys completed.	CM's to encourage members to take survey, gain preferred contact method by member for survey.	Ongoing

☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Total members managed through Q4 2023 across physical, behavioral health, and TCM programs was 4,550. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in PH, BH, & TCM & 90 days after enrollment. Results reported through Q2 include members with active or closed case on or between 1/1/2023 & 6/30/2023 & remained eligible 90 days after case open date. 729 members met criteria. Results of members managed: • Number of admissions and readmissions was lower; 5.6% decrease in readmission rate. • Volume of ED claims/1000/year decreased by 702 • Total health care costs reduction primarily related to reduction in inpatient costs and pharmacy costs, some increase in outpatient services • Member Satisfaction Survey comprised of two sections; Care Team Satisfaction and Quality of Life 31 members were successfully contacted Q1 through Q3 • Care Team Satisfaction - overall members were satisfied with the Care Management program and the help they received from their Care Manager and reported the tools they received from their Care Manager helped them reach the goals they worked on	Decreased referrals from Concurrent Review to some programs due to restructure of Transition of Care program.	Utilized additional reports for outreach.	

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Case Management	☒ Medi-Cal	Providing perinatal risk screening is a valuable way to identify members who would benefit from CM interventions thus resulting in improved outcomes.	Notify PCP's or PPG's of patients identified for program. Measure program effectiveness based on the following measures: ○ Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high-risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Referrals increased from 439 in Q1 to 450 in Q2. Through Q2 565 members managed in PCM program. Quarterly average engagement rate remained steady at 43% in both Q1 and Q2. Texting portion of program on hold while texting policy under review. Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 21 & 56 days after delivery compared to pregnant members who were not enrolled in the program. In addition the rate of pre-term delivery of high risk members managed is compared to high risk members not managed. Results reported in Q1 for 2023 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 36 members met the outcome inclusion criteria for visits; 17 members met preterm delivery criteria • Members enrolled in the High Risk Pregnancy Program demonstrated: o 2.1% greater compliance in completing the first prenatal visit within their first trimester, o 4% greater compliance in completing their post-partum visit 0.5% less pre-term deliveries in high risk members	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Referrals – 1,643 Q1-Q4 2023 with average engagement rate 61.3%. Through Q4 1,276 members managed in PCM program; higher than number managed in 2022 (882). Outcome measures based on member's compliance with completing 1st prenatal visit within 1st trimester & post-partum visit between 7 & 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition, the rate of pre-term delivery	None identified	None	Ongoing

	of high-risk members managed is compared to high risk members not managed. Results reported through Q2 2023 demonstrated greater compliance in managed members for both visit measures and lower pre-term deliveries of high risk members managed. • 106 members met the outcome inclusion criteria for visits; 52 members met preterm delivery criteria • Members enrolled in the Pregnancy Program demonstrated: o 9.4% greater compliance in completing the first prenatal visit within their first trimester o 2.0% greater compliance in completing their post-partum visit o 3.0% less pre-term deliveries in high-risk members Pregnancy Program mailings: January through December • NOP mailings 9,313 • Pregnancy mailings 1,631 Post-delivery packets 2,776			

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFTs, and Program Specialist to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Data reported is a subset of information provided in 4.1. Referrals to behavioral health program decreased from 235 in Q1 to 167 in Q2. Total members managed decreased from 307 in Q1 to 246 in Q2. Total members managed through Q2 was 419. Calendar Year engagement rate 68%. Total Referrals to CM are monitored in the KIR which includes referrals from Impact Pro. Outcome measures include: readmission rates, Emergency Department utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in Behavioral Health Case Management & 90 days after enrollment. Results reported in Q1 and Q2 include members with active or closed case on or between 1/1/2023 & 6/30/2023 and remained eligible. Outcome results are consolidated across Physical Health, Behavioral Health, & Transitional Case Management programs and are reported in 4.1.	Reduced referrals from MHN and county partners as all referrals now handled via MHN process. MHN continues to refer members that need additional follow up.	Increased referrals from ADT reports	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Data reported is a subset of information provided in 4.1. Referrals to behavioral health program Q1-Q4 2023 570. Total members managed decreased in 2023 to 572 compared to 803 in 2022. Overall engagement rate 71.1%. Outcome measures include: readmission rates, ED utilization, overall health care costs & member satisfaction. Measured 90 days prior to enrollment in BH & 90 days after enrollment. Results reported through Q2 include members with active or closed case on or between 1/1/2023 & 6/30/2023 & remained eligible. Outcome results are consolidated across PH, BH, & TCM programs and are reported in 4.1.	Reduced referrals from MHN and County partners as all referrals now handled according to the DHCS-mandated screening and referral process as outlined in APL22-028. This process resulted in increased referrals from MHN to the County behavioral health departments. The members referred tend to be of higher acuity and often receive case management and comprehensive services through the Counties. MHN continues to refer members that need additional follow up.	Increased referrals from ADT reports. Utilized post discharge report for referral source.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a 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. Plan Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Review prevalence data to affirm selection of Chronic Condition Management program offerings. Submit Disease/Chronic Condition Management redesign proposal for approval Q1 2023.	Ongoing 12/31/2023 3/30/2023

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment YTD = 203.

Ongoing program monitoring is conducted to assure that member needs are met. Program elements include:

• educational materials and information about the program are sent to enrolled CVH members.
• outbound telephonic interventions are conducted
• referrals to case management and other programs as needed.

Major conditions reviewed by prevalence and utilization across 12 months of claims. Asthma, diabetes and heart failure continue to be represented, per the below rankings. These 3 conditions continue to be among those with the top inpatient and/or ED visits.

<table>
<tr><th>Condition</th><th>Prevalence</th></tr>
<tr><td>Asthma</td><td>5th</td></tr>
<tr><td>Diabetes</td><td>3rd</td></tr>
<tr><td>Heart Health</td><td>10th</td></tr>
</table>
</td>
<td>None identified</td>
<td>The Q1 2023 Disease/Chronic Condition Management redesign proposal was put on hold.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2024</td>
<td>Chronic Condition Management program continues for asthma, diabetes and heart failure. Program enrollment at year end = 564.

Ongoing program monitoring is conducted to assure that member needs are met. Program elements include:

• educational materials and information about the program are sent to enrolled CVH members.
• outbound telephonic interventions are conducted
• referrals to case management and other programs as needed.

<table>
<tr><th>Condition</th><th>Prevalence</th></tr>
<tr><td>Asthma</td><td>5th</td></tr>
<tr><td>Diabetes</td><td>3rd</td></tr>
<tr><td>Heart Health</td><td>10th</td></tr>
</table>
</td>
<td>None identified</td>
<td>Disease/Chronic Condition Management redesign strategy was established for submission in 2024.</td>
<td>Ongoing</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2023 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. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data.	Monthly report of PA requests.	Continued active engagement with pharmacy. Revised UMQI reporting based on Medical Benefit drug review. Revised DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	UMQI reporting continues in 2023 based on the 2022 Medi-Cal RX changes and shift to medical benefit drug tracking. SHP Quarterly meeting topics for 2023: • Continuous view of Medi-Cal Rx program updates and status post implementation. Discussion of retirement of the 180 day transition policy and reimplementation of PA requirement by Medi-Cal RX DHCS audits completed • DSNP expansion in CalViva counties • Annual CMS DUR survey completed and submitted to DHCS with no errors reported. A&G trends and concerns reviewed for medical benefit drugs. QA/IRR results for medical benefit drug reviews in Q1 2023 completed and Q2 results are pending final review at the Q3 QI meeting.	None identified	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	• No significant Medi-Cal Rx issues addressed or reported in 2023 • A&G cases for medical benefit pharmacy drugs tracked in 2023. For Q1-Q3 2023, 28 total appeals were reviewed in the Quarterly SHP meetings. Similar to 2022,there was a lower number of cases compared to 2021 due to the Medi-Cal RX implementation. No significant findings or trending identified in the reviews. • IRR process reviewed for Q4 2022 through Q3 2023. Results were not at threshold for Q4 2022. 90% threshold met in Q1 through Q3 2023. Q4 2023 results are currently pending review.	None identified	• Medi-Cal RX issues will continue be tracked 2024 to assess impact on patient care. • DUR programs will continue in 2024 based on data from Medi-Cal RX with new DUR program Ventana. • UMQI reporting for medical benefit pharmacy drugs will continue in2024 the same as 2023 with no changes planned.. • A&G data will continue to be tracked in 2024 based on the medical benefit drugs.	Ongoing

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 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 the behavioral health administrator staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that the behavioral health administrator provides.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	MHN has fully implemented the use of the DHCS Screening and Transition of Care Tools for members under 21 and for members 21 and over with Fresno, Kings and Madera counties. The adult and youth Screening Tools for Medi-Cal Mental Health (MH) Services determine the appropriate MH delivery system referral for members **not** currently receiving MH services. The Transition of Care Tool is utilized to ensure members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.	None Identified	Implementation of the DHCS provided Screening and Transition of Care tools. Implementation of an automated referral tracking system in the MHN care management system.	Ongoing

	MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. During the period January, 2023 through June, 2023, MHN received 339 referrals from Fresno, Kings and Madera counties. MHN referred 29 members to the county for Specialty Mental Health or Substance Abuse Services.			

Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	MHN has fully implemented the use of the DHCS Screening and Transition of Care Tools for members under 21 and for members 21 and over with Fresno, Kings and Madera counties. The adult and youth Screening Tools for Medi-Cal Mental Health (MH) Services determine the appropriate MH delivery system referral for members **not** currently receiving MH services. The Transition of Care Tool is utilized to ensure members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system. MHN Care and Case Managers continue weekly rounds with HN medical case management staff and Medical Directors with the purpose of integrating medical and behavioral health services and ensuring that members receive optimal care. PCPs are also offered opportunities to collaborate with MHN MDs for guidance on treating routine psychiatric conditions. Referral activity during the period January, 2023 through December, 2023 is summarized in the table below:	None Identified	None	Ongoing

Count of Action Groupi		Medi-Cal County			
Action Category	Action Grouping	FRESNO (CALVIVA)	KINGS (CALVIVA)	MADERA (CALVIVA)	Grand Total
Received	TOC Add-On (R11)	48	2		50
	Screening MH (R09, R21)	511	16	185	712
	TOC Stepdown (R10, R22)	401	36	20	457
Received Total		**960**	**54**	**205**	**1219**
Sent	Screening MH (R12, R20)	52	2	9	63
	TOC Add-On (SUD) (R15, R23)	2			2
	Screening SUD (R13)	11	1	3	15
	TOC StepUp (MH) (R14)	2	1	2	5
Sent Total		**67**	**4**	**14**	**85**
VID Requests	VID Benefit Explanation (R30)	4			4
VID Requests Total		**4**			**4**
Other	Met SMHS - Member Declined (R	42	1	4	47
	Care Coordination (BHC)	3199	193	656	4048
Other Total		**3241**	**194**	**660**	**4095**
Grand Total		**4272**	**252**	**879**	**5403**

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	In Q1 2023, 14 of the 15 metrics met or exceeded their targets. The Non-ABA authorization timeliness metric result was under 100%, but it exceeded the threshold for action of 95%. Q2 data is not yet available.	There were 35 non-ABA reviews in Q1 2023 and 34 were compliant with timeliness standards. Even though non-ABA authorization timeliness did not meet the 100% target, it exceeded the threshold for action of 95%.	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Overall Performance: In Q4 2022, 15 of the 15 metrics met or exceeded their targets. In Q1 2023, 14 of the 15 metrics met or exceeded their targets. The Non-ABA authorization timeliness metric result was under 100%, but it exceeded the threshold for action of 95%. In Q2 2023, 15 of the 15 metrics with targets met or exceeded their targets. In Q3 2023, 15 of the 15 metrics with targets met or exceeded their targets. Q4 2023 results are not yet available.	There were 35 non-ABA reviews in Q1 2023 and 34 were compliant with timeliness standards. Even though non-ABA authorization timeliness did not meet the 100% target, it exceeded the threshold for action of 95%. Implementing BH data exchange with the county mental health plans to improve member experience and outcomes through visibility to, and coordination of, care between the two BH service delivery systems. Adding substance use disorder data was not approved. Under current federal rules, an additional member consent is required. These federal rule(s) are currently under review to allow more options and should be updated on or before11/11/2024.	The behavioral health team is developing plans to expand an effective member phone outreach program that uses staff clinicians to complete clinical assessments and ensure access to routine outpatient behavioral health care for members with a recent behavioral health-related emergency visit. This outreach program improves outcomes reflected in FUA and FUM measures, without violating privacy requirements. Subject to reviews and approvals, the behavioral health team hopes to implement the expansion to CalViva Health Fresno and Madera members by the end of Q1 2024. Continue to monitor federal rules regarding SUDs services and member consent.	Ongoing

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2023 Planned Interventions	Target Completion Date
5.1 Monitor California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Identify 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, case management, pharmacy, claims review, member appeals and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Collaborate with Public Programs and Coordination of Care Team to facilitate transition of Independent Care Facility CCS membership (begins July 1st 2023). Continue to monitor Aging-out membership, identified 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

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

☒ ACTIVITY ON TARGET

☐ TOO SOON TO TELL</td>
<td>The CCS identification rates for the CVH under 21 population continue to trend above 6%.

2023 Monthly CCS Identification Rates
<table>
<tr><th>Month</th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>8.70%</td><td>7.68%</td><td>7.81%</td><td>8.06%</td></tr>
<tr><td>Feb</td><td>8.19%</td><td>7.36%</td><td>7.39%</td><td>7.65%</td></tr>
<tr><td>Mar</td><td>8.14%</td><td>7.34%</td><td>7.38%</td><td>7.62%</td></tr>
<tr><td>Apr</td><td>8.11%</td><td>7.27%</td><td>7.34%</td><td>7.57%</td></tr>
<tr><td>May</td><td>8.06%</td><td>7.22%</td><td>7.32%</td><td>7.54%</td></tr>
<tr><td>Jun</td><td>8.07%</td><td>7.18%</td><td>7.28%</td><td>7.51%</td></tr>
</table></td>
<td>None identified</td>
<td>Leadership engage large facilities in the area to assist with communication on pending CCS cases and outcomes. These efforts have helped increase the plan’s identification rates because it has produced faster turn-around-times with CCS determinations.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Annual Evaluation

☒ MET OBJECTIVES

☒ CONTINUE ACTIVITY IN 2024</td>
<td>Staff continued efforts to identify and refer cases to CCS in collaboration with supporting departments such as UM and Pharmacy. The team exceeded goal of minimum 5% identification rate for the year.

2023 Monthly CCS Identification Rates
<table>
<tr><th>Month</th><th>Fresno</th><th>Kings</th><th>Madera</th><th>Average</th></tr>
<tr><td>Jan</td><td>8.70%</td><td>7.68%</td><td>7.81%</td><td>8.50%</td></tr>
<tr><td>Feb</td><td>8.19%</td><td>7.36%</td><td>7.39%</td><td>8.02%</td></tr>
<tr><td>Mar</td><td>8.14%</td><td>7.34%</td><td>7.38%</td><td>7.98%</td></tr>
<tr><td>Apr</td><td>8.11%</td><td>7.27%</td><td>7.34%</td><td>7.94%</td></tr>
<tr><td>May</td><td>8.06%</td><td>7.22%</td><td>7.32%</td><td>7.90%</td></tr>
<tr><td>Jun</td><td>8.07%</td><td>7.18%</td><td>7.28%</td><td>7.90%</td></tr>
<tr><td>Jul</td><td>8.07%</td><td>7.14%</td><td>7.31%</td><td>7.90%</td></tr>
<tr><td>Aug</td><td>8.04%</td><td>7.16%</td><td>7.35%</td><td>7.88%</td></tr>
<tr><td>Sep</td><td>7.98%</td><td>7.13%</td><td>7.33%</td><td>7.83%</td></tr>
<tr><td>Oct</td><td>7.86%</td><td>7.00%</td><td>7.24%</td><td>7.72%</td></tr>
<tr><td>Nov</td><td>7.91%</td><td>7.03%</td><td>7.34%</td><td>7.77%</td></tr>
<tr><td>Dec</td><td>7.86%</td><td>6.89%</td><td>7.24%</td><td>7.70%</td></tr>
</table>
Quarterly CCS Identification Rates
<table>
<tr><th>Period</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>2022</td><td>8.69%</td><td>8.72%</td><td>8.31%</td><td>8.44%</td></tr>
<tr><td>2023</td><td>8.17%</td><td>7.91%</td><td>7.87%</td><td>7.73%</td></tr>
</table></td>
<td>None identified</td>
<td>Leadership engaged large facilities in the area to assist with communication on pending CCS cases and outcomes. These efforts have helped increase the plan’s identification rates because it has produced faster turn-around-times with CCS determinations.</td>
<td>On-going</td>
</tr>
</table>

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2023 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Case Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☒ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**	Member stratification being conducted monthly using Impact Pro/related report to identify members for Integrated Case Management (ICM) as noted under 4.1. 842 Seniors and Persons with Disabilities (SPD) members (Supplemental Security Income Dual and Non-Dual) have been managed through Q2. This includes Physical Health Case Management, Behavioral Health Case Management, Transitional Case Management & Obstetrics Case Management, as well as both complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members for Q1 and Q2 (100% on time). 13,149 members were outreached from January through June 2023.	None identified.	None	Ongoing
Annual Evaluation ☒ **MET OBJECTIVES** ☒ **CONTINUE ACTIVITY IN 2024**	Member stratification being conducted monthly using Impact Pro/related report to identify members for ICM as noted under 4.1. 1,359 SPD members (SSI Dual and Non Dual) have been managed Q1-Q4 2023. This includes PH CM, BH CM, TCM & OB CM, as well as both 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 complex and non-complex cases. Timely HRA outreach reported for CalViva SPD members YTD 2023 was 100%. A total of 16,972 members were outreached in 2023.	None identified	None	Ongoing

Item #10
Attachment 10.C

Utilization Management

2024 Program
Description & Change Summary

REPORT SUMMARY TO COMMITTEE

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

FROM: Marianne Armstrong Utilization Management

COMMITTEE DATE: February 15, 2024

SUBJECT: Utilization Management Program Description Change Summary

UM Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Updated year from 2023 to 2024
11, 12, 14, 16, 32, 33	Multiple	Grammatical corrections
ii-iii	Table of Contents	Page numbering and section headers updated to align with content
6	About Health Net	• Changed "Purpose" to "Mission", and "Mission" to "Values". • Clarified Health Net's mission and updated value statements.
6, 9, 14, 19, 22, 23, 26, 28, 30, 32, 34, 39	Multiple	Changed "State Health Programs" references to "Health Net Community Solutions" or removed
7	Goals and Objectives	Added "Provide members with equitable access to care including eliminating identified health disparities such as, structural racism and social risk, social determinates of health (SDoH), and community needs; make recommendations to improve individual and community health outcomes.
9	Scope of Utilization Management	• Changed "preauthorization" to "prior authorization" • Changed "Policy" Letters to "All Plan" Letters. • Spelled out MRMIB acronym.
11	Inpatient Facility Concurrent Review	• Changed "through CCR work and advocacy" to "in collaboration" • Spelled out "nurse"
11, 12, 15, 16, 21, 26, 27, 33, 34	Multiple	Changed behavioral health "administrator" references to behavioral health "team" or similar
13	Post Service/Retrospective	Added "Post Service" to section title and section, added "or retrospective".
13	Provider Participation	Changed "Physician" to "Provider"
15	Behavioral Health Care Services	• Removed "Change Healthcare's InterQual Level of Care Criteria" • Spelled out Quantitative "Treatment Limitations" acronym
21	Over and Under Utilization	Added the following to the examples of data types and metrics: • Population Health Management key performance indicator metrics

		• Provider prescribing patterns including medication utilization metrics
23	Utilization Decision Criteria	• Removed examples of medical association publications • Moved update Up-To-Date from expert opinion to independent entities • Added "Preferred Drug List" to the benefit determinations basis
23	Separation of Medical Decisions from Fiscal and Administrative Management	Removed "Regional" from Medical Directors
24	Inter-rater Reliability (IRR) Review Process	• Added "New hire" • Removed "InterQual (IQ) • Updated description of testing and corrective action
25	Denials	Added "Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the telephone number of the individual who issued the denial and Medical Director contact information is available on the provider portal website."
26	Evaluation of Medical Technology and Procedures	Corrected "HAYES" to "Hayes, Inc. Medical"
30, 31	Health Net Organizational Structure and Resources	Added "LLC" to Health Net CMO reference
32	Medical Directors	Added "and Health Equity" to the Health Net Quality Improvement committee title.
34	Health Net Community Solutions (HNCS) Quality Improvement/Health Equity Committee (QIHEC)	Added "PMH and Health Equity"
36	Delegation	Added "contracted vendors" Removed "Regional" medical directors

~~2023~~2024

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

TABLE OF CONTENTS

Section 1

Introduction and Background

Introduction and Background

Introduction

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

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

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

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

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

Background

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

Provider Network

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

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

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

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

Confidentiality

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

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

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

Information Systems and Analysis

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

- Membership
- Benefits
- Provider
- Claims
- Billing
- Capitation
- Encounters
- Credentialing
- Population Health and Clinical Operations (PHCO)
- Customer Service
- Appeals and Grievance

Analytical resources are directly available from the following Health Net departments: Information Systems, Quality Improvement and Pharmacy Operations. Other analytical

support resources include Actuary, Finance, Provider Network Management, Medical Advisory Council, Customer Service and Claims. Additional sources of information include member and provider feedback.

Section 2

Purpose

About Health Net

Health Net provides access to high-quality health care, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

~~Purpose~~Mission

Transforming the health of the community~~y~~ies we serve, one person at a time.

~~Mission~~Values

Accountability • Courage • Curiosity • Trust • Service
~~Better health outcomes at lower costs.~~

~~State Health Programs~~Health Net Community Solutions UM Purpose

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

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

The purpose of the UM Program is to:

- Assist in the coordination of medically necessary health care services provided to members, as indicated by clinical criteria
- Provide a mechanism to address access and timeliness of care
- Initiate documentation to support investigation of potential quality of care issues
- Identify and resolve problems that result in excessive resource utilization and inefficient delivery of health care services
- Identify and resolve problems that result in under or over utilization
- Assess the effects of cost containment activities on the quality of care delivered
- Promote the role of the primary care physician in the management of patient care
- Identify opportunities to improve the health of members through integration and coordination within PHCO and external Public Health Programs
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs

Goals and Objectives

The Program has the following specific objectives:

- Monitor consistency in application of all UM functions for members
- Review and evaluate health care services for quality, medical necessity and appropriate levels of care
- Identify actual and potential quality issues through this review process and refer to the appropriate quality management personnel
- Evaluate the need for care management and discharge planning in coordination with the hospital and the PCP
- Aggregate utilization data to identify favorable and aberrant practice patterns, and recommend the necessary changes that will improve program effectiveness and efficiency
- Maintain compliance with regulatory timeliness
- Prepare and implement improvement plans for identified problem areas
- Provide a mechanism for maintaining confidentiality of member and provider
- Coordinate Utilization Management, Care Management and Quality Management activities to provide a continuous quality improvement process
- Work collaboratively with Delegation Oversight to determine delegation status for UM activities
- Evaluate the UM Program on a regular basis to respond to changes in the health care environment
- Collaborate with county Public Health-Linked Programs
- Provide members with equitable access to care including eliminating identified health disparities such as, structural racism and social risk, social determinates of health (SDoH), and community needs; make recommendations to improve individual and community health outcomes.

Section 3

Description of Program

Description of Program

Utilization and Care Management

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

Scope of Utilization Management

The scope of Health Net's non-delegated Utilization Management activities includes timely, direct referrals, prior ~~e~~authorization~~'s~~, concurrent review, discharge planning, care management and care coordination with Public Health-Linked Programs. Health Net conducts all utilization management activities in accordance with CA Health and Safety Code 1367.01.

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

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

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

Prior authorization is not required for emergency services, family planning services, preventive services, basic prenatal care, services related to the treatment of sexually transmitted infections, HIV counseling and testing, therapeutic and elective pregnancy termination, biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer and immunizations at the Local Health Department (LHD). Utilization

Management policies and procedures are available to members and providers upon request.

Health Net Utilization Management nurses provide decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources to support the plan of care.

Direct Referrals/Self-Referrals

For delegated PPGs, Health Net allows the medical groups to establish policies and procedures for direct referrals. Health Net has established direct referrals for non-delegated practitioners when the member's Primary Care Physician refers the member directly to a specialist for consultation and evaluation without prior authorization or prior review by the Health Net Medical Director. Health Net and its delegated PPGs do not require prior authorization for emergency services, family planning services (including abortion), preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing as outlined under the Scope of Utilization Management section of the UM Program Description. Direct referrals enhance the member's ability to directly access specialists.

Preauthorization / Prior Authorization

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

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

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

Inpatient Facility Concurrent Review

Concurrent Review (CCR) is an assessment that determines medical necessity or appropriateness of services as they are rendered, i.e., an assessment of the need for continued inpatient care for patients. Any review for continued benefit coverage and

provision of an approved ongoing course of treatment over a period of time or number of treatments. Concurrent review is a member-centric process that includes medical necessity review, discharge and transitional care planning and coordination of care.

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

1) Ensure services are accessed timely,
2) Educate the Member's health care team on the Member's benefit structure and resources,
3) Facilitate expeditious authorization of services when appropriate, and
4) Facilitate referrals to appropriate Member resources, such as the behavioral health ~~administrator~~team, care management, and community resources.

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

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

Health Net non-clinical staff supports pre-service and concurrent review with data entry, receipt and documentation of notification, and receipt and attachment of clinical content.

Reviews of requests that do not meet guidelines or criteria for certification are referred to a Health Net Medical Director for second level case review. During the concurrent review process, nurses assess for member specific care management and disease/ chronic condition management needs and refer such cases to Care Management for

evaluation. Concurrent Review Nurses collaborate with Care Managers on all members identified in active care management.

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

Discharge Planning

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

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

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

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

Post Service/Retrospective Review

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

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

Second Opinion

A member, member's authorized representative or provider may request a second opinion for medical, surgical or behavioral health conditions. PCPs usually refer their assigned members who request a second opinion to a participating physician within their medical group. If a member requests a second opinion about specialty care from a participating specialist physician who practices outside of the member's PCP's medical group, the request will be forwarded to Health Net utilization management for review. Health Net does not routinely require prior authorization for such services given that the second opinion is provided within or outside the member's Participating Physicians Group or Network, but within the Health Net Network. However, in the event the member's plan requires prior authorization of such services, the determination will be made in a timely manner consistent with state specific mandates. The organization provides for second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. There is no cost to the member for second opinion either in network, or authorized out of network.

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

Management of Information Systems

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

Provider Participation

Health Net contracts with primary and multi-specialty group practices, individual providers, hospitals and ancillary service providers to deliver quality, cost effective medical services to members and their dependents. Selection of a Primary Care ~~Physician~~ Provider (PCP) and establishment of a relationship with that ~~physician~~

provider is the foundation for members obtaining appropriate health care services. PCPs include Internists, Family Practitioners, General Practitioners, Pediatricians, Nurse Practitioners and Women's Health Care Providers (WHCP).

Access / Availability to Health Care Services

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

Coordination with Quality Improvement Programs

The Health Net ~~State Health Programs~~ Utilization Management Department and the delegated PPGs identify and refer sentinel events and potential quality of care/service issues to the Health Net Quality Management Department for tracking and trending, investigation and peer review. This review occurs throughout the scope of utilization/care management activities. Quality of care, quality of service and member complaints are monitored and analyzed by the Peer Review Investigations Team (PRIT) to determine whether further actions are needed, including but not limited to: review by the Peer Review Committee (PRC). Corrective actions, as appropriate, may be imposed by the PRC and are designed and monitored to continually improve member care and service.

Coordination with Internal Programs

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

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

delegated provider group status. Disease/chronic condition management activities are provided in coordination with Health Net and/or PPG UM activities.

Behavioral Health Care Services

The behavioral health ~~administrator~~ team administers the Medi-Cal mild to moderate mental health services carved into the Managed Care Plans.

The behavioral health ~~administrator~~ team provides early and periodic screening, diagnosis and treatment services for members ages 0 to 21. These services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore to the maximum practicable, the functioning of the members diagnosed with Autism Spectrum Disorder (ASD) as well as other disorders that result in behavioral disturbances.

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

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

Federal law requires a health insurance issuer to establish parity in the terms and conditions applicable to medical and mental health benefits, as specified. All covered mental health and substance use disorder benefits must be provided in compliance with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26 and Section 10112.27). the behavioral health ~~administrator~~ team and Health Net do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to timelines and processes. CalViva shall also ensure direct access to an initial mental health assessment by a licensed mental health provider within the Plan's provider network. CalViva will not require a referral from a PCP or prior authorization for an initial mental health assessment performed by a network mental health provider. CalViva will cover the cost of an initial mental health assessment

completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service.

Utilization management techniques are considered an NQTL under the definitions of the federal rules. The behavioral health ~~administrator~~ team may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the limitation with respect to medical/surgical benefits in the classification, timelines and processes in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.,

Further, the underlying processes, strategies, and evidentiary standards, considered by the behavioral health ~~administrator~~ team and Health Net when determining if a NQTL will apply to a service, will be conducted in an equitable manner across all medical/surgical and mental health and substance use disorder benefits. Factors considered in the determination process ~~will be~~are supported by internal data reports, internal medical records review, credible medical literature, peer-reviewed journals and other scientific evidence.

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

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

The behavioral health team~~administrator~~ coordinates Continuity of Care (COC) for members following existing COC provisions under California state law.

Pharmacy

The corporate pharmacy division of Health Net, Centene Pharmacy Services, administers and manages the medical drug benefit for Health Net's Medi-Cal membership. Programs are developed to ensure appropriate utilization of medications: Medical Benefit Drug Prior Authorization, Education programs for physicians and members, and Pharmaceutical Safety.

A Pharmacy and Therapeutics Committee, consisting of community practicing Physicians, Health Net Pharmacists and Medical Directors review and approve all medications administered under the medical benefit, as well as approve all criteria guiding prior authorization decisions.

Continuity and Coordination of Care

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

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

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

- Coordinating transition of care for members who are currently under care and are new to the Plan or are changing providers: All Medi-Cal Plan members with pre-existing provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

- Members/Providers who make a continuity of care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another Managed Care Plan (MCP). The Plan will automatically provide 12 months of Continuity of Care for a member in a skilled nursing facility or for the provision of completing covered services by a terminated or out of network provider.

- The continuity of care process is facilitated by licensed nurses based on member or provider request and meeting of continuity of care conditions per DHCS and DMHC regulatory requirements.

- Care Managers are patient advocates and assist members to ensure that they receive timely and uninterrupted medical care during the transition process.

Primary Care Physician responsibility:

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

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

As an additional aid to the primary care provider, Health Net provides a nurse advice line 24 hours a day, 7 days a week. Health Net strives to continually meet the access and availability standards through our network relationships, member and provider education and triage services.

Health Promotion Programs

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

The goal is to offer timely, specific education and coaching around specific disease conditions and/or general health and wellness concerns. It is the goal of the program to have member engagement and to have preventive wellness, and chronic condition management in accordance with national peer-reviewed published guidelines. Preventive medicine services, achieved through proactive education and active engagement of the members, promotes optimal health.

Programs include:

- Disease/ Chronic Condition Management
- Weight Management Programs

- Health education resources are offered to target issues identified for the Medi-Cal population, such as asthma, diabetes, nutrition, heart health and hypertension.

Nurse Advice Line

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

Chronic Condition Management

The Chronic Condition Management Program increases awareness of self-care strategies and empowers participants to better manage their disease. The program targets members with high-risk chronic conditions including, but not limited to: chronic asthma, diabetes and heart failure conditions. It encourages them to participate in the 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 condition management are multichannel and come through provider, Care Management and member self-referrals.

Weight Management Programs

Members have access to a comprehensive Fit Families for Life-*Be In Charge!℠* suite of programs. The Fit Families for Life-Home Edition is a 5-week self-guided, home-based program to help families learn and set weekly nutrition and physical activity goals to achieve a healthy weight. The Healthy Habits for Healthy People weight management educational resource is designed specifically for adults and seniors. Other nutrition and weight control education resources are also available upon request. Providers can complete and fax a copy of the Fit Families for Life – *Be In Charge!℠* Program Referral Form to the CalViva Health's Health Education Department to refer members to the Home Edition program or members can request the information directly.

Health Education Programs, Services and Resources

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

health educators to encourage positive health and lifestyle behaviors. Health Education programs, services and materials vary by membership type but generally include:

- Pregnancy Program – Pregnant members receive educational resources to help them achieve a successful pregnancy and healthy baby. Educational resources include materials on monitoring the baby's movement and handbooks on planning a healthy pregnancy and caring for your baby. High risk pregnancies receive additional case management services.
- Kick It California – Kick It California (formerly known as the California Smokers' Helpline) 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. CalViva offers members a 90-day regimen of all FDA approved tobacco cessation medications with at least one medication available without prior authorization. CalViva Health will cover a minimum of two separate quit attempts per year with no mandatory break between quit attempts. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless if they opt to use tobacco cessation medications.
- Diabetes Prevention Program – Eligible members 18 years old and older with prediabetes can participate in a lifestyle change program that promotes and focuses on emphasizing weight loss through exercise, healthy eating and behavior modification. The program is designed to assist Medi-Cal members in preventing or delaying the onset of type 2 diabetes.
- Healthy Hearts Healthy Lives Program - Members have access to a health heart prevention toolkit (educational booklet, tracking journal, an exercise band, and online fitness videos) and access to community classes to learn how to maintain a healthy heart.
- Digital Health Education - Teens from 13 years old and adults may participate in digital health education campaigns and programs available through T2X's website, text messaging and mobile app. T2X engages members in discussing health topics that are important to them. T2X interventions guide members in learning how to access credible health education information and encourage members in accessing timely preventive health care services. CalViva Health also offers myStrength, a personalized website and mobile application, to help members deal with depression, anxiety, stress, substance use, pain management, and insomnia.
- Health Promotion Incentive Programs - The Health Education Department (HED) partners with Quality Improvement Department to offer incentive programs to encourage members to access HEDIS related preventive health care services.
- Community Health Education Classes - Free classes are available to members and the community. Classes are available in various languages. Topics vary by county and are determined by the community's needs.
- Community Health Fairs – CalViva Health participates in health fairs and community events to promote health awareness to members and the community.

CalViva Health representatives provide screenings, presentations, and/or health education materials at these events.

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- The following educational resources are available to members:

- Health Education Resources – Members or the parents of youth members may order health education materials on a wide range of topics, such as asthma, healthy eating, diabetes, immunizations, dental health, prenatal care, exercise and more. These materials are available in threshold languages.
- Health Education Member Request Form – Members complete an order form to request free health education materials available through the department. The form also contains the toll-free Health Education Information Line. Members can also request CalViva Health's health education resources by contacting the toll-free Health Education Information Line or view some materials online at www.CalVivaHealth.org. They can also get CalViva Health's print resources at contracted providers and health education classes.
- Health Education Programs and Services Flyer – This flyer contains information on all health education programs and services offered to members and information on how to access services.
- Preventive Screening Guidelines – The guidelines are provided to inform members of health screening and immunization schedules for all ages. These are available in English, Spanish and Hmong.
- Member Newsletter – Newsletter is mailed to members on an annual basis and covers various health topics and the most up-to-date information on health education programs and services.

Over and Under Utilization

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

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

Health Net's Utilization Management Department and the behavioral health team~~administrator~~ facilitates the delivery of health care services and monitors the impact of the UM Program to detect and correct potential under- and over-utilization through these comprehensive monitoring efforts:

- Establishing thresholds for compliance and measures compliance to guidelines
- Monitoring utilization data collected to detect potential under- and over-utilization.
- Routinely analyzing all data collected to detect under- or over-utilization.

- Analysis occurs on a semi-annual basis at minimum to ensure appropriate service and to identify opportunities for improvement.
- Tracks performance against established goals
- Implementing appropriate interventions when problems are identified.
- Educates and addresses variances from agreed upon clinical criteria
- Monitors provider prescribing patterns including medication utilization metrics
- Conducts provider outreach programs to modify performance
- Measuring whether the interventions have been effective and implementing strategies to achieve appropriate utilization.

Examples of data types and metrics identified that are relevant to provision of medically necessary services for all members. Examples:

- For outpatient services, units/1000.
- For outpatient services, unique patients/1000.
- For outpatient services, units/unique patient.
- Report likely driving factors for the above patterns of utilization.
- Population Health Management key performance indicator metrics
- Dental anesthesia data is analyzed to identify and mitigate issues that may adversely impact the provision of medically necessary services received by members.
- In addition, suspected fraud, waste and abuse of medical services is monitored and reported.
- Provider prescribing patterns including medication utilization metrics

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

Utilization Decision Criteria

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

A. State law/guidelines (Title 22 CCR, Title 17 CCR, Medi-Cal Managed Care Division (MMCD) All Plan, Policy and Duals Plan Letters, and California Department of Health Care Services (CA DHCS) Medi-Cal Provider Manuals. State definition of medical necessity: Title 22 CCR Section 51303(a) and expanded for those under the age of 21 in W & I Code Section 14132 (v))
B. Plan-specific clinical policy (including plan-specific clinical policies in InterQual® as custom content and vendor specific criteria);
C. Centene clinical policy (including Centene clinical policies in InterQual® as custom content);
D. If no Plan, or Centene specific clinical policy exists, then nationally recognized decision support tools such as InterQual® Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®) criteria are used;
E. In the case of no guidance from A-D, additional information that the applicable Health Plan Medical Director will consider, when available, includes:

1. Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations;
2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
3. Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
4. Medical association publications~~; such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.~~;
5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
6. Published expert opinions~~, including in UpToDate~~;
7. Opinion of health professionals in the area of specialty involved;
8. Opinion of attending provider in case at hand.

Benefit determinations are based on the following:

A. Medi-Cal Benefit Plan Contract
B. Applicable State and Federal Requirements
C. Member Handbook/Evidence of Coverage
~~C.~~D. Preferred Drug List (PDL)

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

Separation of Medical Decisions from Fiscal and Administrative Management

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

- Utilization management decisions are based on medical necessity and medical appropriateness
- Health Net does not compensate physicians or nurse reviewers for denials of service requests
- Health Net does not offer incentives to encourage denials of coverage or service and attention is paid to the risk of under-utilization
- Health Net and its delegates distribute to all practitioners, providers, and employees a statement describing Health Net's policies and restrictions on financial incentives
- Utilization management decision making is based only on appropriateness of care and service and existence of coverage
- Health Net delegates do not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service

- Health Net ~~Regional~~ Medi-Cal Medical Directors and the Health Net ~~SHP~~ Community Solutions CMO/VP Medical Director ~~for State Health Programs~~ do not report to Health Net's Chief Financial Officer or its Marketing Director

Consistency of Application of Utilization Decision Criteria

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

Inter-rater Reliability (IRR) Review Process:

New hire and a~~A~~nnually, IRR ~~InterQual (IQ)~~ testing ~~is~~ are conducted on all licensed UM clinicians with the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. New UM staff are required to successfully complete IRR testing prior to being released from training oversight.

Staff are required to test on the Medical Necessity Criteria products applicable to their role. All staff must score 90% or greater for any ~~subset category~~new hire and annual IRR test. If a staff scores < 90% for any subset the staff must ~~attend~~ complete ~~retraining~~ remediation and successfully retest within 30 days of ~~retraining~~completing remediation. Documented Coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented Coaching may include but is not limited to the following: precepting of staff, retraining of the staff by reviewing the Initial/Retake IRR test(s) or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the New Hire and Annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and Documented Coaching is initiated by the People Leader. ~~Any staff with final score of < 90% for any subset category will have a Corrective Action Plan (CAP) implemented. Staff are required to test on the IQ products applicable to their role. All staff must score 90% or greater for any subset category. If a staff scores < 90% for any subset the staff must attend retraining and successfully retest within 30 days of retraining. Any staff with final score of < 90% for any subset category will have a Corrective Action Plan (CAP) implemented.~~

IRR results are reported annually at the CalViva Health Quality Improvement/Utilization Management (QI/UM) Committee Meeting.

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

- Annual PPG oversight audit, which requires a file audit of denial files using Health Net Provider Delegation Audit Tool with Medi-Cal Addendum
- Annual PPG oversight audit with specific inter-rater reliability verification

- Routine reporting of UM activities on a quarterly basis
- Health Net's Medical Directors evaluate and review all member appeals for PPG denied services for appropriate use of medical necessity criteria. Health Net's Medical Directors provide feedback as needed to PPG Medical Directors through letters or telephonic communication as needed

Standards of Timeliness of UM Decision Making

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

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

Denials

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

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

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

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

Should the requesting practitioner wish to discuss the case related to the denial decision, they are provided with the telephone number of the individual who issued the

denial and Medical Director contact information is available on the provider portal website.

Appeals

A licensed physician reviews all member medical necessity appeals.

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

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

CalViva Health maintains well-publicized and readily available appeal mechanisms for members and practitioners for medical necessity denials issued by CalViva Health, the behavioral health team~~administrator~~ or its delegates.

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

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

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

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

Evaluation of Medical Technology and Procedures

Health Net has a formal process for recognizing and evaluating advances in new medical technologies, behavioral health procedures, pharmaceuticals, devices, and new applications of existing technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages.

The Change Healthcare InterQual® criteria, the ~~HAYES~~ Hayes, Inc. Medical Technology Directory and other evidence-based resources are used as primary sources. This includes:

- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and the National Comprehensive Cancer Network® (NCCN®) Guidelines.
- Medical association publications, government-funded, or independent entities that assess and report on clinical care decisions and technology, including Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, and National Institute for Health and Care Excellence (NICE).

In addition to Health Net's primary sources, Centene's Corporate Clinical Policy Department and Clinical Policy Committee in conjunction with Health Net of California's Medical Advisory Council are responsible for the evaluation of new technology that may be sought by members. A critical appraisal of the current published medical literature from peer-reviewed publications is undertaken to assist in the evaluation of medical technology.

Satisfaction with the Utilization Management Process

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

Communication Services

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

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

The Plan will notify contracting health care providers, as well as members and

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

Emergency Services

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

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

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

Section 4

Organizational Structure and Resources

Organizational Structure and Resources

CalViva Health Staff Resources and Accountability

CalViva Chief Medical Officer

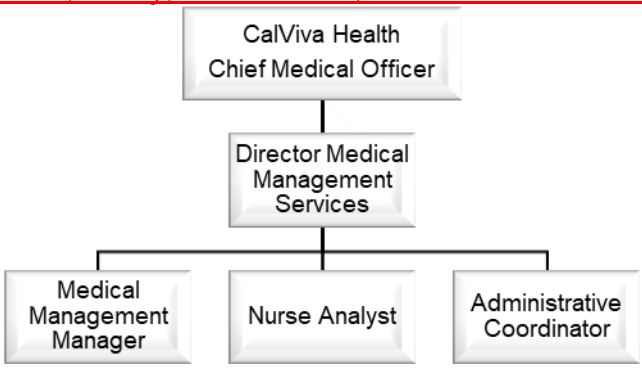
The CalViva Chief Medical Officer's responsibilities include chairing the QI/UM Committee and work group, providing oversight of QI/UM Programs, and assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with 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.

Department Resources

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

Medical Management Team

The Medical Management team will include a Chief Medical Officer, Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Nurse Analyst, and an Administrative Coordinator 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 Utilization Management program are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.



CalViva Health Quality Improvement/Utilization Management Committee

The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, and

Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.

The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity. Members of the committee are appointed by the RHA Commission Chairperson. The Committee is chaired by the CalViva Chief Medical Officer ("CMO"). Committee size is determined by the RHA Commission with the advice of the CMO.

The QI/UM Committee is composed of Participating health care providers, including physicians, behavioral health practitioners, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population and provide mental health services. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

Health Net Organizational Structure and Resources

Health Net LLC's Chief Medical Officer has direct responsibility for the Utilization Management Program.

Population Health and Clinical Operations (PHCO) Resources

Health Net, LLC Chief Medical Officer (CMO)

The Health Net, LLC CMO'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.

The CMO has overall decision-making responsibilities for Health Net medical matters. The CMO oversees, directs and coordinates all health services functions in partnership with Senior Medical Directors, Medical Directors and other PHCO leadership team members. PHCO departments for which he/she has clinical oversight responsibility to include: Quality Improvement, Utilization Management, Care Management, Appeals and Grievances, Compliance, Program Accreditation and Disease/ Chronic Condition Management.

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

Health Net Community Solutions (HNCS) CMO / Vice President (VP) Medical Director~~, State Health Programs~~

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

This position makes recommendations to the Health Net Community Solutions Board of Directors to initiate major program revisions and communicates Board of Directors' directives to both internal and external stakeholders.

Medical Directors

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

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

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

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

Senior Vice President of Population Health and Clinical Operations (VP PHCO)

The Senior VP PHCO is a registered nurse with experience in utilization management and care management activities. The Senior VP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management Programs. The Senior VP PHCO reports to the Plan Chief Operating Officer. The Senior VP PHCO, in collaboration with the HNCS CMO/VP Medical Director ~~(SHP)~~, assists with the development of the Utilization Management Program strategic vision in alignment with the corporate and Plan objectives, policies, and procedures.

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

Utilization Management (UM) Resources

Director, PHCO

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

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

Health Net UM Clinical Staff

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

- First level approvals of pre-service, concurrent and post-service approvals of care,
- Case review for inpatient, outpatient, and ancillary service requests,
- Discharge planning and authorizations for post-hospital support and care,
- Referral of potential UM denial cases to a Medical Director,
- Referral of members to Care/Chronic Condition Management when appropriate,

- Management of out-of-area cases, and
- All UM LVN, LCSW and RN staff are under the direct supervision of a Manager, who is an RN.

Additional Resources

- Additional licensed and clerical staff supports UM activities.
- Referral of members to County CCS offices when eligible
- Referral of members to LTSS and Waiver Programs
- Coordination with Regional Centers to ensure Medi-Cal members receive the full range of benefits to which they are entitled
- Coordination with CCS offices, PPG's and facilities to ensure the CCS eligible members are receiving their full benefits through managed care and carve out programs
- Referral to Local Educational Agencies (LEA) for therapeutic and diagnostic services related to educational performance
- Coordination with County programs, such as County social services for in home support services and County mental health
- Monitoring effectiveness of delegated entities and contracted providers

The Behavioral Health ~~Administrator~~ Team Medical Director and Medical Staff

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

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

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

Health Net Community Solutions (HNCS) Quality Improvement/Health Equity Committee (QIHEC)

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

Section 5

Delegation

Delegation

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

Health Net has a thorough process in place to assess a potential delegate's readiness for delegation and to systematically monitor the performance. Health Net has designated Utilization Management (UM) Compliance Auditors to perform this evaluation. UM Compliance Auditors evaluate and monitor delegated partners annually, or more frequently if needed, to ensure compliance with Federal, State, Contractual and Health Net's criteria for delegated activities. Additionally, UM Compliance Auditors are the responsible party to oversee Corrective Action Plans (CAPs) when such plans are needed.

Outside of scheduled audits, UM Compliance Auditors, in conjunction with the ~~Regional~~ Medical Directors, focus efforts on delegated partners with areas of noncompliance that indicate potential problems in the UM process to implement improvement strategies. UM Compliance Auditors evaluate and report on the effectiveness of the improvement strategy to the Delegation Oversight Workgroups (DOW)/Delegated Oversight Committee (DOC). Summary reports are provided to CalViva Health's monthly Management Oversight Meeting.

Delegated partners are required to submit monthly/quarterly reports (for Medi-Cal) to Health Net. Reports are reviewed and assessed for content and feedback is given for reports submitted.

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

A. Assessing and determining the appropriateness of delegation for each component of the delegated responsibilities: utilization management, credentialing and recredentialing, claims processing and payment. Communicates all delegation decisions, as well as any recommendations and requests for corrective action plans (CAPs), to the delegated partners in writing.

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

Delegation Oversight Committee

A. Reviews Delegation Oversight activities and recommendations of the DOW and, as needed identifies corrective actions specific to delegated partner(s) that are not meeting compliance. The DOC will review the results of annual or focused audits, the corrective actions recommended and already undertaken by the delegate, minutes from the follow-up

meetings or correspondence with the delegate, and results of follow-up audits, as appropriate.

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

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

Sub-delegation

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

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

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

Section 6

Utilization and Care Management (UM/CM) Program Evaluation

UM/CM Program Evaluation

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

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

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

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

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

UM/CM Program Work Plan

Health Net Community Solution's ~~SHP~~ CMO/VP Medical Director and Senior Vice President Population Health and Clinical Operations annually develop the CalViva Health UM/CM Work Plan using the previous year's evaluation and adding new UM/CM activities when appropriate. The development of the work plan provides a disciplined approach to UM/CM activity monitoring. The work plan process also encourages measurement throughout the year of progress towards the outlined plan.

Section 7

Approvals

Fresno-Kings-Madera Regional Health Authority Approval

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

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

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

Health Net Medi-Cal Utilization Management Program Approval

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

_____ Date _____
Alex Chen, MD
Chief Medical Officer

_____ Date _____
Jennifer Lloyd
Senior Vice President of Population Health and Clinical Operations

Item #10
Attachment 10.D

Utilization Management
Case Management

2024 Work Plan

CalViva Health
2024
Utilization Management (UM)/ Care Management (CM)
Work Plan

Last updated: February 7, 2024

TABLE OF CONTENTS

1. Compliance with Regulatory & Accreditation Requirements

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.1 Ensure that qualified licensed health professionals assess the clinical information used to support Utilization Management (UM) decisions.	☒ Medi-Cal	Qualified licensed and trained professionals make UM decisions.	Health Net (HN) has a documented process to ensure that each UM position description has specific UM responsibilities and level of UM decision making, and qualified licensed health professionals supervise all medical necessity decisions. Nurse, physician and pharmacy (for pharmacists and technicians) licensure status is maintained in Workday (HN software). Credentialing maintains records of physicians' credentialing. 100% compliance with maintaining records of professional licenses and credentialing for health professionals.	Provide clinical continuing education opportunities to staff. Conduct Population Health and Clinical Operations (PHCO) Staff new hire orientation training. Review and revise staff orientation materials, manuals and processes. Verification of licensure/certification, participation in InterQual training and IRR testing. Conduct training for nurses.	Ongoing As needed Ongoing Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.2 Review and coordinate UMCM compliance with California legislative and regulatory requirements.	☒ Medi-Cal	Each year there is new healthcare related legislation. Compliance, Legislation Implementation staff reviews and analyzes the operational impact of these new laws and regulations. This information is utilized to plan and implement new processes or changes to existing processes to ensure compliance.	Review and report on legislation signed into law and regulations with potential impact on medical management. Appropriate and timely changes are made to PHCO processes to accommodate new legislation as appropriate. 100% compliance of UMCM staff and processes with all legislation and regulations.	Review new legislation and regulations, either through e-mail or department presentation. Participate in all appropriate implementation workgroups and/or activities to ensure new legislation that affects UMCM department is executed in a timely manner. Participate in monthly compliance committees, and Program Metrics Reporting (PMR) to review and monitor compliance to standards.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.3 Separation of Medical Decisions from Fiscal Considerations	☒ Medi-Cal	DHCS, DMHC, and CMS, at a minimum, require that Medical Decisions made by Medical Directors (MDs) and Nurse reviewers are free from fiscal influence.	Affirmative statement about incentives is distributed to employees and communicated to members in member mailings and to practitioners/providers in Provider Updates. 100% compliance with acknowledgement of affirmative statement about financial incentives to practitioners, providers and employees.	All individuals involved in UM decision making must sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that the Plan does not offer financial incentives for UM decisions that result in underutilization or adversely affects subsequent claim activity. UM staff review and acknowledge this statement upon hire through the Plan's online learning platform and reminded annually thereafter. Management Incentive Plan (MIP) Goals will not be created that benefit MDs or Nurse reviewers based on any potential to deny care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.4 Periodic audits for Compliance with regulatory standards	☒ Medi-Cal	Ensure compliance with regulatory standards.	Conduct regularly scheduled quarterly review of UM denial files compared to regulatory standards, which include such items as: turnaround time requirements, clinical rationale for denials, quality and timeliness of communications with providers and members, documents opportunity for provider to discuss case with Medical Director making denial decision.	Conduct File Reviews for compliance with regulatory standards. Provide ongoing education and/or UM process improvement with staff on issues revealed during the file review process. File Audits completed the month following each quarter.	Ongoing Ongoing January 2024, April 2024, July 2024, October 2024

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.5 HN Medical Director's and CalViva Health Chief Medical Officer Interaction with State of California (DHCS)	☒ Medi-Cal	Health Net (HN) Medical Directors (MDs) interact with the Medi-Cal Managed Care Division (MMCD) of DHCS: ▪ MMCD Medical Directors Meetings ▪ MMCD workgroups ▪ Quality Improvement workgroup There are benefits to HN MD participation: ▪ Demonstrates HN interest in DHCS activity and Medi-Cal Program. ▪ Provides HN with in-depth information regarding contractual programs. ▪ Provides HN with the opportunity to participate in policy determination by DHCS.	HN Medical Directors and CalViva Health Chief Medical Officer participate on DHCS workgroups, and meetings. Ensures participation by MDs at the quarterly MMCD meetings, with input for agenda and summary of findings discussed with each MD. HN and CalViva remain a strong voice in this body with participation on key workgroups.	The Medical Director and Chief Medical Officer of CalViva will attend scheduled meetings, workshops and project meetings for 2024. Ongoing report out with CalViva to ensure CalViva is aware of all DHCS activities.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 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 as needed and 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. Senior Physician involvement is ensured, including behavioral health aspects of the UM Program.	Core group comprised of State Health Programs Chief Medical Officer (CMO), Regional Medical Directors, Director of PHCO and PHCO Managers for Medi-Cal review and revise existing Program Description and supporting UMCM Policies and Procedures.	Write and receive CalViva approval of 2024 UM and CM Program Descriptions. Write and receive CalViva approval of 2023 UMCM Work Plan Year-End Evaluation. Write and receive CalViva approval of 2024 UMCM Work Plan. Write and receive CalViva approval of 2024 UMCM Work Plan Mid-Year Evaluation. Prepare and Submit UMCM Program Description and Work plan to CalViva QIUM Committee and CalViva RHA Commission annually, providing mid-year updates and any ad hoc queries from CalViva Health leadership. Continue to monitor and revise policies and procedures based on DHCS and DMHC requirements.	Q 1 2024 Q 1 2024 Q 1 2024 Q 3 2024 Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.7 Annually review, approve and update when appropriate UM clinical criteria and clinical practice guidelines related to UM decision making	☒ Medi-Cal	All new and current UM clinical criteria and practice guidelines related to UM decision making are reviewed and approved annually by HN of California's Medical Advisory Council (MAC), which includes input from local Medical Directors. HN makes UM criteria and clinical practice guidelines available to practitioners via the healthnet.com site.	Centene's Corporate Clinical Policy Committee and HN California's Medical Advisory Council (MAC) reviews and approves policies on clinical criteria annually. Clinical practice guidelines are reviewed and approved at least every two years. Medical policies and clinical practice guidelines are available to providers upon request; Change Healthcare, Inc.'s InterQual criteria are available to providers upon request.	Confirm annually: • Health Net of California's Medical Advisory Council (MAC) in conjunction with Centene's Corporate Clinical Policy Committee reviews, updates as necessary, and approves policies for clinical criteria for UM decision making. • Ensure UM clinical criteria and UM clinical practice guidelines are made available to practitioners via healthnet.com site and practitioners are notified of new policies and changes via the Quarterly Medical Policy provider fax.	Ongoing Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
1.8 Evaluate inclusion of new technologies and new application of existing technologies in applicable benefit packages including: medical, behavioral procedures, pharmaceuticals, devices, and new application of existing technologies	☒ Medi-Cal	Standardized process is used for review of new technologies to ensure members have equitable access to safe and effective care and for inclusion in applicable benefit packages	New technologies are reviewed and approved by Centene's Corporate Clinical Policy Committee and Health Net's Medical Advisory Council (MAC). Decisions are based on nationally recognized primary sources including: Hayes® Medical Technology Directory and Hayes® Alert technology-based evaluations, InterQual® and information from evidence-based medical journals, colleges and academies.	Evaluate new technologies and ensure inclusion in member benefits as applicable throughout 2024.	Ongoing monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

2. Monitoring the UM Process

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.1 The number of authorizations for service requests received	☒ Medi-Cal	Provide oversight, tracking, and monitoring of authorization requests and evaluate opportunities to modify prior authorization requirements. Track and trend all types of prior authorization and concurrent review activities based on requirements.	Track and trend authorization requests month to month. Tracking includes: • Number of prior authorization requests submitted, approved, deferred, denied, or modified • Turnaround times (TAT) • Number of denials appealed and overturned	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of Prior Authorization process. Assess staffing needs for prior authorization process completion and ensure staffing is included in annual budget and quarterly budget revisions. Continue support for long-term care benefit carve in and ensure continuity of care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.2 Timeliness of processing the authorization request (Turnaround Time =TAT)	☒ Medi-Cal	TAT Compliance is based on DHCS standards for processing authorization requests and includes all decision categories (Approvals, Deferrals, Denials, and Modifications). Provide oversight, tracking, and monitoring of turnaround times for authorization requests.	Track and trend authorization requests month to month in all categories and report monthly in the Key Indicator Report.	Utilize the Key Indicator Report on a monthly basis as a tool for systematic oversight of TATs. Identify barriers to meeting Utilization Management timeliness standards and develop action plans to address deficiencies. Continue to focus on meeting TAT requirements. Monthly Management review of TAT results, with drill down on all cases that fail to meet TAT requirements. Ongoing training of staff and evaluation of work processes to identify opportunities for streamlining.	Ongoing UM TAT summaries due monthly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.3 Conduct annual Interrater Reliability (IRR) testing of healthcare professionals involved in UM decision-making	☒ Medi-Cal	Consistency with which criteria are applied in UM decision-making is evaluated annually. Opportunities to improve consistency are acted upon.	PHCO Learning and Development administers new hire and annual IRR tests to licensed UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews All new hire and annually staff must achieve a minimum passing score of 90% on each IRR test	Administer the Change HealthCare InterQual IRR test in Q3-Q4 2024 to UM clinicians that have the responsibility to conduct, educate, audit, and/or oversee UM medical necessity reviews. Documented coaching will be initiated by the People Leader for any staff with a final score of less than 90% for any IRR test. Documented coaching may include but is not limited to the following: precepting of staff, retraining of the staff by reviewing the Initial/Retake IRR test(s) or auditing five (5) cases in production, for any IRR Product(s) not passed. In the event the new hire and annual IRR test(s) are not completed within the designated testing period, a failure of all applicable IRR tests is applied, and documented coaching is initiated by the People Leader.	Q3-4 2024 Q4-2024

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.4 The number of appeals of UM authorization decisions received, appeals upheld and overturned, and timeliness of appeals.	☒ Medi-Cal	Track the number of clinical appeals received for authorization decisions and also the number upheld and overturned to determine where modifications in authorization process are appropriate.	Measure UM Appeals volume as a percentage of the total authorization requests. Measure the number upheld and overturned, as well as Turnaround Times.	Appeals data, the numbers received, timeliness of completion of appeals will be reported to CalViva Health QIUM Committee and RHA Commission meeting at each regular meeting. 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. 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. 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

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
2.5 Review annual member and practitioner surveys to assess satisfaction with UM process and to address areas of dissatisfaction	☒ Medi-Cal	Continually assess customers' satisfaction with the UM process to identify areas that c an be improved. Interventions are made to improve satisfaction levels where dissatisfaction is identified	The Plan strives to improve Satisfaction with UM Process. Annually satisfaction surveys are conducted and followed by: • Review of satisfaction survey data and trends. • Comparison of survey results with other source data. • Prioritization and implementation of interventions to improve member and practitioner satisfaction with UM processes. • Re-measurement of satisfaction periodically to ensure interventions is effective. • Improved member and practitioner satisfaction results based on surveys and other satisfaction data, including but not limited to: <u>Member</u> Consumer assessment of healthcare providers and systems (CAHPS) survey Member Grievances <u>Practitioner Survey</u> Provider Satisfaction Survey	Complete annual Member and Practitioner Satisfaction survey to assess satisfaction with UM Process. Establish process to assess annual satisfaction survey outcomes.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

3. Monitoring Utilization Metrics

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 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 PHCO manage the non-delegated shared risk PPGs and a sizable FFS membership.	Health Net manages shared risk non-delegated PPGs and FFS inpatient UM. Data reported quarterly at State Health Programs UM/QI Committee meeting ▪▪▪▪▪▪▪▪▪▪▪▪▪▪ Key Metrics (SPD, Non-SPD, MCE) Bed days/k ALOS Admit /K All cause readmits within 30 days 2024 Goals: • 2% reduction in readmissions between 8-30 days over 2023 • 2% reduction in ALOS over 2023	Continue care management initiatives for adults to include correct aid code assignments, early intervention to establish medical home, and care coordination for carve out services. Use data to identify high cost/high utilizing members to target for care management. The UM team will continue transition care management collaboration and enhanced discharge planning to increase discharges to alternative and recuperative care settings. The effectiveness of the utilization management program will be tracked using key indicator performance reports for review and improvement. Leverage Member Connections to support on-site bed side enrollment of members into programs such as MedZed, CalAim, Complex Care Management and Community Supports. Explore areas for on-site support (clinical or non).	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
3.2 Over/under utilization	☒ Medi-Cal	Health Net ensures appropriate use of services for members by monitoring relevant data types for under- and over-utilization of services for SPD and Non-SPD members. Fraud, Waste and Abuse of medical services is monitored and reported. PPG Reports are used internally and externally with medical groups to develop member and population level interventions. Quarterly reports are made available for PPGs with member Non-SPD >1000 and SPD greater than 500 members. And MCE members >1000.	The UM metrics will be reported quarterly and the procedure metrics will be reported annually for PPGs with greater than 1,000 non-SPD, greater than 1,000 MCE or 500 SPD Medi-Cal Members. Metrics for the PPGs and CCR will be for the SPD, MCE and TANF populations and will include: 1. Admissions/K 2. Bed days/K 3. Acute care average length of stay 4. ER admits/K 5. All case readmits 6. Authorization appeals, denials, deferrals, and modifications In addition, PPG metrics will include: 7. Specialty referrals for target specialties PPG profile reports are made available quarterly and specialty referrals are assessed on a biannual basis. Additionally PHM KPI monitoring includes: • Percentage of members who had more ED visits	Continue to enhance provider profile. Identify PPG PIP, outcome results and barriers and present aggregated results to CalViva. (Over and Under Utilization reports) Identify possible fraud, waste and abuse issues. Report any issues to the SIU and Compliance Department Thresholds for 2024 are under evaluation. <u>Referral Rates: Specialist</u> PM/PY referral rates are calculated from claims and set as internal thresholds by PPG. Referral rates to be determined and compared with PPG peers including Health Net Region 3 (Central Valley) and Health Net Medi-Cal State wide. PPGs with significant deviation from the peer comparison will be identified as potential outliers and engaged to determine the drivers of variation. Reevaluate appropriate metrics to be included in the PPG dashboard. Specialties and PPGs identified as potential outliers for the metrics measured undergo further analysis by the MD to determine if a Quality Improvement Plan is indicated. The Quality Improvement Plans, if applicable are reviewed at the regional joint operations meetings lead by the Medical Directors. Results of the reviews will be reported to CVH leadership quarterly in the PPG dashboard. New quarterly over-under report being generated will include direct network and PPG membership. Report will include ambulatory care measures (OP visits PTMPY, ED visits PTMPY) and selected surgical procedures PTMPY as markers of over-underutilization.	Ongoing

			than primary care visits within a 12-month period; • Percentage of members who had a primary care visit within a 12-month period; • Percentage of members with no ambulatory or preventive visit within a 12-month period.		

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
3.3 PPG Profile	☒ Medi-Cal	PPG Profiles provide performance metrics for delegated PPGs. The data is collected from the PPGs for CalViva members and compiled in a dashboard. Variances of 15% or more from previous quarter are researched and reported quarterly during the CalViva MOM.	Medi-Cal PPGs with delegated CalViva members provide quarterly reporting to Health Net Delegation Oversight (DO). Delegation oversight compiles the data, seeks root causes for any variances of 15% or greater and normalizes the data to PMPY. The following metrics are tracked by Delegation oversight: 1. Prior authorization volume & timeliness 2. Specialty referral volume for in network/out of network 3. Specialty referral access timeliness The 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, Operations, Access, Clinical, Financial, Specialty Referral, Appeals and Grievance, etc.	CalViva Clinical PPG profile dashboard includes metrics for utilization management processing and timeliness for delegated providers. CalViva delegated PPG reports are evaluated on a quarterly basis for inpatient and specialty referrals. Referral time to services by specialty are reported to Provider Network Management. Variance rate is calculated from previous quarter and all Variances >+- 15% are researched Compliance rate is calculated as identified by DHCS for: • Prior authorization timeliness CalViva delegated PPGs identified as non- compliant are requested to complete a root cause analysis and submit a corrective action plan to HN Delegation Oversight. Corrective Action Plans and ongoing monitoring of success of interventions will be reported to CVH at regular intervals. CAPs identified during an annual audit by the HN Delegation Oversight is monitored and followed-up by HN Delegation Oversight. These activities will be reported to CVH during Annual Oversight Audits of HN.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

4. Monitoring Coordination with Other Programs and Vendor Oversight

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.1 Care Management (CM) Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing physical and emotional health and well-being and improving quality of life. Assisting members with complex and serious medical conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs. Reviewing Member self-referrals to ECM and Community supports and referring members to ECM providers as appropriate. Members not meeting criteria will be referred to care management.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report including PHM Key Indicators to track and trend Care Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in care management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction o Percentage of members eligible for CCM who are successfully enrolled in the CCM program; and o Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post discharge. o ECM Enrollment and Graduation Rates	Dedicated staff of RNs, LCSWs, Program Specialists, Program Coordinators to perform physical health and integrated CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly. Member connections team to collaborate with care management by providing in home visits to support appropriate interventions and improve member outcomes. ECM program and provider performance by county are reported quarterly CVH UM/QI Committee	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.2 Referrals to Perinatal Care 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 PPGs of patients identified for program. Measure program effectiveness based on the following measures: ○ Member compliance with completing • 1st prenatal visit within the 1st trimester and • post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program • pre-term delivery of high-risk members managed vs high risk members not managed	PCM Outreach to OBGYN MD's to promote referrals into PCM program for high risk moms. Dedicated staff of RNs, Program Specialists, and Program Coordinators to perform perinatal CM activities. Use of NOP reports to identify members with moderate and high-risk pregnancy for referral to the pregnancy program. Review outcome measures quarterly.	Ongoing Ongoing Ongoing Quarterly

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.3 Behavioral Health (BH) Case Management Program	☒ Medi-Cal	Providing members with access to quality health care delivered in an appropriate setting and compassionate manner; optimizing emotional health and well-being and improving quality of life. Assisting members with behavioral health conditions through the continuum of care and identifying barriers to accessing care will support and help members and caregivers manage their health care needs.	Monthly new member outreach reports for care management assessment. Measure, track and trend care management interventions resulting from triage processes. Monitor Key Indicator report to track and trend Case Management activities and acuity levels monthly Utilize stratified health risk assessment data to identify high-risk members and engage them in case management programs Measure program effectiveness based on the following measures: o Readmission rates o ED utilization o Overall health care costs o Member Satisfaction	Dedicated staff of LCSWs, LMFTs, and Program Specialist to perform BH CM activities. The Population Health Management report that includes use of Impact Pro (a predictive modeling tool) is used to identify high risk members for referral to CM. Review outcome measures quarterly.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.4 Disease/ Chronic Condition Management	☒ Medi-Cal **Diabetes Age Groups** 0-21 CCS Referral (100%) >21 Enrolled in program	The Managed Care Plan is responsible for initiating and maintaining a 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. Plan Chronic Condition Management Programs may include, but are not limited to: ○ Asthma ○ Diabetes ○ Heart Failure	Ongoing program monitoring. Review prevalence data to affirm selection of Chronic Condition Management program offerings. Submit Disease/Chronic Condition Management redesign proposal for approval.	Ongoing 12/31/2024 12/31/2024

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology	2024 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. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to remove unnecessary PA obstacles for practitioners and pharmacists. SHP MDs and the CalViva Health Chief Medical Officer work with Pharmacy to improve CCS ID using pharmacy data.	Monthly report of PA requests.	Continued active engagement with pharmacy. Revised UMQI reporting based on Medical Benefit drug review. Revised DUR reporting based on Medi-Cal RX data. Continued A&G tracking of pharmacy cases related to medical benefit drug review.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 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 the behavioral health team staff are facilitating coordination of care. Each month is compared to data from previous months to ensure the number of referrals to County follows an acceptable trend. For example, a consistent drop in referrals may indicate the need for additional staff training. Review data that indicates when a PCP has referred a member to a BH provider. Each month's data is compared to those from previous months to ensure that coordination of care between medical and behavioral health is occurring. For example, a drop in these referrals may indicate a need for enhanced medical provider training on the services that the behavioral health team provides.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
4.7 Behavioral Health Performance Measures	☒ Medi-Cal	CalViva collaborates with Behavioral Health practitioners to improve performance measures for the CalViva behavioral health care members.	Performance Measures to be monitored: Appointment Accessibility by Risk Rating Authorization Decision Timelines Potential Quality Issues Provider Disputes Network Availability Network Adequacy: Member Ratios Timeliness to first appointment for member's diagnosis with Autism Spectrum Disorder.	Participate in cross functional team to improve quality of behavioral health care.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

5. Monitoring Activities for Special Populations

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objective(s)	2024 Planned Interventions	Target Completion Date
5.1 Monitor California Children's Services (CCS) identification rate.	☒ Medi-Cal	Health Net State Health Programs (HN SHP) will monitor Medi-Cal CCS identification rate YTD.	All HN SHP staff will work with Public Programs Specialists and UM staff to identify potential CCS cases and refer to county for approval. Based on the standardized formula, monthly report indicates CCS %. Goal: Identify 5% of total population for likely CCS eligibility.	CCS identification and reporting continues to be a major area of focus. Continue current CCS policies and procedures. Continue to refine CCS member identification and referral through concurrent review, prior authorization, care management, pharmacy, claims review, member appeals and member services (welcome calls and Child and Adolescent Health Measurement Initiative (CAMHI) screening tool). Continue to improve and refine coordination with CCS between specialists and primary care services. Collaborate with Public Programs and Coordination of Care Team to facilitate transition of Independent Care Facility CCS membership (begins July 1st 2024). Continue to monitor Aging-out membership, identified 12 months before their 21st birthday, and continue Care Management referrals. Meet with county CCS offices to improve identification of member CCS status.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

Activity/ Study/Project	Product Line(s)/ Population	Rationale	Methodology Measurable Objectives	2024 Planned Interventions	Target Completion Date
5.2 Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements	☒ Medi-Cal	California Section 1115 waiver requires mandatory enrollment in managed care for SPDs. Essential elements of the waiver include risk stratification, health risk assessment (HRA), and care coordination/care management.	All UM Policies and Procedures revised as needed and submitted to DHCS on time for approval, all state required reporting completed and submitted through tracking and trending of SPD UM/CM program. Monitor HRA outreach	Perform Risk Stratification for all SPD's on a monthly basis, and identification of members for enrollment into the appropriate program, such as Care Management, the Pharmacy Program, the Pregnancy Program, or a Chronic Condition Management Program. Continue to meet all requirements for SPDs and utilize all programs to support them, including CM, Chronic Condition Management, Long Term Services Supports, and Care Coordination.	Ongoing

Report Timeframe	Status Report/Results	Barriers	Revised/New Interventions	Target Completion Date
Mid-Year Report ☐ **ACTIVITY ON TARGET** ☐ **TOO SOON TO TELL**				
Annual Evaluation ☐ **MET OBJECTIVES** ☐ **CONTINUE ACTIVITY IN 2025**				

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

Item #11
Attachment 11.A

Case Management

2024 Program Description
& Change Summary

REPORT SUMMARY TO COMMITTEE

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

FROM: Carrie-Lee Patnaude, Manager Care Management

COMMITTEE DATE: February 15th, 2024

SUBJECT: Care Management Program Description Change Summary

CM Redline Page #	Section/Paragraph name	Description of change
1	Title page	Updated year from 2023 to 2024
7-10	Organizational Structure	Added in CalViva QI/UM info and organization, updated health net job titles (removed VP PHCO and added CM Director, VPMM changed to CMO), removed Member Connections.
24	Transitions of Care	Updated Transitions of Care program section to reflect requirements for 2024
25	Palliative Care	Palliative Care has changed to a prior auth benefit, and so the section is updated to reflect this change.

Health Net Community Solutions and CalViva Health Care Management Program Description 2024

Table of Contents

PURPOSE

The purpose of the Care Management Program Description is to define care management, identify care management functions, describe methods and processes for member identification, assessment, components of managing member care, and measuring outcomes.

The primary care provider (PCP) is the cornerstone of the Plan's service delivery model serving as the "medical home" for the member. The medical home concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost-effective care and better health outcomes. The PCP is expected to manage and coordinate the holistic care needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety.

Delegated Participating Physician Groups (PPG) conduct basic care management activities in compliance with the Plan's standards.

In both delegated and non-delegated situations, the Care Management program provides individualized assistance to members experiencing complex, acute, or catastrophic illnesses, and to 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 with their providers, and improve health and functional status. In addition, certain Care Management responsibilities are an integral part of Carve-Out and Public Health programs (e.g., California Children's Services, Regional Centers).

The Plan provides a comprehensive, high-risk perinatal program to members regardless of delegation status. Care Managers work with PCPs and other providers to develop individualized plans for appropriate members.

SCOPE

Definition of Care Management

Care Management is a key component 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 Care Management program and the tools utilized to manage care were developed from 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 tools including the PHQ2/9. Disease-specific assessments include research of latest scientific sources, along with articles and publications from national organizations such as the American Diabetes Association. The Program also adheres to HEDIS effectiveness of care measures and the associated technical specifications to promote member adherence.

Care Management associates are trained in and utilize motivational interviewing techniques to guide member goal identification and associated actions.

Levels of Care Management Include:

1. **Basic Population Health Management (BPHM)**
    A. **Care Coordination** – Appropriate for members with primarily social determinants of health (SDOH) such as housing, financial, etc. with the need for referrals to community resources for 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 at this level of coordination include outreach to member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure follow-through. In addition, this level of care management is used for continuity of care transitions and supplemental support for members managed by the county.
    B. **Care Management** – Appropriate for members needing a higher level of service, with clinical needs. Members in Care Management may have a complex condition or multiple co-morbidities that are generally well-managed. Members in Care Management typically have adequate family or other caregiver support and are in need of moderate to minimal assistance from a care manager. Services at this level include those provided at the level of Care Coordination along with identification of member agreed-upon goals, identification of interventions needed to meet the goals, and necessary support to meet those goals.
2. **Complex Care Management (CCM)**
    CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner. CCM is 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. CCM is provided by Health Net for members who need additional support to avoid adverse outcomes, and/or those 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 include all Care Coordination and Care Management services described above, along with more frequent member contact to assess continued appropriateness and adherence with their treatment plan, and progress towards meeting goals. Care Managers monitor members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence. Care Managers also evaluate members for referral to Enhanced Care Management (ECM) services as appropriate.

Goals and Objectives

The Mission of the Plan's Care 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 identifying and accessing necessary benefits and resources.
- Work collaboratively with members, their 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 Care 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 within 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

Care Management Functions:

Care 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, 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/care management activities.
- Addressing the member's right to decline participation in the Care Management program or disenroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all care management procedures in compliance with HIPAA and state law.

Program Segments

The Plan has defined a set of care 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 Care Management program effectiveness across the Medi-Cal membership. The criteria below is not all inclusive; clinical factors are also considered to determine a member's appropriateness for each level of care management, considering such factors as stability of the condition(s), available support system, current place of residence, etc.

Complex Care Management Criteria

The Plan uses the Population Health Management (PHM) report to identify members for Complex Care 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 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 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, MicroStrategy®, is used to produce adjunctive analytical reports for related PHM programs including Complex Care Management.

Members stratified as described below are identified as complex and are referred to care 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)
- 05b Chronic Moderate Risk

AND have:

- ER likelihood: highly or most likely

Members referred from other sources may also be managed as a complex care based on the member's need.

Care Management Criteria
Diagnostic categories typically associated with high intensity of services and/or high cost, but are generally well-managed in the individual. Diagnoses include, but are not limited to: • HIV/AIDS • Cancer • Asthma, with associated inpatient admission • Sickle cell • Diabetes • Congestive Heart Failure • Depression • Anxiety • Children with special health care needs • Other State-mandated criteria such as members under 21 years of age receiving private duty nursing services • Members otherwise meeting criteria for Complex Care Management but do not have an additional parameter such as ER likelihood: high
Care Coordination Criteria
• Primarily social determinants of health issues such as housing, financial, etc. with need for referrals to community resources • Need for assistance with accessing health care services related to continuity of care • Participation in county program requiring supplemental Plan support

INFRASTRUCTURE AND TOOLS

Organizational Structure

CalViva Health Quality Improvement/Utilization Management Committee

The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.

The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity. Members of the Committee are appointed by the RHA Commission Chairperson. The CalViva Chief Medical Officer ("CMO") chairs the Committee. Committee size is determined by the RHA Commission with the advice of the CMO.

The QI/UM Committee is composed of Participating health care providers, including physicians, behavioral health practitioner (s), as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network. The Committee composition may also include Commission members who are participating health care providers

and is composed of less than a quorum of voting Commissioners. Committee membership reflects an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population and provide mental health services. Participating Practitioners from other specialty areas are retained as necessary to provide specialty input.

CalViva Health Staff Resources and Accountability

CalViva Chief Medical Officer

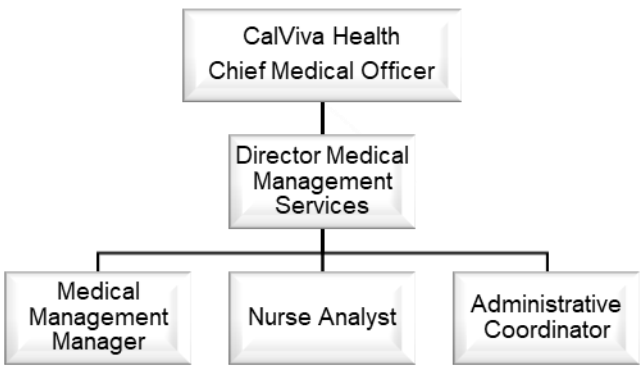
The CalViva Chief Medical Officer's responsibilities include chairing the QI/UM Committee and work group, providing oversight of QI/UM Programs, and assuring that the QI and Utilization Management Programs are compatible and interface appropriately with the provider network, overseeing compliance with 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.

Department Resources

CalViva staff, with assistance from HNCS interdisciplinary staff, contribute to the success of the CalViva Utilization Management & Case Management (UMCM) Program. These administrative and clinical staff work with CalViva's Chief Medical Officer and Director of Medical Management to oversee UMCM activities for CalViva's Medi-Cal members and provider network. The resources and responsibilities of departments most involved in the UMCM process are described below.

Medical Management Team

The Medical Management team will include a Chief Medical Officer, Director of Medical Management Services, who is a Registered Nurse, a Medical Management Manager, a Nurse Analyst, and an Administrative Coordinator 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 Utilization & Care Management programs are appropriately trained and experienced in Utilization Management, Safety, Public Health, Health Administration, and Care Management.



Health Net Organizational Structure

Chief Medical Officer

The Health Net Community Solutions (HNCS) Chief Medical Officer (CMO) has operational responsibility for and provides support to the Plan's Care Management program. The Plan CMO, Sr. Vice President of Population Health & Clinical Operations (SVP PHCO), and/or any designee as assigned by the Plan President and CEO are the senior executives responsible for implementing the Care Management program including cost containment, quality improvement, medical review activities, outcomes tracking, and reporting relevant to care management. A behavioral health practitioner participates in the implementation, monitoring, and directing of behavioral health aspects of the Care Management program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. In addition to the CMO, the Plan may have one or more Medical Director and/or Associate Medical Directors.

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

- Assist in the development and revision of care management policies and procedures as necessary to meet state statutes and regulations.
- Monitor compliance with the Care Management program.
- Provide clinical support to the care management staff in the performance of their care management responsibilities.
- Provide a point of contact for practitioners with questions about the care management process.
- Communicate with practitioners as necessary to discuss care management issues.
- Assure there is appropriate integration of physical and behavioral health services for all members in care management as needed.
- Educate practitioners regarding care management issues, activities, reports, requirements, etc.
- Report care management activities to the Quality Improvement Health Equity Committee and other relevant committees.

Behavioral Health Practitioner

A behavioral health practitioner participates in implementing, monitoring, and directing the behavioral health care aspects of the Plan's Care Management program. A behavioral health practitioner may participate in care 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 Population Health & Clinical Operations (SVP PHCO)

The SVP PHCO is a registered nurse with experience in utilization management and care management activities. The SVP PHCO is responsible for overseeing the activities of the Plan's Utilization Management and Care Management programs. The SVP PHCO reports to the Plan Chief Operating Officer. The SVP PHCO, in collaboration with the CMO, assists with the development of the Care Management program strategic vision in alignment with the Corporate and Plan objectives, policies, and procedures.

Care Management Director

The Care Management Director is a registered nurse or other appropriately licensed healthcare professional with experience in care management activities. The VP PHCO is responsible for overseeing the operational activities of the Plan's Care Management program. The Care Management Director reports to the Sr. Vice President of Population Health & Clinical Operations and assists with the development and oversight of the strategy, policy, and operational planning and execution of work processes for the Care Management program. The Care Management Director works in conjunction with the Utilization Management Director to execute the strategic vision of Plan objectives and attendant policies and procedures and state contractual responsibilities.

Care Management Manager

The Manager of Care Management is a registered nurse or other appropriately licensed healthcare professional with care management experience. The Care Management Manager directs and coordinates the activities of the department including supervision of Care Managers, Program Specialists and Program Coordinators. The Care Management Manager reports to the Director of Care Management.

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/Care Management (CC/CM) teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-licensed 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 cases. The Integrated Care Team roles and responsibilities include care managers, social workers, other licensed clinical staff, program specialists, program coordinators, and care coordinators.

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 care management process.
- Communicates with practitioners as necessary to discuss care management issues.

Care Manager (CM)

- Registered Nurse (RN), Licensed Marriage and Family Therapist (LMFT), or Licensed Clinical Social Worker (LCSW)
- CM certification preferred.
- Responsible for oversight of non-clinical members of the CC/CM team.
- Responsible for collaborating 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 care team to ensure that member's needs are addressed.

Social Workers/Program Specialists/Licensed Vocational Nurse (SW/PS/LVN)

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

- Non-clinical staff person working under the direction and oversight of a PC Supervisor.
- 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.

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 PCPs or specialists, behavioral health providers and/or County Mental Health Plan staff 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 care 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 care management interventions.

MEMBER IDENTIFICATION AND ACCESS TO CARE MANAGEMENT

A key objective of Plan's Care Management program is early identification of members who have the greatest need for care coordination and care 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 less successful in less intensive programs; or are frail, elderly, disabled, or at the end of life.

Data Sources

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

- Claim or encounter data
- Predictive modeling software
- Hospital discharge data
- Pharmacy data
- UM data, e.g., hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data
- Emergency department utilization reports
- Laboratory data
- Readmission reports
- State/CMS enrollment process and other State/CMS supplied data

- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD/SSI)
- Information provided by members or their care givers, such as data gathered from Health Risk Assessments, Member Evaluation Tool (MET)
- Information provided by practitioners, such as Notification of Pregnancy

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

Referral Sources

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

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Care Management program and referral process through the Provider Handbook, the Plan website, provider newsletters, and by Provider Services staff.
- Nurse Advice Line has policies and procedures in place for referring members to the Health Plan for care 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.
- Disease Management (DM) program staff work closely with the Care 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 care management rounds, are held between the care team and DM staff.
- Hospital staff (e.g., hospital discharge planning and emergency department staff) are educated about the Plan's Care Management program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff are encouraged to inform Plan UM staff if they feel a member may benefit from care management services; UM staff then facilitate the referral.
- Health Plan staff, including Utilization Management, work closely with Care Management staff on a daily basis and can initiate a referral for care management services 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 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 care 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 agency staff are informed of the Care 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 care management needs to Plan staff (California Children's Services (CCS), Local Health Department (LHD), Local Mental Health Plan (MHP) etc.).
- State agency/state enrollment center.

The specific means by which a member was identified as a potential candidate for care management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to care management. Multiple referral avenues help to minimize the time between need for and initiation of care 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 seven (7) calendar days of identification as a potential candidate for care management. Care Team staff complete the care management screening and/or initial assessment once member contact is made. Care Management staff also explains the Care Manager role and function, and benefits of the Care Management program to the member and/or their authorized representative or guardian. Members can opt out of Care Management at any time.

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 care 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 enrolled in the Care Management program and are informed they may opt out or decline participation/disenroll from care management at any time.

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. If a member declines participation, it is documented.

Members unable to be contacted via telephone, following multiple attempts, are mailed a letter requesting that the member call the Care Team.

Based on application of the criteria in the screening assessment, candidates are preliminarily stratified as low, moderate/medium, or high priority in terms of frequency of contact and intensity of interventions required to achieve favorable outcomes. Generally, candidates identified as stable regarding any medical condition, and with primarily social determinants of health needs are designated as low priority/low frequency of contact and are assigned to Care Coordination. Members with complex medical conditions where the condition is mostly stable, and the member has adequate care giver support are identified as a moderate/medium priority with a moderate frequency of contact. Members designated as moderate/medium priority are

assigned to a care team who confirms the findings of the screening assessment and may complete a more thorough assessment with the member. Outpatient outreach to members is initiated within seven (7) calendar days and completed within 21 calendar days of identification/referral. Inpatient outreach to members is initiated within one (1) business day, and a minimum of three (3) outreaches in three (3) business days are made. 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/es 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, Care Management, or Complex Care Management may be revised at this time or following further assessment.

The Care Manager then begins outreach to the member and/or authorized representative or guardian telephonically within one (1) day for inpatient members, and within one week for outpatient members identified as high priority and appropriate for Complex Care Management to perform an in-depth assessment to identify and prioritize the member's individual needs. An additional, condition-specific assessment may also be completed to obtain 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 care management assessment, the Care Manager evaluates the full scope of the member's situation and documents their conclusions about the data collected, 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 care 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 started within 30 days of enrollment in Care Management. The assessment is completed in 30 days for non-complex cases. For complex cases the assessment is completed no later than 60 days after the identification/referral of the member to Care Management (per National Committee for Quality Assurance [NCQA] standards), but in most cases is completed earlier. A member is considered eligible for care 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., home health, physical therapy, occupational therapy)
- Behavioral health providers
- Representatives from community social service, civic, and religious based organizations (e.g., United Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation, companionship, etc.)
- Other non-health care entities (e.g., Meals on Wheels, home construction companies)

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, prevention, and early intervention. Specialty mental health services are not covered under the Plan and are paid under Medi-Cal FFS. The Plan ensures 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 also assists 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. Whether the member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health Care Manager will serve as the lead Care Manager. The medical and behavioral health Care Managers confer with each other to confirm which Care Manager will serve as the lead or secondary Care Manager. If the Care Managers cannot agree, a supervisor is consulted for a decision.

When assigned to a physical health Care Manager, they review the member's clinical information to ensure the member is receiving appropriate behavioral health care. If the member does not appear to be receiving appropriate care, the Care Manager:

- Contacts the medical provider to ask about a behavioral health consult.
- Assists the member or coordinates with the Behavioral Health Care 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 care management), the medical and behavioral Care Managers confer with each other to ensure that the necessary expertise is available to monitor and guide the members' care. The primary Care Manager is responsible for ensuring appropriate physical and behavioral health follow-up in care management discharge planning.

Coordination with External Programs

The Plan refers 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), Regional Center for the developmentally disabled, Home and Community-Based Services (HCBS) Waiver program administered by the State Department of Developmental Services (DDS), Regional Center or local governmental health program as appropriate for the provision of Targeted Case Management (TCM) services. The Plan continues 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 ensures the coordination of services and joint care management between its PCPs, specialty providers, and local programs or agencies.

ONGOING MANAGEMENT

Plan of Care Development

The initial assessment serves as the foundation for the member's care plan. The Care Team identifies issues and needs, and utilizing input from team participants, develops a proposed care plan. The care plan is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care plan as needed. Prioritized goals are established and barriers to meeting goals are identified, as well as possible solutions to the barriers. The proposed care plan is based on medical necessity, appropriateness of discharge planning as applicable, support systems to assist 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 are obtained and used to modify the interventions/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 Care Management have an abbreviated care plan. The care plan for members in Complex Care 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 verbally assures the member has a full understanding of their responsibilities they identified they will do to reach their goal(s) and assists the member in identifying achievable steps within their~~per the~~ self-management plan. Interventions also include action steps the care manager will take to help member reach their goals.
- Planning for continuity of care.
- Collaboration with and involvement of family and significant others, health care providers, etc. (as applicable).
- The schedule for on-going communication with the member and other involved parties, based on individual needs and member preference.
- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated.

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

Monitoring and Evaluation

Once the plan of care is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Revisions to the care plan are made when necessary, e.g., when the member's condition progresses or regresses, when goals are reached. 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 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 Care 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 care 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 Care 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 care management. If the member loses eligibility for more than 30 days, then a new assessment is performed upon enrollment back into the complex care management program to ensure the member is being assessed for current care 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 Care 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 Care Management should occur:

- Member terminates with the Health Plan.
- Member/family requests to disenroll/opt out of the Care Management program.
- The member/family refuses to participate in Care 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 Care 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 care management.
- Discusses the impending discharge from Care 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 Care 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 initiated by email, text, or phone.

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 are made to the Care Management program if opportunities for improvement or gaps in care management services are identified. Potential revisions to the Care Management program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.
- Revisions to types of care 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 Health Equity Committee, for review and feedback.

Member Experience with Care Management

Member experience with the Care Management program is assessed no less than annually. Member experience surveys, specific to care management services, are completed at least annually for members enrolled in care management. Surveys may be completed by email, text, or telephonically for members who have been enrolled in care 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 Care 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 Care 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 Care Management program, as needed.

Outcomes

Care 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 Care Management no less than annually using at least three (3) measures that assess the process or outcomes of care for members in Complex Care 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 pregnant members who have a pre-term delivery

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

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

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

Condition Specific CM and Chronic Condition Management Programs

Members in condition specific Care/Chronic Condition Management programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The Care 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 Care Management when not specifically addressed in the Program. Chronic Condition Management has been delegated to the Centene Corporate Disease Management team and the Plan Care Manager coordinates care and member interaction to prevent duplication of contacts and services.

Plan Care Management programs may include, but are not limited to:

- Children and Adults with Special Health Care Needs
- Sickle Cell
- Transition of Care (hospitalization follow-up)
- High Risk Pregnancy

- Transplant
- First Year of Life

Plan Chronic Condition Management programs may include, but are not limited to:

- Asthma
- Diabetes
- Heart Failure

SPECIAL PROGRAMS
CalAIM

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 Supports are the first two programs that launched on January 01, 2022. Populations of Focus (POF) in 2022 and 2023 were those members that were previously in (WPC) or (HHP); Adults and Their Families Experiencing Homelessness; Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization; Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; Adults with Intellectual or Developmental Disabilities (I/DD); Adults who are Pregnant or Postpartum; Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; Adult Nursing Facility Residents Transitioning to the Community; Adults without Dependent Children/Youth Living with Them Experiencing Homelessness; Children & Youth Populations of Focus. Populations of Focus for 2024 will be Birth Equity; Individuals Transitioning from Incarceration; and Pre-Release Medi-Cal Services.

- **Enhanced Care Management (ECM**) is a Plan benefit that provides a community based, high-touch, person-centered/whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need members through systematic coordination of services.
- **Community Supports** 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 may include Asthma Remediation; Community Transition Services/Nursing Facility Transition Services to a Home; Day Habilitation programs; Environmental Accessibility Adaptation (Home Modification); Housing Deposit; Housing Tenancy and Sustaining Services; Housing Transition Navigation; Medically Tailored Meals; Nursing Facility Transition/Diversion to Assisted Living Facilities; Personal Care Services and Homemaker Services; Recuperative Care; Respite Services; Short-Term Post-Hospitalization Housing; and Sobering Centers.

Members can self-refer to ECM and assigned staff will make contact to determine if they fall within the POF. If they are, staff will send notification to the assigned ECM provider to outreach to the member. Care Management staff may also refer members to ECM services if they identify members in a POF and would benefit from ECM services. Care Management staff also regularly refer members to CS. Members accepted into ECM cannot be in the Plan's Complex Care Management program due to duplication of services, but can still be referred to Community

Support services, Condition Specific Disease Management programs, and the Transition of Care program.

Transition of Care Program (TOC)

The purpose of the TOC program is to provide a comprehensive, integrated transition process that supports members during movement between levels of care with an identified care manager as the single point of contact for all transitional care management services. TOC Care Manager responsibilities including information sharing, discharge risk assessment, discharge planning documentation, medication reconciliation, referrals, are addressed when updating the Transition of Care policy and procedures. Care Transition interventions are focused on coaching the member and the member's support system during the inpatient stay and the immediate post-discharge period to ensure timely, safe, and appropriate medical care in the most efficient and cost-effective manner. Knowledge of internal and external processes surrounding the inpatient and post-discharge stay is essential in navigating the health care continuum and addressing barriers to post-discharge success for the member.

The TOC program ensures a smooth transition from one setting to another and reduces 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 an initial outreach call within one (1) day of inpatient referral to complete an inpatient discharge risk assessment
- Initiating Community Support referrals as appropriate
- Focus on the member's goals and treatment preferences during the discharge process
- Review of the member's disease symptoms or "red flags" that indicate a worsening condition and strategies for 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 member's self-management role
- Encouraging the member to follow up with the PCP/and or specialist within 7-10 days of discharge, and providing scheduling assistance if not listed on the post-discharge instructions
- Ensuring member transition is successful and needs are met
- Post-discharge medication reconciliation

During the post-discharge period, staff evaluate the member to provide effective support to the member in managing their continued needs. Members are referred to Care Management, Complex Care Management programs, or ECM as appropriate for ongoing/longer term support.

First Year of Life (FYOL)

The FYOL program is available for children from birth to fifteen (15) months old. The purpose of the FYOL program is to increase HEDIS rates for Well Child Visits and immunizations, reduce unnecessary/inappropriate emergency room visits, and provide parent/caregiver support. The Program consists of Care Managers and Program Specialists with pediatric nursing and/or post-partum outreach experience. Telephonic outreach is completed at 2, 4, 6, 9, 12 and 15 months.

Calls are completed two (2) weeks prior to each scheduled Well Child Visit. Program staff help with establishing pediatric care, complete age-appropriate assessments, and provide education.

Palliative Care

Palliative Care is a member benefit that requires a prior authorization. This prior authorization requirement launched in October of 2023, and the Palliative Care program sunset in December of 2023, as providers were trained on how to submit the prior authorization forms.

REFERENCES: NCQA 2024 Health Plan Standards and Guidelines

REVISION LOG

REVIEW TYPE (New, Annual, Ad Hoc)	REVISION SUMMARY	DATE APPROVED
New Policy Document	Program Segments: Complex Case Management Criteria section updated to reflect new Population Health Categories in ImpactPro. Program Assessment and Impact Measurement: updated to reflect Plan's overall population assessment - not limited to CM. Member Experience with Case Management deleted or 60 days after >45 days. Condition Specific CM and DM programs deleted DM programs not offered. Attachments: removed reference to Complex CM Program Description as information is consolidated into one document. Other minor grammatical and formatting changes made throughout.	11/28/18
Annual Review	Screening and Assessment: changed reference to outreach by priority to calendar days for all for consistency.	2/13/19
Annual Review	1. Goals of CM program added outcome measure for pre-term delivery and clarified goal percentage is percentage difference for the OB measures. 2. Infrastructure and Tools, Organizational Structure changed Chief Medical Director to VP Medical Affairs, updated VPCM to Sr. VPMM. 3. Care Team Staffing, changed average caseload of 40-50 to average active caseload of 62. 4. Screening and Assessment, paragraph 1, changed outreach initiated within 30 calendar days to 7 calendar days. Paragraph 5 changed to outreach is initiated within 7 calendar days and completed within 14 calendar days.	1/13/20

	5. Discharge from Case Management, bullet 4, deleted WIC. 6. Outcomes, added pre-term delivery as an outcome measure for OB program. Condition Specific CM and DM programs, plan program list changed Post Hospitalization Follow-up Care to Transitional Care Management.	
Annual Review	1. Levels of Case Management added header for Non-complex CM 2. Goals of CM program updated time frame for postpartum visit and clarified goal percentage for pre-term delivery. 3. Updated criteria for Complex CM, and Case Management. 4. Integrated care team meetings updated frequency and added weekly huddles. 5. Infrastructure and Tools, Organizational Structure added description for VPMM and updated reporting for Director CM. 6. Care Team Staffing, changed average active caseload to up to 70. 7. Members Experience with Case Management updated methods used to complete survey and related criteria. 8. Added Special Program section including subsections for TCM and Palliative Care References – updated NCQA standards to 2020.	1/21/21
Annual Review	1. Changed Dept to Care Management 2. Updated criteria for Complex CM, and Case Management. 3. Care Team Staffing, changed average active caseload to up to 73. 4. Members Experience with Case Management updated methods used to complete survey and related criteria. 5. Updated what the TOC program includes 6. Updated template 7. Added CalAIM to special programs 8. Changed Disease Management program to Chronic Condition Management	1/4/22
Annual Review	1. Updated Dept to PHCO 2.Added information about medical home/PCP expectations in Purpose section. 3. Updated job titles for VP and SVP. 4. Updated levels of CM section to include Basic Pop Health management.	1/9/23

	5. Added FYOL program in special programs. 6. Updated CalAIM info. 7. Updated DM and NurseWise teams to reflect change from EPC to Corporate. 8. updated all program references from Case Management to Care Management	
Annual Review	1.Removed Palliative Care program, as this is now a benefit, 2. Updated job titles (removing VP PHCO and adding CM Director, changing VPMM to CMO), 3. Updated TOC program description, 4. Updated NCQA Standards reference to 2024. 5. Removed references to Member Connections.	1/16/24

Please note: This Microsoft Word File is not 36 CFR 1194, Section *508 Compliant and not meant for electronic distribution. For an electronic PDF file of this policy, please refer to the Medical Management Remediation Work Process (MM.PM.03)*

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer, Centene's P&P management software, is considered equivalent to a physical signature.

Fresno-Kings-Madera Regional Health Authority Approval

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

_____

_____

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

_____

_____

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

Item #13
Attachment 13.A-13.D

Compliance

- 13.A 2023 Annual Compliance Program Evaluation
- 13.B 2024 Compliance Program Description
- 13.C 2024Fraud Prevention Program
- 13.D 2024 Privacy and Security Plan

CALVIVA HEALTH
2023 ANNUAL REGULATORY AFFAIRS & COMPLIANCE EVALUATION

I. EXECUTIVE SUMMARY

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

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

The Compliance Program is guided by the Plan's mission "To provide access to quality cost-effective healthcare and promote the health and well-being of the communities we serve in partnership with health care providers and our community partners." The Compliance Program is implemented by all Plan Departments: Compliance, Medical Management, and Finance. The Compliance Program results are the collective achievements of dedicated Plan staff members, the Plan's Administrator (Health Net Community Solutions, Inc.), providers, and community-based organizations working together to meet the needs of CalViva Health members and the communities it serves.

In 2023, the Compliance Program was focused on the following key activities:

- Standing up an Exclusively Aligned Enrollment, Dual Eligible Special Needs Plan ("EAE-DSNP") with Health Net named, "Wellcare CalViva Health Dual Align (HMO D-SNP)".

- Completing all 2024 Operational Readiness Contract requirements and executing the 2024 Contract on December 20, 2023.

- Responding to the annual 2023 Department of Health Care Services ("DHCS") audit and the 2022 triennial Department of Managed Care ("DMHC") audits.

- Implementing the Plan's California Advancing and Innovating Medi-Cal (CalAim) Models of Care for the Children and Youth and Justice Involved populations of focus ("POF"); and

- Preparing for the National Committee for Quality Assurance ("NCQA") accreditation.

Overall, the Plan maintained its network adequacy, compliance with timely access standards, and completed the carve-in of the long-term care ("LTC- SNF") benefit.

In 2024, the Compliance Program will continue to focus on meeting the new regulatory requirements associated with the execution of the 2024 DHCS Contract, working with our Plan Administrator towards achieving NCQA Accreditation, and overseeing Health Net's operation of the EAE-DSNP in our service area. As always, the Plan will continue to focus on improving performance by maintaining overall operational effectiveness, ensuring regulatory compliance, and addressing any issues through the Corrective Action Plan (CAP) process.

II. REGULATORY AFFAIRS

A. Administrative and Operational Regulatory Reporting

As a licensed health plan, CalViva Health is required to submit a wide variety of information and data for review and approval to the DMHC in compliance with Knox-Keene regulations, and to the DHCS in compliance with its contract, Medi-Cal regulations, and All Plan Letters ("APLs"). Regulatory filing activities include but are not limited to: DMHC's Knox-Keene license amendments (e.g., material modifications, annual timely access/annual network reports changes in commission/committee members); and DHCS contractual requirements (e.g., annual network and subnetwork certification, fraud waste and abuse case submissions, member-informing materials, new benefit-associated deliverables, and required policies and procedures).

In 2023, CalViva Health made over 400 regulatory filings to DMHC and DHCS. These filings do not include the various "routine" monthly/quarterly program data reports or audit-related information that are sent to the two agencies. In addition to regulatory filings and report submissions, the Plan underwent an annual audit by DHCS and an annual DHCS HEDIS® audit. Any agency's findings were all addressed by the Plan through the regulatory agency's CAP process as needed.

B. Summary of State Audits, Corrective Actions, and Medi-Cal Contract Amendments

1. Department of Health Care Services (DHCS):

- 2023 DHCS Audit - The Plan received DHCS's Final Report on September 18, 2023, and a corresponding CAP request on September 20, 2023. The CAP identified one finding stating that the Plan did not classify, process, review, or resolve all expressions of dissatisfaction as grievances. The Plan submitted its initial response

on 10/20/2023 and must continue to submit monthly updates until the CAP is closed.

- DHCS 2021-2022 EQR Performance Evaluation – On July 6, 2023 the Plan received DHCS' annual external quality review (EQR) Report and associated recommendations. There were two recommendations that focused on the following: working to resolve the findings from the DHCS 2021 annual audit and improving MY2021 HEDIS measures; The Plan submitted its response to how it would address the recommendations on July 27, 2023.

- DHCS 2023 Encounter Data Validation (EDV) Study – The Plan submitted records by the due date of 5/30/2023. The results were released on 12/7/2023. Overall, the Plan did not meet Encounter Data Completeness standard (i.e.,<10%) in the following categories: Date of Service, Diagnosis Code, Procedure Code, Procedure Modifier and Rendering Provider Name. The Plan did not meet the Encounter Data Accuracy standard (>90%) in the following categories: Rendering Provider Name, All-Element Accuracy and All -Element Accuracy Excluding Rendering Provider Name. The Plan is working with Health Net on strategies to improve standards in 2024.

- DHCS RY 2022 Subnetwork Certification – The Plan submitted RY 2022 SNC data on May 12, 2023 which was reviewed and accepted by the DHCS on May 23, 2023 without additional action.

- 2023 DHCS Annual Network Certification (ANC) - The Plan submitted the first part of the ANC in September of 2023 (i.e., ANC Time or Distance Analysis Review). Phase 1 of the ANC is due February 2024.

- DHCS 2024 Operational Readiness Work Plan – On September 1, 2023, DHCS approved the Plan's Operational Readiness Work Plan submissions with the understanding that the remaining Memorandums of Understanding ("MOUs") with Local Health Departments and state agencies will be submitted quarterly in 2024;

- DHCS Contract Amendments - Several DHCS Medi-Cal contract amendments were executed between DHCS and CalViva Health in 2023:

    - **Contract 10-8750 A28** – This amendment incorporates changes add new requirements for Population Health Management, Dyadic Care Services and Family Therapy Benefit, Risk Sharing mechanisms, and carve-in Long-Term Care Services, and new aid codes;

    - **Contract 10-8750 A29** - This amendment adjusted the 2021 calendar year capitation rates that are now split into Satisfactory Immigration Status ("SIS") and Unsatisfactory Immigration Status ("UIS");

    - **Contract 10-8750 A30** – This amendment incorporates updated CY 2022 Capitation Payment rates that are now split into SIS/UIS;

- **Contract 10-8750 A31** - This amendment incorporates CY2023 Capitation Payment rates, as well as new requirements for Subcontractor Agreements, Electronic Visit Verification, American Indian Health Service Programs, Doula Services, Mental Health Services, Financial Performance Guarantee, Medical Loss Ratio, and Special Contract Provisions Related to Payment;

- **Contract 23-30220** – The 2024 DHCS Medi- Cal Managed Care Contract ("Primary Contract") was executed on December 20, 2023;

- **Contract 23-30220 A01** - This amendment incorporates CY2024 Capitation Payment rates;

- **Contract 23-30252 –** The 2024 DHCS State Supported Services Contract ("Secondary Contract") was executed December 16, 2023

2. Department of Managed Health Care (DMHC):

- Compliance with Timely Access and Network Reporting Statutes - The Plan successfully submitted and received approval for its Timely Access Verification Study, and its Timely Access P&Ps on March 6, 2023 and October 20, 2023, respectively. The Plan is on track to submit all requirements for its Network Reporting P&Ps and Compliance documentation by January 16, 2024.

- Measurement Year (MY) 2022 Timely Access Report (TAR) – The Plan submitted its MY2022 TAR on May 8, 2023 and issued 10 CAPs to PPGs and 11 CAPs to direct network providers for not meeting provider appointment access availability and after hours standards. All providers have submitted their improvement plans and completed follow-up training.

- 2022 DMHC Triennial Audit – The Plan received the Preliminary Audit Report on November 1, 2023, which included a CAP request covering eleven deficiencies. Several of the deficiencies were related to template letters and some related to post-stabilization. The Plan submitted its response to DMHC on December 15, 2023 and is awaiting DMHC response.

- DMHC Enforcement Matter (22-724) - On August 10, 2023, the Plan received a DMHC Subpoena requesting documents related to a member appeal for services. The Plan complied with the subpoena and submitted all documents on October 4, 2023. The Plan has not heard back from the DMHC on this matter.

C. DHCS Fraud, Waste and Abuse Required Reporting:

In 2023, the Plan and its delegate, Health Net's Special Investigations Unit (SIU), identified four (4) cases which were determined to reflect suspected fraud and/or abuse

and all four cases were referred to the DHCS via the MC609 process. All cases were promptly reported to DHCS within the ten (10) working days requirement. All four cases were provider-related:

- One (1) was a participating provider who was routinely billing high level Evaluation and Management (E/M) services at a rate that was significantly higher than peers;
- One (1) was referred to the Plan by the California DOJ regarding a DME provider of pulmonary equipment;
- One (1) was a participating Applied Behavior Analysts (ABA) provider, allegedly billing all services under on credentialed Board-Certified Behavior Analyst (BCBA), but the services were rendered by two non-credentialed BCBAs;
- One (1) was a non-participating provider suspected of billing services not rendered or non-appropriate billing.

D. Privacy and Security Oversight

1. Regulatory and Contractual Obligations

CalViva Health continued to review and refine their practices and processes to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) contractual obligations and any other privacy and security related laws and regulations. The following key activities were completed for 2023:

- Breach Notifications and Assessments – Risk assessments were conducted on cases to determine the probability of compromise of protected health information in the event of a breach of unsecured protected health information.

- Periodic and Ongoing Training – The Plan conducted ad-hoc and annual privacy and security training to all employees. Educational newsletters were distributed quarterly.

CalViva Health continued efforts in the oversight and monitoring of Business Associates (BA) who create, maintain and/or transmit protected health information (PHI) through the receipt and assessment of privacy incident reports (PIRs).

CalViva Health maintained a contract with a company to conduct security and vulnerability scans. From 2014-2023, CalViva Health utilized the SolarWinds platform for network vulnerability scans. For the purpose of network vulnerability scans, in Q4 2023 CalViva Health replaced Solar Winds with the LogRhythm platform.

In 2024, CalViva Health will continue assessing their practices and processes to ensure compliance with HIPAA and any applicable state regulations. These assessments could include, but are not limited to, reviewing operational business practices, engaging in ongoing risk management activities, and reviewing and updating program documents related to HIPAA.

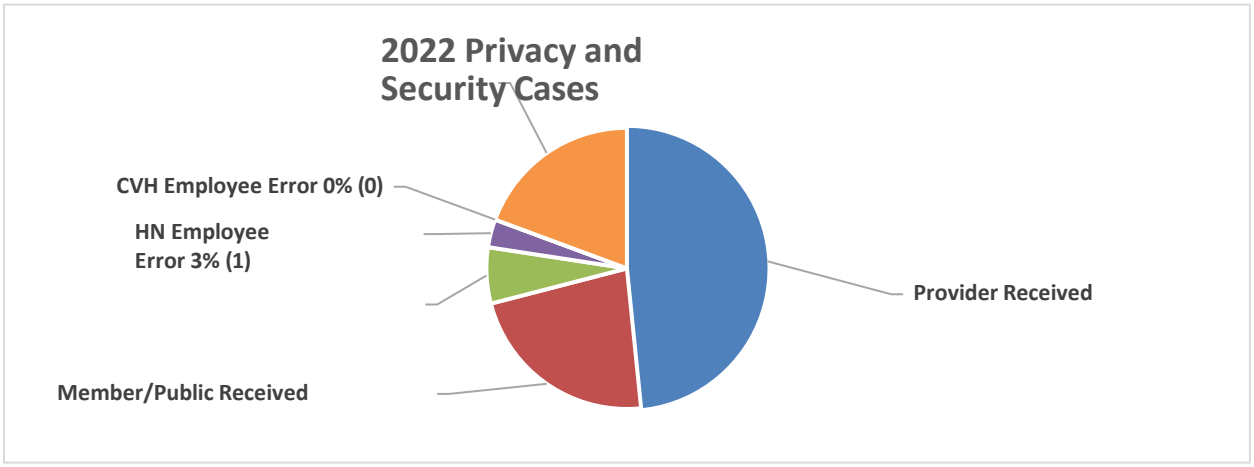
2. Reports of Possible Privacy and Security Incidents/Breaches

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

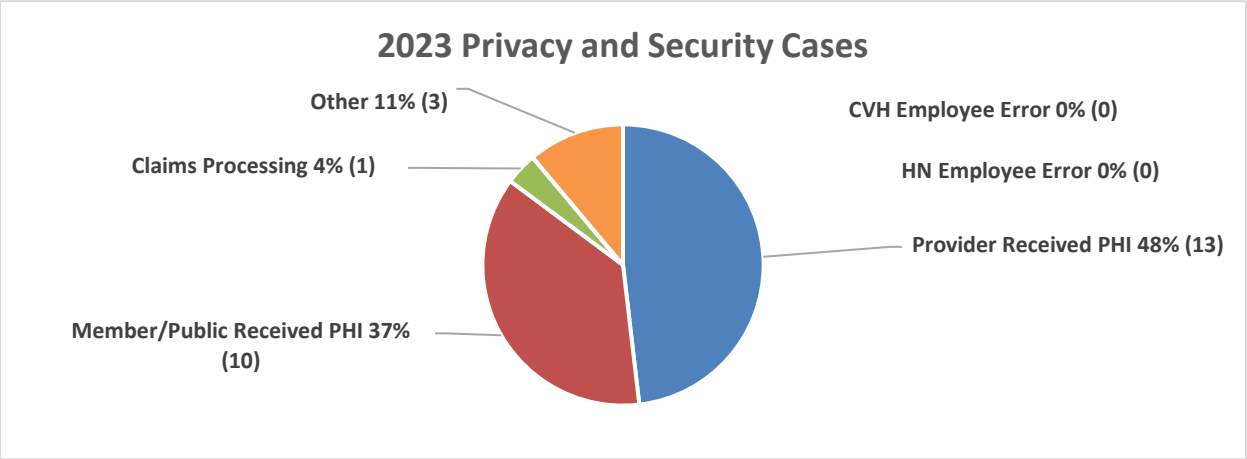
In 2023, twenty seven (27) privacy and security incidents were reported to the DHCS. Zero (0) incidents occurred within CalViva Health. All 27 incidents involved the Plan's Administrator. Thirteen (13) cases involved providers receiving PHI, ten (10) cases involved members/public receiving PHI, one (1) case involved claims processing, and three (3) cases were categorized as "other". Additionally, three (3) of the twenty-seven (27) cases were classified as high risk breach cases. Any cases that have not been closed out by the DHCS will be followed and tracked until case closure.

The first pie chart provides a high-level overview of the types of incidents which occurred in 2022. The second pie chart provides high-level overview of the types of incidents which occurred in 2023 for comparison purposes:

2022 Privacy and Security Cases



2023 Privacy and Security Cases



The pie charts reveal that the total number of privacy and security incidents have decreased between 2022 (31 incidents) and 2023 (27 incidents), with only a 13% increase in 2023. The number of incidents involving providers receiving PHI also experienced the same 13% decrease between 2022 and 2023. The number of incidents involving CalViva members/public receiving PHI had increased by 30%.

3. CalViva Health Internal Audits

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

In 2023, there were no incidents where an employee was subject to disciplinary action due to a privacy and security non-compliance issue.

4. CalViva Health Privacy Group Mailbox Oversight

In 2023, CalViva Health made available the privacy group mailbox for members to contact for assistance and the submission of privacy related forms. The privacy group mailbox was not available prior to the inauguration of the Confidential Communications Request process in 2022.

E. New or Expanded DHCS Benefits, and New Plan Coverage Requirements:

1. Enhanced Care Management (ECM) and Community Supports (CS) – The Plan continued to develop Models of Care for the populations of focus (POF) that went live on July 1, 2023 (Children of Youth) or were scheduled to be effective January 1, 2024 (Birth Equity).

2. Adult Expansion - Effective January 1, 2024, DHCS is expanding Medi-Cal eligibility to individuals who are 26 through 49 years of age. The Plan will be working with providers to maintain PCP assignment.

3. Long-Term Care Phase II Carve-In – In 2023, the Plan completed the network readiness and policy deliverables for the January 1, 2024 carve-in of coverage for Intermediate Care Facility/Developmental Disabilities ("ICF/DD") and Subacute Care (Adult and Pediatric).

F. Implementation Activities for 2024 DHCS Contract Requirements

The Plan executed the 2024 DHCS Medi-Cal Contract on December 20, 2023. Some key new requirements are briefly described below along with the Plan's compliance efforts:

- Hire a Health Equity Officer - Interviews were initiated with a final candidate selection by February 2024.

- Develop Diversity, Equity, and Inclusion (DEI) policies – In 2023, the Plan created/revised two policies (CL-005-Health Equity, Diversity and Sensitivity Training, CL-013 – Health Equity, Quality Review and Data Capture).

- Achieve and maintain full NCQA Health Plan Accreditation and Health Equity Accreditation - In preparation for meeting NCQA requirements, the Plan executed the 9th Amendment to the Administrative Services Agreement ("ASA") with Health Net which included a list of delegation roles and responsibilities (i.e., the "Delegation Agreement"), and developed several new annual delegate oversight reports. The Plan will be audited by NCQA in May 2024 with a six month look back period.

- Provide all Medically Necessary Covered Services for members residing in or obtaining care in an Intermediate Care Facility/Developmental Disabilities ("ICF/DD") and Subacute Care facilities. In preparation for this carve-in, the Plan has been developing an adequate network in each of its counties and also submitted several key policy deliverables to DHCS for approval.

- Submit fully-executed MOUs with third-party entities (i.e., Local Government Agencies, Health Departments, etc.) – DHCS-specific base templates have been distributed to each of the applicable agencies in the Plan's service area and will be submitted on a rolling basis in 2024.

- Implement a EAE D-SNP product in the Service Area – Effective January 1, 2024, DHCS will expand the availability of Medi-Medi Plans (i.e., EAE-D-SNPs) to five additional central valley counties including Fresno, Kings and Madera. In preparation for this, HNCS successfully executed a State Medicaid Agency Contract ("SMAC") with DHCS on June 15, 2023 which includes CalViva Health as the affiliated Medi-Cal Plan. In support of the alignment with HNCS' Medicare Advantage Plan, in August 2023, the Plan submitted a request to DMHC to allow the Plan to co-brand with Health Net for

purposes of integrating member materials (e.g., EOC, Member ID Card, Annual Notice of Change, etc.). The Plan received DMHC approval on September 21, 2023. On January 1, 2024, the EAE-DSNP will be launched and is named, "Wellcare CalViva Health Dual Align".

- Develop a Population Health Management Strategy – On December 15, 2023, the Plan submitted its PHM Strategy and received approval on December 21, 2023.

III. Compliance Program Activities

A. Program Document Reviews/Updates:

CalViva Health continued to operate a comprehensive Compliance Program in 2023. The Plan's Compliance Program includes the following written descriptions which were reviewed and approved in 2023.

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

B. Oversight and Monitoring of Delegated Activities:

The Plan continues to provide oversight and work closely with Health Net on an ongoing daily basis to ensure CalViva members have information and access to services.

1. Delegation Oversight Audits and CAPS

The table below lists the Plan's 2023 completed oversight audits of functions delegated to Health Net. Audits included desk reviews of any applicable functions subdelegated by Health Net, policies and procedures, reports, and evidence submitted to meet the required audit elements.

Appeals and Grievances	Claims*	FWA
Credentialing*	Provider Disputes	Pharmacy
Health Education	Utilization Management*	Call Center
Privacy and Security		

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

2. Periodic Monitoring of Health Net

During 2023, CalViva Health staff continued a wide variety of activities to provide oversight and monitoring of the functions performed by Health Net and Health Net's delegated provider groups and subcontracted health plans on CalViva Health's behalf. These activities included:

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

C. 2023 CalViva Internal Audit

During 2023, the Compliance Department conducted an internal audit of employee, Commission and Committee member files to ensure completion of a Statement of Economic Interests (Form 700) and/or conflict of interest disclosure statement as applicable. Records were also reviewed to ensure that no individual was listed on the Office of Inspector General ("OIG") exclusion list, the Medi-Cal suspended and ineligible provider lists, and licensing board sites. All files were compliant, and no CAP was issued.

D. CalViva Health Staff Trainings

A primary requirement of a successful Compliance Program is conducting ongoing education and training programs. Ongoing training helps CalViva Health staff to carry out daily Plan operations in an efficient and compliant manner. During 2023, the Plan conducted training for one new hire as well as the following mandatory annual staff trainings:

Compliance Program	Anti-Fraud and Abuse Program
Privacy and Security Program	Code of Conduct

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

Drug Free Workplace Statement	Confidentiality Agreement
Conflict of Interest Statement	

All employees successfully completed all required Compliance trainings.

E. Member Communications

CalViva Health maintains a process for the review and approval of communications with members. In 2023, 33 communications were reviewed by CalViva Health. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2023 Annual Mailing was distributed to members in 2023. The 2024 Member Handbook/Evidence of Coverage (EOC) was developed and approve by both DHCS and DMHC and was scheduled to be posted to the Plan's website on January 1, 2024.

F. Provider Communications

CalViva Health maintains a process for the review and approval of communications to contracted providers within the CalViva Health service area. In 2023, contracted providers were sent approximately 266 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 38 informational letter templates and 19 forms intended for provider use.

H. Provider Engagement

CalViva Health continued productive relationships with participating providers. The following information reflects activities from January to December 2023. There were 5,554 provider in-person visits and 11,238 trainings throughout Fresno, Kings, and Madera Counties. Plan staff conducted outreach, training and assisted providers with Medi-Cal guidelines and CalViva Health requirements in their day-to-day operations.

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

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

The following table summarizes the number and type of A&G cases received in 2023, and the percent resolved within the compliance turnaround times (TAT) standards. For instances of non-compliance, corrective action was implemented to ensure there would not be future similar occurrences.

	No. of Cases Received	No. of Cases Resolved †	% of Cases Resolved within TAT (No.)
Expedited Grievances	126	126	100 % (126)
Standard Grievances	1761	1703	99.94% (1702)
Expedited Appeals	34	35	100% (35)
Standard Appeals	331	326	99.69 % (325)
Total:	**2252**	**2190**	**99.91% (2188)**
SPD Appeals & Grievances *	681	668	100% (668)
Exempt Grievances #	1885	1885	100%

† Total will not match as some cases received in December 2023 may remain open at the start of 2024, and the resolved case number may include some cases received in December 2022 and resolved in 2023.

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

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

J. Independent Medical Reviews (IMRs) and State Hearings

The following table summarizes the number of DMHC IMR and DHCS State Hearing requests processed by the Plan in 2023. All cases were submitted within the required turnaround times.

Cases Received	2023 Total	% Cases Submitted w/in the TAT
DMHC Cases	**51**	**100%**
DHCS State Hearings	**42**	**100%**
Total:	**93**	**100%**

K. COVID-19 Public Health Emergency (PHE) – The PHE ended as of March 31, 2023, and the Plan is currently in the continuous coverage unwinding period. This unwinding period will continue through May 2024. The Plan has been communicating with Members about the unwinding period and conducting outreach to help Members maintain their coverage.

IV. 2024 ACTIVITIES

In 2024, the Compliance Program will continue to focus on meeting the regulatory requirements associated with the 2024 DHCS Contract, working with our Plan Administrator towards achieving NCQA Accreditation, and overseeing Health Net's operation of the EAE-DSNP in our service area, and supporting Population Health Management regulatory activities.

The Plan will continue its efforts to implement ECM/CS in Fresno, Kings and Madera counties by submitting updated Models of Care (MOCs) that include updated reports of new POFs transitioning into ECM and expanding provider capacity for ECM/CS.

In 2024, CalViva will once again be audited by DHCS, and will continue to submit all required outstanding documentation in fulfillment of the 2024 DHCS Contract (i.e., the MOUs with Third Party Entities).

Generally, the Plan expects increased regulatory oversight and monitoring of health plan activities, in the following areas:

- Provider network adequacy and certification requirements for direct and delegated networks.
- Timely Access.
- Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).
- Behavioral Health.
- Encounter data quality and timeliness.
- Clinical Quality Improvement (MCAS measures).
- Member Grievances/Appeals.
- Health Equity.
- Member Experience/Member Rights.

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

APPRO
VAL:

_____ **Date: February 15, 2024**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

_____ **February 15, 2024**

Date:

Name: Jeffrey Nkansah

Title: Chief Executive Officer

Date: **February 15, 2024**

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

REPORT SUMMARY TO COMMITTEE

TO: RHA Commission

FROM: Mary Lourdes Leone

COMMITTEE DATE: February 15, 2024

SUBJECT: Compliance Program Description Change Summary

Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Inserted year 2024
1	I. CalViva Health Overview	Added clarifying language that the Compliance Program extends to CalViva's oversight of its First-Tier, Downstream and Related Entities ("FDRs"), and contracts with third-party local government agencies and health departments.
4	II. Scope	Specified HNCS as a Knox-Keene licensed health plan
	IV.C. Authority and Oversight - The Compliance Committee	Change Anti-Fraud Plan to Fraud Prevention Program
7	VI. A. Compliance Program Elements – Policies and Procedures	Revised Table 2 to include Fraud Prevention, Population Health Management, and Health Equity
8	VI.B. Compliance Program Elements - Monitoring	Clarified joint operational and management meetings are held with HNCS; Revised Table 3 to identify current Oversight Audits of HNCS.
9	VI. C. Compliance Program Elements – Education and Training	Revised Table 4 to change Anti-Fraud Plan to Fraud Prevention
11	IX. Program Documents	Changed Anti-Fraud Plan to Fraud Prevention Program, and added the Emergency Preparedness and Crisis Response Plan.

2024

COMPLIANCE PROGRAM

For inquiries regarding this Compliance Program, please contact:

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Last Reviewed/Revised 2/15/2024

CALVIVA HEALTH COMPLIANCE PROGRAM

I. CALVIVA HEALTH OVERVIEW

The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. RHA is governed by a board ("The Commission") consisting of representatives from these three counties. On April 15, 2010, RHA Commission adopted the name "CalViva Health" under which it does business. RHA was licensed on December 30, 2010 as a full-service health care plan ("The Plan") pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 as amended. RHA is licensed to offer health care services to enrollees in the Medi-Cal Managed Care Plan under the Two Plan Model in the counties of Fresno, Kings, and Madera. On December 30, 2010, RHA executed a contract with the California Department of Health Care Services ("DHCS") to provide services to Medi-Cal managed care enrollees in all zip codes in these three counties. On December 11, 2023, RHA executed a new contract with DHCS with a start date of January 1, 2024.

CalViva Health's compliance commitment not only includes its own internal operations but also extends to its oversight of its First Tier, Downstream and Related Entities ("FDRS"). These FDRs perform administrative functions and/or provide health care services to CalViva Health's members under the Plan's DHCS contract, and are required to have programs, standards, policies, and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.

CalViva Health ("The Plan") has an Administrative Services Agreement ("ASA") with Health Net Community Solutions, Inc. ("HNCS") to provide certain administrative services on the Plan's behalf. The Plan also has a Capitated Provider Services Agreement ("CPSA") with HNCS for the provision of health care services to CalViva Health members through Health Net's network of contracted providers. HNCS is CalViva Health's first tier, downstream subcontractor. Although the CPSA with HNCS covers a significant portion of the Plan's network, the RHA also maintains direct contracts with three (3) federally qualified health centers ("FQHCs") in Fresno, Kings, and Madera counties. HNCS provides the same administrative services for the Plan's direct contracted providers as it does for Health Net's contracted provider network.

CalViva Health also contracts with several local government health departments and agencies ~~health plans, provider organizations and other contractors~~ to provide ~~administrative services on behalf of the Plan and/or~~ provide health care services to CalViva Health members.

~~These first-tier subcontractors, and their downstream contracted entities, are required to have programs, standards, policies and processes in place that comply with state and federal regulations and Medi-Cal requirements as applicable to the type of entity.~~

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

II. COMPLIANCE PROGRAM PURPOSE AND OBJECTIVES

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

Table 1 presents the primary objectives implicit in this purpose.

Table 1. Program Objectives

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

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

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

III. SCOPE

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

IV. AUTHORITY AND OVERSIGHT

A. GOVERNMENT AGENCIES

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

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

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

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

B. RHA COMMISSION

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

C. THE COMPLIANCE COMMITTEE

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

the Health Insurance Portability and Accountability Act (HIPAA).

7. Reviews and approves disciplinary and corrective actions related to non-compliance with the Compliance Program.

D. CHIEF COMPLIANCE OFFICER (CCO)

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

V. COMPLIANCE RISK AREAS

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

A. Access & Availability, and Quality of Care:

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

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

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

C. Member Grievance and Appeal Procedures:

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

D. Emergency Services:

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

E. Kickbacks and Other Inducements:

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

F. False Claims:

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

G. Confidentiality:

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

H. Excluded Providers:

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

I. Member Dis-Enrollment:

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

J. Marketing

- Improper or misleading marketing materials

VI. Compliance Program Elements

A. Policies and Procedures

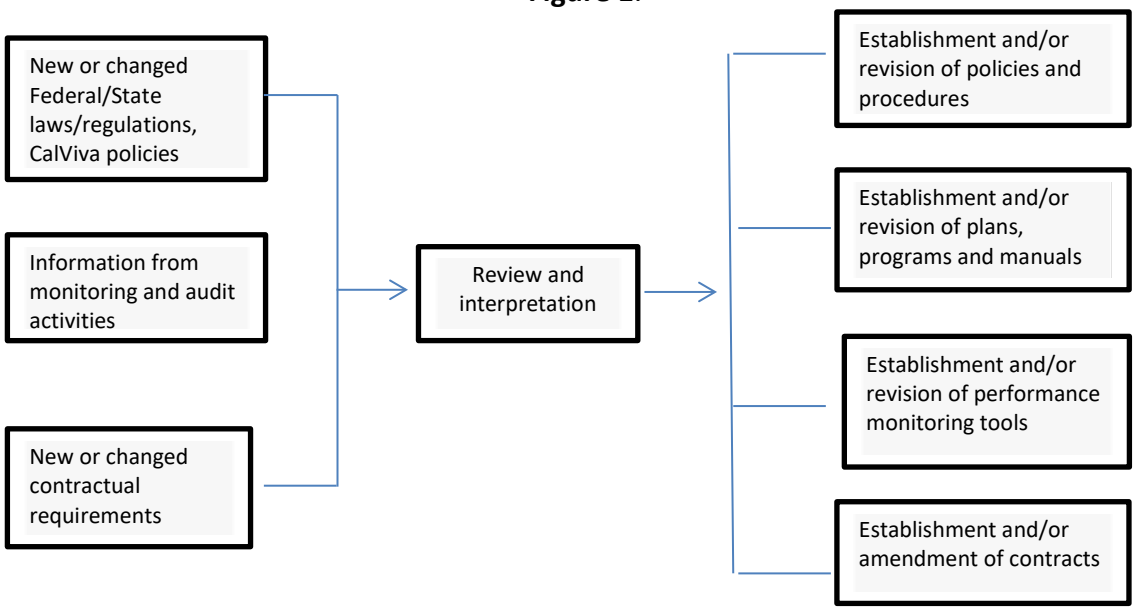
Prevention is the cornerstone to CalViva's Compliance Program. Efforts to prevent noncompliance are articulated through written policies, procedures, work plans, program descriptions and manuals. The Compliance Department staff implements the Program in collaboration with its internal stakeholders from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

Table 2. Key Compliance-Related Policy Topics

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

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

Figure 1.



B. MONITORING

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

Table 3. Activities Monitored by CalViva

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

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

C. EDUCATION AND TRAINING

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

Table 4. Program Documents

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

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

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

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

D. REPORTING NONCOMPLIANCE

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

of particular concern for expeditious reporting and corrective action:

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

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

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

E. Response and Corrective Action

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

VII. Summary

CalViva's Compliance Program employs a comprehensive approach to ensuring its business operations are compliant with ethical standards, contractual obligations, and all applicable state and federal statutes and regulations, including those specifically related to the Medi-Cal program. Moreover, CalViva maintains an on-going commitment to

ensure that the Compliance Program remains relevant and vigilant to the requirements of a constantly evolving and regulated managed health care system.

VIII. AUTHORITY

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

IX. Program Documents

1. Code of Conduct
2. ~~Anti-Fraud Plan~~Fraud Prevention Program (fmr. Anti-Fraud Plan)
2.
3. Privacy and Security Plan
4. CalViva Health Policies & Procedures
~~4.~~5. Emergency Preparedness and Crisis Response Plan

Mary Lourdes Leone

X. APPROVAL

February 1~~6~~5, 202~~3~~4

Jeffrey Nkansah

	_____	_____
Name:	Mary Lourdes Leone	Date
Title:	Chief Compliance Officer	

February 1~~6~~5, 202~~3~~4

	_____	_____
Name:	Jeffrey Nkansah	Date

Title: Chief Executive Officer

February 1~~6~~5, 202~~3~~4

Name: David S. Hodge, M.D. Date
Title: Chair, RHA Commission

DOCUMENT HISTORY	
Date	**Comments**
03/01/2011	New Program Description
02/09/2012	Annual Update of Program Description
01/17/2013	Annual Update of Program Description
02/06/2014	Annual Review: Changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
01/26/2015	Annual Review: Changes to clarify monitoring and auditing activities
02/08/2016	Annual Review, added reference document
02/02/2017	Annual Review: Program Description is replaced in its entirety. Overall content is the same; reduced duplication with other program plans, formatting, editorial and organizational enhancements to all sections.
2/1/2018	Annual Review: Deleted "Privacy & Security Officer" from the CCO's responsibilities. CalViva's COO will now serve as the "Privacy & Security Officer", and this is reflected in the Privacy and Security Plan.
01/07/19	Annual Review: No changes.
01/21/20	Added additional Discrimination language to V. Compliance Risk areas, Section A.
10/22/20	Annual Review: Edited IV, D. (3.) to reflect current practice of preparing the annual Compliance Program Evaluation.
2/7/22	Annual Review: Updated CCO to Mary Lourdes Leone and CEO to Jeffrey Nkansah; added "Privacy Officer" to Section IV. D.; added Fraud, Waste & Abuse to Table 3.
1/29/23	Annual review; No changes

1/25/24	Annual Review: Section I, ~~A~~added new 2024 DHCS Contract; Section VI.A, ~~A~~added Population Health Management and Health Equity; - Section VI.B, ~~A~~added Member Experience and Behavioral Health Oversight audits, and -changed C&L to Health Equity.

REPORT SUMMARY TO COMMITTEE

TO: RHA Commission

FROM: Mary Lourdes Leone

COMMITTEE DATE: February 15, 2024

SUBJECT: Fraud Prevention Program Change Summary

Clean Page #	Section/Paragraph name	Description of change
Throughout	Title page and Footer	Inserted year 2024
Throughout	Throughout	Changed name "Anti-Fraud Plan" to "Fraud Prevention Program"
2	Table of Contents Section II.6	Updated "Freedom of Retaliation" to "Freedom from Retaliation and Conflicts of Interest"
2	Table of Contents Section II.7	Updated "Referrals" to "Investigation Reports and Referrals"
2	Table of Contents Section II.10	Updated "Participating Provider" to "Participating Providers Awareness"
2	Table of Contents Section II.11	Updated "Location" to "Report to DMHC"
2	Table of Contents Section II.12	Updated "Annual Report to DMHC" to "Reports to DHCS"
2	Table of Contents Section III	Added "Page 13 Authority"
2	Table of Contents Section IV	Added "Page 13 References"
4	Section I.1	Added RHA executed the "2024 DHCS-CalViva Health Plan Contract (No. 23-30220, 12/20/23)."; added that the Fraud Prevention Program is a key component of the overall Compliance Program.
5-6	Section II.1	Added address for CEO, CCO and RHA Commission Chairperson "CalViva Health 7625 N. Palm Ave., Suite 109 Fresno, CA 93711"
6	Section II.1.9	Added #9, "Participate in DHCS' quarterly program integrity meetings, as scheduled."
7	Section II.2.16	Added #16 "Prepare and submit the annual CalViva Health Anti-Fraud Report and submit it to the DMHC."
7	Section II.3	Added Policy information to "Processes used to investigate suspected cases of fraud are described in CalViva's policies and procedures (CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation, and RX-120 Drug Utilization Review)."
9	Section II.7	Changed Paragraph name from "Referrals to or from Appropriate Outside Agencies" to "Investigation Reports and Referrals"
9-10	Section II.8	Removed "Depending on the nature of fraud cases, CalViva may receive notices directly from the DHCS or will refer cases to the appropriate regulatory authority. 1. Fraud, Waste and Abuse Reporting to DHCS - CalViva will comply with the DHCS contractual requirements for prompt referral of any potential Fraud, Waste, or Abuse that the Plan identifies to the DHCS Audits and

		Investigations Intake Unit. The Plan shall conduct, complete, and promptly report to DHCS, the results of a substantiated preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity."
10	Section II.7.1	Updated Title to "Preliminary Fraud, Waste and Abuse Report"
10	Section II.7.1	Added that the Plan will submit a Preliminary Report when FWA is suspected.
10	Section II.7.1	Added PIU name and email address to show how we do submissions
10	Section II.7.2	Updated TAT for PIU Submissions "**Completed Investigation Report**: Within 10 working days of completing the Fraud, Waste or Abuse investigation (including both CalViva-initiated and DHCS-initiated, referrals), CalViva will submit a completed report to the DHCS' PIU."
10	Section II.7.1	Removed email, fax and mailing address as a form of submission
11	Section II.7.4	Updated PIU email and removed fax and mailing address as a form of submission.
13	Section II.7.10	Updated title from "Participating Health Care Provider" to Participating Health Care Providers Awareness"
13-14	Section II.7.12	Removed location address for the CEO, CCO and the Chairperson of the RHA Commission
14	Section II.7.12	Added TAT for quarterly submissions "**Reports to the Department of Health Care Services (DHCS)**: In compliance with the 2024 DHCS-CalViva Health Plan Contract, Exhibit A Attachment III, 1.3.2 (No. 23-30220, 12/20/23), CalViva will submit a **Quarterly Report** on all Fraud, Waste and Abuse investigative activities within 10 working days after the close of every calendar quarter."
14	III Authority	Updated DHCS Contract "The 2024 DHCS-CalViva Health Plan Contract, Exhibit A Attachment III, 1.3.2 (No. 23-30220, 12/20/23)"
14	IV References	Added policy "RX-120 Drug Utilization Review"

~~ANTI-FRAUD~~ ~~PLAN~~FRAUD PREVENTION PROGRAM

For inquiries regarding this Anti-Fraud Plan, please contact:

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
MLLeone@calvivahealth.org
Phone: 559-540-7856

2/15/2024

Table of Contents

I. CalViva Health Overview

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

RHA has an Administrative Services Agreement ("ASA") with Health Net Community Solutions ("Health Net") to provide certain administrative services on the Plan's behalf. RHA also has a Capitated Provider Services Agreement ("CPSA") with Health Net for the provision of health care services to CalViva Health members through Health Net's network of contracted providers. Health Net is contracted to provide a broad range of administrative and operational services on CalViva Health's behalf, including but not limited to: enrollment processing, provider contracting and credentialing, utilization management, claims processing, member and provider services and maintaining the systems for most CalViva Health operations.

Under the term of the ASA and CPSA, Health Net is responsible for fraud and abuse investigations related to potential fraud cases involving CalViva Health members, providers, Health Net employees and subcontractors performing functions on behalf of CalViva Health. CalViva Health maintains overall responsibility for anti-fraud and abuse activities, and performs oversight and monitoring of Health Net and their Special Investigations Unit ("SIU"). The Plan also retains responsibility for investigating and addressing any potential incidents of fraud and abuse involving CalViva Health employees and consultants.

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

1. Statement of Purpose:

The purpose of the RHA/CalViva Health ("CalViva" or the "Plan") ~~Anti-Fraud Plan~~Fraud Prevention Program is to organize and implement an anti-fraud strategy to identify and reduce costs to the Plan, providers, members, and others caused by fraudulent and

abusive activities, and to protect members and the public in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. Through the ~~Anti-Fraud Plan~~ Fraud Prevention Program, CalViva also seeks to prevent violations of the Federal False Claims Act, as codified in Section 3729 of Title 31 of the United States Code. The Plan's ~~Anti-Fraud~~ Fraud Prevention Program will also comply with the federal Medicaid managed care requirements in 42 CFR 438.608, Health & Safety Code Section 1348 and the ~~the Department of Health Care Services Medi-Cal Contract requirements in Exhibit E, Attachment 2, Provision 26.~~ 2024 DHCS-CalViva Health Plan Contract (No. 23-30220, 12/20/23).

CalViva's Fraud Prevention Program is a key component of CalViva's overall Compliance Program (Ref. CalViva Health's Compliance Program Description)

2. Definitions:

A. **Fraud** is defined as the intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2; W&I Code Section14043.1(i).)

Health care fraud is a crime. Any person convicted of health care fraud faces imprisonment and substantial fines. Health care fraud could be committed by dishonest health care providers such as doctors, laboratories, medical equipment suppliers, by health plan members, Plan staff, and Plan subcontractors.

Some examples of fraud include:

1. Billing for services or supplies not provided,
2. Altering or falsifying claims,
3. Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary,
4. Using another person's Medi-Cal card to obtain medical care.

See Appendix A for a more extensive set of examples.

B. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Some examples of abuse include:

1. Excessive charges for services or supplies,
2. Overutilization/underutilization of medical or health care services.

C. **Waste** means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit (42 CFR 455.2).

II. Scope of ~~Anti-Fraud Plan~~Fraud Prevention Program:

In an effort to assure public accountability, conduct proper business practices, and operate within the limited resources of the Medi-Cal program, CalViva/delegated organizations will investigate and pursue prosecution of fraudulent activity by providers, enrollees, employees, and other individuals or entities. CalViva/delegated organizations also cooperate with local, state and federal authorities whenever appropriate.

The ~~Anti-Fraud Plan~~ Fraud Prevention Program is part of CalViva's comprehensive Compliance program and includes the following:

- the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations,~~;~~
- training of plan personnel and contractors concerning the detection of health care fraud,~~;~~
- the plan's procedure for managing incidents of suspected fraud~~;~~, and
- the internal procedure for referring suspected fraud to the appropriate government agency.

1. Responsibilities for ~~Anti-Fraud Plan~~ the Fraud Prevention Program:

The RHA Commission has ultimate responsibility for this ~~Anti-Fraud Plan~~ Fraud Prevention Program. The Anti-Fraud Plan will be submitted to the Commission for annual approval. An annual report will be made to the Commission regarding the Plan's Anti-Fraud activities, subject to any confidentiality protections which may be required.

The implementation of the ~~Anti-Fraud Plan~~ Fraud Prevention Program will be the responsibility of the Chief Compliance Officer ("CCO"), under the supervision of the Chief Executive Officer ("CEO"). The CEO will make certain that sufficient resources are in place to properly implement the Anti-Fraud Plan. The CCO will be responsible for overseeing any investigation or necessary corrective action, except as otherwise provided in this Plan.

The address for the CEO, the CCO, and the Chairperson of the RHA Commission is:

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

The CCO will serve as the ~~Anti-Fraud~~ Fraud prevention Officer and have the following duties:

1. Receive information (formal and informal) on cases of suspected fraud,
2. Provide oversight of activities and investigations carried out on CalViva's behalf by Health Net and other delegated entities,
3. Receive information from Health Net and other delegated entities on cases of suspected fraud and abuse related to CalViva and investigated by the delegated entities' SIU,
4. Provide oversight and receive information from delegated organizations on cases of suspected fraud and abuse related to CalViva,
5. Report to the CEO on suspected cases of fraud, plan of investigation, timelines, and resources required,
6. Maintain logs to assure timely investigations and reporting,
7. Review and approve training and other anti-fraud materials sent to participating providers on CalViva's behalf,
8. When directed by the CEO or legal counsel, make referrals to appropriate law enforcement agencies,
~~8.~~9. Participate in DHCS' quarterly program integrity meetings, as scheduled.

2. General ~~Anti-Fraud~~ Fraud Prevention Oversight Mechanisms:

The general oversight mechanisms of the Plan's ~~Anti-Fraud program~~Fraud Prevention Program include the following:

1. CalViva Health will conduct background checks on all employees, which includes staff designated to handle funds and prepare financial statements,
2. Policies and procedures for identifying, investigating, and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program,
3. Development and implementation of corrective actions addressing fraud and abuse issues as appropriate,
4. Ongoing monitoring and oversight by the CalViva Compliance Committee,
5. Provide contracted providers with anti-fraud information including how to report suspected fraud incidents,
6. Provide members with information on how to report suspected fraud incidents such as in the CalViva Health EOC/Member Handbook,

7. Investigate cases of suspected fraud with the most appropriate internal or external resources, appropriate to the problem,
8. ~~Assure~~ Ensure that conflicts of interest are not present in the investigation of suspected fraud cases,
9. Ensure that findings from independent audits and regulatory audits and surveys are followed up promptly by both the Plan as well as the subcontractors who may be cited; and identify any recurring trends,
10. Monitor member and provider issues, tracking and trending types of grievances and settings; and implementing corrective action when necessary,
11. Perform an annual file audit of a sample of contracted providers credentialed by Health Net and their delegated entities which have delegated credentialing responsibilities,
12. Monitor and review fraud cases/issues reported by delegated organizations,
13. Conduct formal and informal ongoing monitoring of the administrative services contracted to Health Net and delegated entities through the review of performance reports, annual audits, and quarterly member service verification reports; and developing corrective action plans, when appropriate,
14. Review the ~~Anti-Fraud Plan~~ Fraud Prevention Program annually and, if revised, maintain documentation that approval has been received from the Department of Managed Health Care (DMHC),
15. Review Health Net's annual anti-fraud report to the DMHC,
~~15.~~16. Prepare and submit the annual CalViva Health Anti-Fraud Report and submit it to the DMHC,
~~16.~~17. ~~Assure~~ Ensure that Medicaid/Medi-Cal or Medicare terminated or suspended providers do not receive program funds,

3. Procedures for Investigating Suspected Fraud:

Processes used to investigate suspected cases of fraud are described in CalViva's policies and procedures (CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation, and RX-120 Drug Utilization Review).

1. The procedure for undertaking an investigation includes:
   A. A review of all identified related documents;
   ~~B.~~ Consultation, if necessary, with internal or external resources with
   ~~C.~~ knowledge of applicable law, regulations or policies, procedures
   ~~D.~~B. or standards; and
   ~~E.~~C. Interviews with persons with knowledge of the alleged activity.
2. A description of the investigation process is included in Plan policies and procedures. The policies and procedures are reviewed annually and revised as needed.

3. The Compliance Committee reviews reports of fraud, waste and abuse cases investigated and any corrective actions implemented.
4. All cases of suspected fraud, waste and/or abuse where there is reason to believe that an incident of fraud, waste and/or abuse has occurred by subcontractors, members, providers, or employees will be reported to the DHCS.
5. In addition, in situations where fraud is confirmed, disciplinary action may be taken and reports to appropriate third parties may be made, including the following:
   A. For employees, incidents may be grounds for immediate dismissal, and, if appropriate, referral to law enforcement agencies;
   B. For contracted providers, disciplinary action may include terminating any contracted relationship between the Plan and the provider or, in the case of a group or institutional provider, removal of the provider's subcontractor or employee from providing services with respect to CalViva members; and
   C. For Medi-Cal members, disciplinary action will include referral to the Department of Health Care Services and, if appropriate, the initiation of procedures to disenroll the member from CalViva, according to provisions of the Medi-Cal managed care contract.
6. Appropriate local, State or Federal authorities will be notified as necessary.
7. A summary report of cases and outcomes is provided quarterly to the Compliance Committee and summary reports are included in the regular compliance reports to the RHA Commission.
8. To prevent repeat offenses, the CCO, and if applicable, in consultation with Health Net, may create new policies, procedures and employee training programs to address new issues regarding the Anti-Fraud Plan's implementation as they arise.

4. Use of External Resources for Special Investigations:

The following external resources are utilized by the Plan:

1. **CalViva Employee, Consultant and Contractor Investigations**: CalViva has retained Epperson Law Group, PC to provide its General Counsel services. The law firm has municipal and litigation attorneys experienced in matters involving public agency ethics rules, restrictions on self-dealing, and prohibited financial transactions. Cases involving alleged fraud and improprieties by CalViva employees, officers, directors, consultants or contractors will be referred to Epperson Law Group, PC for investigation as needed.
2. **CalViva Member and Provider Investigations**: As described in Section I, *CalViva Health Overview*, in accordance with the ASA and CPSA between CalViva and Health Net, the Special Investigations Unit (SIU) for Health Net performs fraud and abuse investigations (i.e. prepay reviews; retrospective reviews, etc.) related to potential fraud cases involving CalViva members or providers. Health Net also conducts routine reviews of provider's billing/coding practices to ensure compliance with state and federal regulations. In addition, Health Net will review claim reports to ensure that

codes and practices used in billing are correct and that the Plan has paid health care providers appropriately. The SIU team has a diverse range of qualifications that stem from the legal, healthcare, loss prevention, law enforcement, medical and other experience/educational backgrounds. Several members of the team are also credentialed as Accredited Health Care Fraud Investigators ("AHFI"), Certified Professional Coders ("CPC"), and Certified Fraud Examiners ("CFE").

5. Additional Internal and External Resources:

Other internal and external investigative resources available to the Plan include the following:

1. The Plan's Chief Medical Officer, Chief Financial Officer and other Plan staff,
2. The Plan's independent financial audit firm,
3. DHCS audits and surveys,
4. DMHC audits and surveys.

6. Freedom from Retaliation and Avoiding Conflicts of Interest:

CalViva will promote an environment free from retaliation or threats of retaliation against individuals who report suspected fraud. The Plan will comply with Section 3730(h) of Title 31 of the United States Code, which prohibits employer discrimination against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the False Claims Act. In training sessions with employees regarding the Plan's anti-fraud efforts, employees will be informed that there is no retaliation against employees for reporting fraudulent activities. Employees are also notified in writing of the procedures for reporting potentially fraudulent activities, and that there is no retaliation against individuals for reporting those activities. If the reporting party still has concerns about retribution, the reporting party may choose to remain anonymous.

If the CEO, CCO, or member of the RHA Commission has a conflict of interest regarding an incident of suspected fraud, the individual must report the conflict of interest to the Chairperson of the RHA Commission, and disassociate him/herself from the relevant investigation. If appropriate, the investigation will be referred to outside counsel for investigation.

~~7.~~ ~~Invetigation~~Investigation Reports and **Referrals** ~~to or from Appropriate Outside Agencies~~**:**

~~8.~~7.

~~Depending on the nature of fraud cases, CalViva may receive notices directly from the~~

~~DHCS or will refer cases to the appropriate regulatory authority.~~

~~Fraud, Waste and Abuse Reporting to DHCS - CalViva will comply with the DHCS contractual requirements for prompt referral of any potential Fraud, Waste, or Abuse that the Plan identifies to the DHCS Audits and Investigations Intake Unit. The Plan shall conduct, complete, and promptly report to DHCS, the results of a substantiated preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.~~

~~1.~~ **Preliminary Fraud, Waste and Abuse Report**: On CalViva's behalf, the Health Net SIU will investigate suspected Fraud, Waste and Abuse cases and provide the Plan with a Preliminary ~~r~~Report of the results. CalViva retains the discretion to determine if potential fraud and abuse claims are reportable to DHCS. The Plan's CCO will review the report with other Plan executives as appropriate to determine if the results involve a matter of suspected Fraud, Waste or Abuse. The CCO or designated Compliance staff will submit reports of suspected Fraud, Waste or Abuse to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. The report will be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that ~~can be~~ is ~~sent~~emailed to DHCS' Program Integrity Unit (PIU) ~~in one of three ways~~: PIUCases@DHCS.ca.gov.

1.

2. **Completed Investigation Report**: Within 10 working days of completing the Fraud, Waste or Abuse investigation (including both CalViva-initiated and DHCS-initiated, referrals), CalViva will submit a completed report to the DHCS' PIU.

~~a. Email at PIUCases@DHCS.ca.gov;~~
~~b. E-fax at (916) 440-5287; or~~
~~c. U.S. Mail at:~~
~~Department of Health Care Services~~
~~Audits & Investigations Division~~
~~Attention: Chief, Intake Unit1500 Capitol Avenue~~
~~Sacramento, CA 95814~~

~~2~~3. **Receipts of a Credible Allegation from DHCS**: ~~-~~ ~~-~~ CalViva may be notified by DHCS when there has been a credible allegation of fraud against a provider that is part of the Plan's provider network. In these cases, CalViva must take one or more of the following four actions and submit all supporting documentation to the PIUCases@DHCS.ca.gov inbox:

a. Terminate the provider from its network
b. Temporarily suspend the provider from its network pending resolution of the fraud allegation
c. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or

d. Conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

~~3~~4. **Removed, Suspended, Excluded, or Terminated Provider Report:** ~~—~~ CalViva/delegated organizations are prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. CalViva/delegated organizations will check the list of suspended and ineligible providers maintained in the Medi-Cal Provider Manual, which is updated monthly and available on-line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). CalViva/delegated organizations are deemed to have knowledge of any providers on these lists. CalViva will notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 ~~State~~ working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report ~~can~~ will be ~~sent~~ emailed to DHCS' at PIUCases@DHCS.ca.gov. ~~in one of three ways:~~

~~a. Email at PIUCases@DHCS.ca.gov;~~
~~b. E-fax at (916) 440-5287; or~~
~~c. U.S. Mail at:~~
~~Department of Health Care Services~~
~~Managed Care Division~~
~~Attention: Chief, Program Integrity Unit~~
~~MS 4417~~
~~P.O. Box 997413~~
~~Sacramento, CA 95899-7413~~

5~~4~~. **Referrals to Other Regulatory Authorities**: ~~—~~If the occurrence of fraudulent activity is highly suspected or confirmed, CalViva may refer cases to the appropriate local, state or federal authority for prosecution of health care fraud committed by enrollees, providers, agents, company employees and other individuals. Such referrals include but are not limited to:

a. Local police departments,
b. U.S. Postal Inspector,
c. Federal Bureau of Investigation,
d. Office of the Inspector General of the U.S. Department of Health and Human Services,
e. Internal Revenue Service
f. Local departments of Public Health in Fresno, Kings, or Madera counties,
g. DMHC,

h. Centers for Medicare and Medicaid Services,
i. State medical licensing and disciplinary boards or
j. Any other appropriate authorities or agencies.

~~5~~6. **Prosecution**: ~~—~~In the event of fraud, the CEO or the RHA Commission will evaluate the appropriateness of pursuing civil prosecution. The Plan will consult with legal counsel, as described in section II.4.1.

~~9.~~8. Staff Training and Education:

CalViva recognizes that the most effective way to combat fraud is to increase staff awareness through education. The Plan is therefore committed to ~~assuring~~ensuring the education and training of its staff, the staff of its administrative contractor, and providers on fraud and fraud prevention.

The CEO and CCO, in consultation with the RHA Commission, and other executive staff as applicable, will develop a strategic approach to educating CalViva and its community about fraudulent activities that occur in health care environments. CalViva will work closely with Health Net to ~~assure~~ensure that appropriate fraud prevention strategies are in place and that staff are trained and educated to detect, deter, and refer instances of suspected fraud to the appropriate levels of the organization.

~~1.~~ CalViva will provide information regarding the detection, prevention, and investigation of fraudulent activity to all new staff during initial employment orientation. Employees will also be notified in writing of the procedures for reporting fraud and that there is no retribution taken against individuals reporting fraud.

~~2.~~1.

~~3.~~2. An annual training session will be required for all CalViva staff. External experts for training will be consulted, as necessary, to augment and implement the training program.

~~10.~~9. Public Awareness:

CalViva members and their families are the ultimate victims of any fraud activity occurring within the Plan. It is therefore essential for them to be aware of activities that may constitute fraud and to have avenues to report suspected fraudulent activities in order to assist with the prevention and cessation of such activities. Information is included in the Member Handbook/Evidence of Coverage and articles regarding health care fraud and CalViva's efforts to prevent fraud will be sent out in periodic newsletters to members.

The Plan will publicize a fraud reporting telephone number. Potential fraud, waste and abuse incidents may be reported directly to CalViva via one of the following methods:

Toll-free Phone: 1-866-863-2465
Fax: 559-446-1998
Mail: Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
Email: fraudtips@calvivahealth.org

CalViva is sensitive to providing a quick response to any member service concerns that may arise for health plan members. Plan employees will convey any complaints, grievances and/or customer service concerns to the CCO, its administrative subcontractor, Health Net, or, if necessary, to the appropriate regulatory or law enforcement agency.

Concerns expressed are documented and investigation is initiated immediately. If appropriate, within 30 days, a letter is sent out to the originator to acknowledge receipt of the concern and to provide a brief status update.

Medi-Cal anti-fraud information resources are also available on the Department of Health Care Services website: dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx

The Medi-Cal Program has a hotline maintained by the Department of Health Care Services: Medi-Cal Fraud Hotline: 1-800-822-6222

~~11.~~10. **Participating Health Care Provider~~s~~ Awareness:**

The Plan contracts with health care provider organizations, Health Net and may contract with other delegated organizations to provide services to CalViva members through their network of health care providers. These provider networks include but are not limited to~~:~~ primary care providers, medical specialists, mental health specialists, acute care hospitals, skilled nursing facilities, clinical laboratories, pharmacies and other ancillary providers. Providers are given information about fraud prevention, how to report suspected fraud or abuse incidents, and how the Plan and/or contracted organizations respond to fraudulent activity.

~~12. Location:~~

~~The address for the CEO, the CCO, and the Chairperson of the RHA Commission is:~~

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

~~13.~~11. ~~Annual~~ **Report to the Department of Managed Health Care (DMHC):**

In compliance with California Health & Safety Code Section 1348, CalViva will annually file with the ~~Department of Managed Health Care~~ DMHC a written ~~annual~~ **Anti-Fraud Fraud ~~r~~Report** regarding the Plan's anti-fraud activities, including, but not limited to:

1. CalViva's efforts to deter, detect and investigate fraud, and report cases of fraud to law enforcement agencies~~.~~,
2. The cases reported to law enforcement agencies, a listing of the number of cases prosecuted and the status of prosecution if known~~.~~,
3. Recommendations to further improve and refine the Plan's Anti-Fraud Plan.

12. Reports to the Department of Health Care Services (DHCS):

In compliance with the~~ the~~ 2024 DHCS-CalViva Health Plan Contract, Exhibit A Attachment III, 1.3.2 (No. 23-30220, 12/20/23), CalViva will submit a **Quarterly Report** on all Fraud, Waste and Abuse investigative activities within 10 working days after the close of every calendar quarter.

III. Authority

- ~~DHCS Contract, Exhibit E, Attachment 2, Provision 26~~
- Health & Safety Code Section 1348
- Code of Federal Regulations, 42 CFR 438.608, 42 CFR 438.610 and 42 CFR 455.2
- United States Code, 31 U.S.C. Section 3729 and 42 USC Section 1396a(a)(68)
- Welfare & Institutions Code Section 14043.1(a) and (i), and Section 14115.75
- DHCS All Plan Letters 08-007, 15-026, ~~16-001~~21-003, 23-026
- The 2024 DHCS-CalViva Health Plan Contract, Exhibit A Attachment III, 1.3.2 ~~-~~(No. 23-30220, 12/20/23)

IV. References

- CalViva Health Compliance Program
- CO-005 Fraud, Waste and Abuse Prevention Detection, Investigation
- RX-120 Drug Utilization Review

APPENDIX A

Types of Fraudulent Acts and Examples/Indicators of Potential Fraud (Adapted from National Health Care Anti-Fraud Association publications)

I. Types of Fraudulent Acts

It is virtually impossible to itemize every conceivable health care fraud; any opportunity to bill for services is an opportunity to commit health care fraud and every fraud scheme has its own unique characteristics. Most health care frauds, however, fall into one or more broad categories of activity, including the outright fabrication of claims and the falsification of claims.

A. Fabrication of Claims

In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct entirely fictitious claims, or adds to otherwise legitimate claims fictitious charges for treatments or services that were never provided. Some examples of such fabrication are:

1. An individual provider who, using existing information on his/her patients creates claims for office visits or treatments that never took place.
2. A provider who, in the case of billing for patient treatments, adds charges for x-rays or lab tests that were never performed.
3. A contracted service provider/institution bills for services that were ordered but did not occur due to unforeseen circumstances (patient refused or was unable to make the appointment).

B. Falsification of Claims

In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more element(s) of information in a claim for the purpose of obtaining, a payment (or a higher payment) to which he/she is not entitled. Examples of outright falsifications include:

1. Falsifying patients' symptoms or diagnosis and/or the procedures performed as a pretext for obtaining payment for otherwise non-covered services (i.e.: alternative therapies; elective cosmetic surgeries etc.) and/or performing medically unnecessary services solely in order to submit claims and be paid.
2. Falsifying the dates on which service was provided so as to fall within a given coverage period.

3. Falsifying the identity of the provider of the service in an attempt to obtain payment for services rendered by a non-covered and/or non-licensed provider (i.e.: billing for massages as licensed physical therapy or counseling by a Social Worker as psychiatric treatment).
4. "Upcoding" or falsifying the nature of services provided to obtain a higher rate on payment (i.e.: filling a prescription with the generic equivalent but billing for the higher-priced brand-name drug).
5. "Unbundling" or deliberately billing separately for the various elements of a given medical procedure to which one all-encompassing billing code applies, so as to obtain a higher aggregate payment.

II. Examples of Indicators of Potential Fraud

Indicators of potential claims fraud are as varied as they are numerous, ranging from the obvious to more subtle signs. Visibly discernible alterations or handwriting anomalies on a given claim are examples of an obvious indicator. A subtler indicator would be an inconsistency of diagnosis and treatment or an unusually high incidence of a given condition among a provider's patients.

Deciding what factors represent indicators of potential fraud is a subjective matter that varies widely. There is no formulaic or universal set of such indicators. The presence of one or more indicators in and of itself does not necessarily signify fraud, it merely serves to call attention to a claim or situation that is out of the ordinary and therefore requires further review.

The following examples illustrate some of the signs that might represent indicators of potential fraud on the part of a dishonest provider, a provider employee and/or a dishonest claimant:

1. Misspelled medical terminology on claim.
2. Similarity of patient/provider handwriting.
3. Apparent alteration of dates, amounts and/or other claim information.
4. Claims for non-emergency services dated Sundays or holidays.
5. Inconsistency between treatment billed and patient's diagnosis, age, gender etc.
6. Inconsistency between provider type and treatment billed.
7. Inconsistency between patient diagnosis and prescription billed.
8. Inconsistency between patient's medical history and treatment billed.
9. Consistent submission of photocopied claims.
10. Provider's lack of support documentation for claim selected for audit.
11. High-dollar claim for service dated either soon after effective date of coverage or just before the termination of coverage.
12. Unusual time lapse between date of service and date claim submitted.
13. Anonymous and/or persistent telephone inquiries re: status of claims.
14. Undue pressure to pay claims quickly.
15. Payments to P.O. Box not under provider or claimant name.

16. Any confirmed cases based on Service Verification (SV) member reporting.

APPENDIX B

CalViva Health Referral Form for Incident of Suspected Fraud

Please Note: CalViva Health will not discriminate against employees in the terms or conditions of their employment because of the employees' lawful acts in furtherance of an action under the Federal or California False Claims Act, including an investigation for, initiation of, testimony for, or assistance in such an action.

Name: _____ Contact Phone: _____

Department: _____

Please indicate here if you wish to remain anonymous: _ Yes, I wish to remain anonymous

Case Type: __ Provider __ Member __ Employee ___ Subcontractor ____Other ____

INFORMATION ABOUT THE SUSPECTED INDIVIDUAL/ENTITY

Name of Individual or Provider or Other: _____

Address: _____

Phone: _____

Other Identifying Information (Member ID Number, Date of Service, etc.) _____

Please describe how you were informed of the incident: _____

_____

_____

Please provide a description of the suspect incident: _____

_____

_____

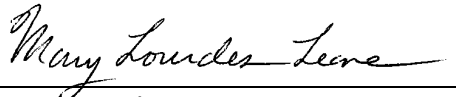
_____

_____

Signed: _____ Date: _____

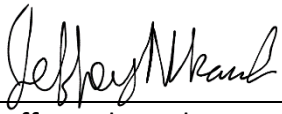
The completed form should be put in an envelope marked "Confidential, for CalViva Health Chief Compliance Officer and submitted to CalViva Health, 7625 N. Palm Ave., Suite 109, Fresno, CA 93711

APPROVAL:



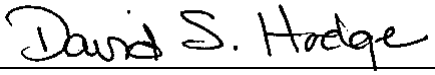
Date: **February 1~~5~~6, 202~~3~~4**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer



Date: **February 1~~6~~5, 202~~3~~4**

Name: Jeffery Nkansah
Title: Chief Executive Officer



Date: **February 1~~6~~5, 202~~3~~4**

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Program Description History		
Date	**Section #**	**Comment(s)**
3/1/2011		New Program Description
4/30/2012	Replaces former version	Annual review; changes to clarify and reflect current activity
1/7/2013	various	Annual review, clarified descriptions of activities
6/7/13	Cover page, sections 8 & 9	Changes to address DMHC requirements
2/6/14	Various	Annual review, changes to clarify current contractual relationships and activities
1-26-15	Sections 5, 6, 7, 8, 11, 13 and 15	Annual review, changes to update General Counsel information, clarify several sections to better reflect current activities and correct typographical errors

2-18-16	Section 11 and office address throughout	Updated office address and phone numbers and added information from APL15-026
2-17-17	Various	Clarified the overview and operational structure of CalViva Health. Removed reference to Optum as Health Net no longer uses Optum in their SIU activity.
2-15-18	Various	Annual Review, minor grammatical changes and added a reference to the COO and Operations Department staff.
01/07/19	Section II 7.	Inserted PIU e-mail address.
2-20-20	Overview; Sections II.4.1; II.7, 1 & 4	Clarified contractual relationships related to anti-fraud activity; updated external resources information; added revisions to reflect new requirements specified in DHCS–CalViva Contract (10-87050 A12) and made other minor editorial changes (grammar, regulatory citations, clarification to reflect current activities, etc.).
7/8/20	Section II # 9	Updated the DHCS website URL. Deleted an obsolete DHCS URL.
10/20/20	Section II, 2(6. And 13.); Section II, 6; Section II, 7(1. And 3); and Appendix A. II (16.)	Section II, 2(6. And 13.) added reference to EOC, and new Service Verification (SV) language; Section II, 7(1.) deleted typo and added "Promptly" reported and "Substantiated" preliminary to paragraph. Section II, 7(3.) added correct department name for mailing, "Managed Care Operations Division." Appendix A, II, #16 added reference to Service Verification (SV) reporting.
1/17/22	Cover Page and throughout	Updated the CCO to Mary Lourdes Leone and the CEO to Jeffery Nkansah; Under References, specifically added the name of CalViva's policy (CO-005).
1/29/23		Annual Review; No Changes
1/18/2024	Whole document	Revised the report title to "Fraud Prevention Program" to be consistent with the 2024 DHCS Contract; Updated and/or added language regarding reporting requirements to both DMHC and DHCS; Updated current method of electronically submitting referrals to DHCS' PIU; Added citation to the 2024 DHCS Contract; Reorganized and formatted the contents for easier flow/readability; Updated Table of Contents.

REPORT SUMMARY TO COMMITTEE

TO: RHA Commission

FROM: Mary Lourdes Leone

COMMITTEE DATE: February 15, 2024

SUBJECT: 2024 Privacy and Security Plan Change Summary

Clean Page #	Section/Paragraph name	Description of change
Throughout	Multiple	Grammatical and formatting corrections
2	Table of Contents	Page numbering
4	Confidentiality Guideline	• Added language surrounding the privacy of medical information as it relates to gender-affirming care and abortion. • Added language surrounding AB 254 as it relates to reproductive or sexual health digital device.
10, 11	Definitions	• Added definition for Medical Information • Updated definition for PHI • Added definition for Reproductive or sexual health application information • Added definition for Social Needs Data.

PRIVACY AND SECURITY PLAN

For inquiries regarding this Privacy and Security Plan, please contact:

Mary Lourdes Leone
Chief Compliance Officer
CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711
mlleone@calvivahealth.org
Phone: 559-540-7856

Table of Contents

I. CalViva Health Overview

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

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

All of the processes and activities performed by contracted or delegated entities on CalViva Health's behalf are performed in compliance with CalViva Health's Privacy and Security Plan described in the following pages. These entities agree to the same restrictions and conditions that apply to CalViva Health with respect to Protected Health Information (PHI) and applicable provisions governing the use of PHI are incorporated into CalViva Health's service and/or business associate agreements with contracted or delegated entities.

1. **Statement of Purpose**:

   The purpose of CalViva Health's Privacy and Security Plan is to safeguard the Confidentiality of personal information (PI) and Protected Health Information (PHI) while not impeding the exchange of information needed to provide quality health care treatment, payment and operations. To that end, CalViva Health develops and implements policies and procedures designed to enable compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the American Recovery and Reinvestment Act (ARRA) California's Information Practices Act of 1977 (IPA) and Confidentiality of Medical Information Act (CMIA). CalViva Health is committed to creating a culture that effectively encourages its employees and associates to comply with applicable laws, regulations and policies related to privacy of health information and to perform work duties with a conscious regard for the privacy rights of its members.

CalViva Health ensures that member health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

Everyone has a responsibility for monitoring and reporting any activity that appears to violate this program or the supporting policies and procedures. Failure to follow the Privacy and Security Plan and related policies and procedures are grounds for appropriate discipline, which may include immediate termination.

2. **Confidentiality Guideline:**

CalViva Health and its business associates have adopted a strict guideline regarding the Confidentiality of certain information provided to CalViva Health employees and business associates. This guideline applies to all CalViva Health employees/business associates:

All employees/associates are prohibited from any unauthorized access to, use or Disclosure of patient (~~"~~"Member~~"~~") Protected Health Information (PHI), health care provider confidential information, or CalViva Health proprietary information. This includes~~,~~ but is not limited to~~:~~: medical records, claims, benefits or other administrative data that is personally identifiable, CalViva Health ~~c~~Compliance program cases, peer review cases, quality improvement and utilization management programs, reports and disease management information containing PHI (hereinafter, collectively referred to as ~~"~~"Confidential Information~~"~~"). All employees/associates are prohibited from disclosing medical information related to sensitive services to anyone other than the enrollee without the individual's express written authorization, including the policyholder or parent of a minor patient.

The Plan is prohibited from requiring a protected individual, as defined, to obtain the policyholder, primary subscriber, or other enrollee's authorization to receive the sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care. Upon written request from a member, the Plan must direct communications regarding a member's protected health information (PHI) directly to the member's designated alternative mailing address, email address, or telephone number.

The Plan is prohibited from releasing medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

The Plan is prohibited from knowingly disclosing, transmitting, transferring, sharing, or granting access to medical information in an electronic health records system, or through a health information exchange, that would identify an individual, and that is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an

abortion that is lawful under California law to any individual or entity from another state, unless authorized under Section 56.110.

As it regards California AB 254, the Plan does not currently offer a reproductive or sexual health digital device. The Plan will deem any business that offers a "reproductive or sexual health digital service" to its members for the purpose of allowing individuals to manage their individual information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider subject to the requirements of the Confidentiality of Medical Information Act.

Employees/associates must hold in strict confidence, and not copy, disclose or permit the Disclosure to any person of any PHI or Confidential Information disclosed or delivered to ~~him/her~~ them by CalViva Health or any provider except that which is allowable based on employee job role, by regulation, or by contractual and business associate agreements. Employees/associates must comply with all CalViva Health policies and procedures concerning the maintenance of all Confidential Information made known to ~~him/her~~ them as a CalViva Health employee/associate.

Employees must comply with all applicable state and federal laws and regulations regarding the Confidential Information. CalViva Health limits access to CalViva Health employee data to a subset of employees who are permitted the use and Disclosure of other employee confidential information as required in the scope of their duties.

Any violation of statutes, regulations, policies and/or procedures designed to safeguard the Confidentiality of the Confidential Information may include a range of disciplinary and corrective actions up to and including immediate discharge from CalViva Health. Failure to comply with this guideline and all applicable policies, laws, and regulations may result in legal action brought against the violating employee/associate.

II. OVERSIGHT AND EVALUATION OF PLAN

1. Designation of Privacy and Security Officer:

CalViva Health has appointed a Chief Compliance Officer ("CCO") to serve as the focal point for privacy and security activities and report directly to the Chief Executive Officer and to the RHA Commission. The CCO is charged with the responsibility for developing, operating and monitoring the Privacy and Security Plan. This includes establishing and overseeing an auditing and monitoring plan, continuously reviewing organizational risk areas to identify necessary auditing and monitoring activities; assisting management with formulation of corrective action plans and overseeing and/or verifying implementation of corrective action. The CCO works with a Compliance Committee to assist in implementation of the Privacy and

Security Plan.

The CCO responsibilities include:

A. Serving as the Privacy and Security Officer

~~B.~~ Ensuring a Privacy and Security Plan is developed along with any applicable policies and procedures;
B.

~~C.~~ Ensuring Risk Analyses and Risk Mitigation plans are implemented;
C.

~~D.~~ Ongoing oversight and monitoring of Privacy and Security activities;
D.

~~E.~~ Preparing and overseeing distribution of the Notice of Privacy Practices;
E.

~~F.~~ Reporting on a regular basis to the RHA Commission on implementation and compliance;
F.

~~G.~~ Developing, coordinating and participating in an educational and training program on the elements of the Plan and ensuring that employees and managers are informed;
G.

~~H.~~ Developing an atmosphere to encourage employees to report possible noncompliance to CalViva Health, DHCS, or the Secretary of HHS without fear of retaliation;
H.

~~I.~~ Acting on matters related to privacy compliance, with the authority to design and coordinate internal reviews and any resulting need for corrective action;
I.

~~J.~~ Coordinating with the CEO regarding disciplinary sanctions for violations of the Privacy and Security Plan, policies and procedures;
J.

~~K.~~ Coordinating mitigation efforts in the event of a Disclosure that violates the privacy laws; and
K.

L. Periodically evaluating and revising the Privacy and Security Plan and policies and procedures in light of changes at CalViva Health or in response to changes in federal or state requirements.

2. CalViva Health's Compliance Committee:

CalViva Health has a Compliance Committee to advise the Privacy and Security Officer and to assist in the implementation of the Privacy and Security Plan. The Committee is composed of the Plan's Chief Officers and meets at least quarterly and more frequently, as necessary. The Chief Compliance Officer ("CCO") serves as chairperson of the meeting. The Committee shall maintain minutes of all its meetings to document its activities and recommendations.

The Committee's responsibilities include:

A. Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy and security policies and procedures as part of daily operations;

~~B.~~ Determining the appropriate strategy/approach to promote compliance with the Privacy and Security Plan and detection of any potential violations, such as through hotlines and other reporting mechanisms;

B.

~~C.~~ Developing a system to solicit, evaluate and respond to complaints and problems;

C.

~~D.~~ Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;

D.

~~E.~~ Reviewing and tracking of possible Confidentiality Breaches that may be identified through incident reports, reports from CalViva Health's CCO, reports from contractors, appeals and grievances, etc.;

E.

~~F.~~ Overseeing the analysis and data collection of business processes, systems and relationships to understand the cause of a Breach;

F.

~~G.~~ Creating or revising policies to better prevent or address privacy and security Breaches; and

G.

~~H.~~ Overseeing development of resolutions to Breach issues.
H.

When a potential problem is identified, the CCO may also select various individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

3. CalViva Health Management:

Chief Officers and Directors must be available to discuss with each employee under their direct supervision and every contractor/business associate with which they are the primary liaison:

A. The content and procedures in the Privacy and Security Plan and any applicable Policies and Procedures

~~B.~~ The legal requirements applicable to Employees' and Contractors' job functions or contractual obligations, as applicable
B.

~~C.~~ That adherence to the Plan and Policies and Procedures is a condition of employment
C.

~~D.~~ That CalViva Health shall take appropriate disciplinary action, including termination of employment or a Contractor's agreement with CalViva Health, for violation of the principles and requirements set forth in the Privacy and Security Plan and applicable law and regulations
D.

The Chief Compliance Officer will include any significant privacy and Security issues as part of the operations reports to the RHA Commission (CalViva Health's governing board).

4. Auditing and Monitoring of Delegated Activities and Internal Operations:

CalViva Health is committed to aggressive monitoring of its Privacy and Security Plan and applicable policies and procedures. Routine and random audits will be conducted to identify problems, reduce identified problems and maintain a high level of privacy.

The CCO along with Department staff are responsible for ensuring the implementation of the Privacy and Security Plan and all associated policies and procedures, performance standards and activities. This includes oversight and monitoring activities of CalViva Health internal business units and subcontractors (i.e. administrative services contractors, delegated providers).

Oversight monitoring of delegated entities is done to ensure that delegated responsibilities and

services comply with requirements and the appropriate state and federal regulatory requirements. Any deficiencies identified during the monitoring process will result in corrective action plans. The corrective action plan developed will identify the deficiency, outline how the deficiency will be corrected and set a time frame for implementing the corrective actions.

III. **DEFINITIONS, MISSION, AND GOALS AND OBJECTIVES**

1. Definitions:

A. Abuse – Incidents or practices of a provider, which although are not usually considered fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may directly or indirectly result in unnecessary cost to the program, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.

~~B.~~ **Access and Uses** – Allows employee access to PHI subject to qualifying job requirements. Each employee is provided appropriate levels of Security to perform their job duties.

B.

~~C.~~ **Authorization** – Written authorization for any use or Disclosure of PHI that is not for treatment, payment, health care operations or otherwise permitted or required by regulations and/or statutes.

C.

~~D.~~ **Breach** – The acquisition, access, use, or Disclosure of Protected Health Information, where the Security or privacy of an individual's information is compromised; the compromise shall be presumed to be a breach unless CalViva Health or one of its Business Associates as applicable demonstrates that there is a low probability that the Protected Health Information has been compromised based on a Risk Assessment. See 45 C.F.R. § 164.402.

D.

a. "Breach" excludes three scenarios:

- Any unintentional acquisition, access, or use of Protected Health Information by a CalViva Health employee or person acting under the authority of CalViva Health or one of its business associates, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or Disclosure.

- Any inadvertent Disclosure between employees of CalViva Health or of a CalViva Health business associate, where both employees are authorized to access such Protected Health Information, and where the information received as a result of such Disclosure is not further used or disclosed.

-

- A Disclosure of Protected Health Information where CalViva Health or one of its business associates has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.

E. Confidentiality – The obligation of the holder of personal information to protect an individual's privacy. This obligation is determined by common practice, federal and state laws and regulations.

~~F.~~ **Data Aggregation** – The combining of PHI created or received by the Plan on behalf of DHCS with PHI received by CalViva Health in its capacity as the contractor of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

F.

~~G.~~ **Disclosure** – The release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

G.

H. Medical information - Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

~~H.~~ **Protected Health Information (PHI)** – Individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. "Individually identifiable health information" is information, including demographic and social needs data collected from an individual, that relates to: 1) the individual's past, present or future physical or mental health or condition, 2) the provision of health care to the individual, or 3) the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

I.

~~I.~~ **Protected Individual** – Any adult member covered under the Plan, or a minor

member who can consent to a health care service without the consent of a parent or legal guardian.

J.

K. **Reproductive or sexual health application information** - -Information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.

~~J.~~ **Risk Assessment/Analysis** – The process of identifying, prioritizing, and estimating risks of organizational operations (including mission, functions, image, and reputation), organizational assets, individuals, other organizations, and the Nation, resulting from the operation of an information system.

L.

~~K.~~ **Risk Management** – The program and supporting processes to manage information Security risk to organizational operations (including mission, functions, image, reputation), organizational assets, individuals, other organizations, and the Nation, and includes: (i) establishing the context for risk-related activities; (ii) assessing risk; (iii) responding to risk once determined; and (iv) monitoring the risk over time.

M.

~~L.~~ **Risk Mitigation** – Prioritizing, evaluating, and implementing the appropriate risk-reducing controls/countermeasures recommended from the Risk Management process.

N.

~~M.~~ **Security** ~~–~~ – Security or security measures encompassing all of the administrative, physical and technical safeguards in an information system. It relates to the extent to which information can be stored and provided with access limited to those who are authorized and have a legitimate "need to know".

O.

Sensitive Services ~~–~~ – all health care services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

P.

~~N.~~ **Social Needs Data** – Includes information related to financial insecurity, food insecurity, housing stability, access to transportation, interpersonal safety, barriers to accessing health care, including experiences with discrimination, bias or racism, or

access to technology-based services, race, ethnicity, language, gender identity, and sexual orientation information.

Q.

~~O.~~ **Threat** – Any circumstance or event with the potential to adversely impact organizational operations (including mission, functions, image or reputation), organizational assets, individuals, other organizations, or the Nation through an information system via unauthorized access, destruction, Disclosure, or modification of information, and/or denial of service.

R.

~~P.~~ **Vulnerability** – Weakness in an information system, system Security procedures, internal controls, or implementation that could be exploited by a threat source and lead to a compromise in the integrity of that system.

S.

2. **Mission:**

CalViva Health has incorporated the HIPAA General Administrative Privacy Rule Requirements, the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the HITECH Act and the National Institute of Standards and Technology (NIST) Risk Management Guide for Information Technology systems into its Privacy and Security Plan. CalViva Health has administrative and management arrangements or procedures, including a Privacy and Security Plan, which is designed to guard against the unauthorized access and/or use of PHI. This document provides a description of these requirements, which are as follows:

A. Written standards of conduct, policies, and procedures, which promote CalViva Health's commitment to comply with all applicable Federal and State standards.
B. The designation of a Privacy and Security Officer and compliance committee responsible for implementing and monitoring privacy and security activities.
C. Effective lines of communication with the organization~~'~~'s employees
D. Conducting ongoing education and training programs
E. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.
F. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.
G. Monitoring and auditing processes to assess the effectiveness of the Privacy and Security Plan.
H. An internal reporting system for receiving complaints and for prompt response to detected offenses.
I. Mechanisms for enforcing compliance standards through well-publicized disciplinary guidelines.

J. The implementation of appropriate measures to prevent future offenses.

The elements of the mission allow CalViva Health to:

A. Ensure that Member's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.
B. Comply with the requirements of ARRA including, but not limited to, Member requests for restrictions and accounting of disclosures.
C. Protect the public's health and well-being.
D. Adhere to the HIPAA General Administrative Privacy Rule Requirements as published in the final rule on December 28, 2000 and amended on March 27, 2002 and August 14, 2002. These requirements are found in 45 C.F.R. Part 160 and Part 164, sections 101 through 106 (otherwise known as Subparts A, B and C).
E. Adhere to the HIPAA General Administrative Security Rule as published in the final rule on February 20, 2003. These requirements are found in 45 C.F.R. Part 160, 162 and 164.
F. Adhere to the HIPAA Omnibus Rule as published on January 25, 2013.
G. Comply with the administrative, physical and technical safeguards of the HIPAA Security Rule, as required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
H. Comply with the California Civil Code sections 1798.29(a) and 1798.82(a), California Confidentiality of Medical Information Act, Assembly Bill 1184, Civil Code 56 et seq. and California Health and Safety Code sections 1364.5 and 1386 (b) (15) requirements and the California information Practices Act of 1977.
I. Comply with the California Department of Health Care Services (DHCS) contract requirements Exhibit G; Department of Managed Health Care (DMHC), California Civil Code section 1798.82, Center for Medicare and Medicaid Services (CMS); and, the HITECH Act Breach reporting requirements.
J. Ensure privacy and Security training is provided to CalViva Health employees, management and business associates.
K. Ensure Risk Analyses and Risk Mitigation Implementation Plans are conducted and implemented.

3. **Goals and Objectives:**

The goal is to assure that a CalViva Health member's personal health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care.

CalViva Health's Privacy and Security Plan incorporates the following objectives:

A. Provides oversight and monitoring of responsibilities delegated to contracted and sub- contracted entities.
B. Implement corrective action plans to address deficiencies in the safeguard or use of Protected Health Information.
C. Conducting ongoing Risk Analyses to identify Threats and vulnerabilities within the organization.
D. Conducting ongoing Risk Mitigation efforts to protect PHI from Threats and vulnerabilities.
E. Conduct internal monitoring and auditing of CalViva Health operations and functions to assess compliance with state and federal requirements.
F. Identify and investigate potential privacy and Security Breaches. Take appropriate action(s) to resolve and report Breaches.
G. Provide education and other available resources to assist contracted providers and sub- contractors in becoming compliant with privacy and information Security requirements.
H. Educate staff and enforce adherence to CalViva Health's Code of Conduct standards, privacy and Security policies and procedures and mission.
I. Provide new legislation updates to providers and contractors that specify required actions to ensure contractual compliance and makes available additional information about privacy and Security activities and requirements on an ongoing basis as needed.

Anyone with questions or concerns about the Privacy and Security Plan or a particular policy or procedure should seek the guidance of the Privacy and Security Officer. The Privacy and Security Officer provides support in CalViva Health's ongoing commitment to provide quality services in compliance with the health information privacy and Security laws.

IV. SCOPE OF PLAN

1. Policy and Procedures:

CalViva Health has adopted a set of Privacy and Security policies and procedures. The policies and procedures are available to employees and business associates. Employees and business associates are able to access the policies in either a paper or electronic format. The policies and procedures along with this plan are the core of CalViva Health's Privacy and Security Plan and outline areas such as:

A. How PHI is used and disclosed
B. The individual's rights to PHI
C. CalViva Health's relationship with contractors and sub-contractors
D. CalViva Health's response plan for complaints and privacy Breaches
E. CalViva Health's training programs
F. CalViva Health's Risk Analyses and Risk Mitigation measures
G. CalViva Health's contingency plans
H. CalViva Health's utilization of technology to communicate with members, providers, consumers, and employees.

2. Permitted Uses and Disclosures:

CalViva Health's Privacy and Security Plan covers the permitted uses and disclosures pertaining to Protected Health Information. This includes sending a Notice of Privacy Practice to members upon enrollment and annually thereafter explaining how CalViva Health uses and discloses Protected Health Information. CalViva Health is permitted to use and disclose Protected Health Information for activities that are directly connected with the administration of the Plan's healthcare program, which includes but is not limited to establishing eligibility and methods of reimbursement, and providing services for members. CalViva Health extends this commitment to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners. CalViva Health provides DHCS with a list of external entities, including persons, organizations, and agencies to which it discloses PHI annually. The guiding principles of CalViva Health's Permitted Uses and Disclosures of PHI include:

A. Use/Disclosure of PHI for CalViva Health management and administration
B. Use/Disclosure of PHI by CalViva Health for Data Aggregation services to DHCS
C. Use/Disclosure of PHI by CalViva Health for conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan's healthcare program
D. Use/Disclosure of PHI by CalViva Health for legislative investigations/audits related to the administration of the Plan's healthcare program

3. CalViva Health Responsibilities:

CalViva Health has made several commitments in its Privacy and Security Plan, policies and procedures and business operations. CalViva Health takes steps to ensure a member's Medi-Cal status is not divulged without prior approval except for treatment, payment and operations, or as required by law. CalViva Health's commitment to privacy and security of PHI also includes:

A. Implementing Safeguards – CalViva Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in both electronic and hard-copy form. CalViva Health employees are trained in methods to assure that they use all reasonable measures to safeguard Protected Health Information from any use or Disclosure that would violate the HIPAA or state regulations or CalViva Health's privacy and security policies. CalViva Health's employees have limited access to Protected Health Information through role-based access and password protections. CalViva Health also has firewalls to protect information from those who do not need to access the Protected Health Information to perform their job functions.

B. Implementing Security Measures – CalViva Health employees working with PHI sign a confidentiality agreement; undergo a background check and use workstations and laptops with encryption mechanisms. CalViva Health enforces the "minimum necessary" principle in regards to PHI and ensures employees send secure emails or utilize another appropriate secure method (i.e. secure file transfer protocol ("FTP") when PHI is involved. CalViva Health uses the latest antivirus software and security patches on their workstation and/or laptops. Any uses of removable media devices or remote access used by CalViva Health associates for PHI are encrypted. CalViva Health incorporates a data destruction method consistent with the Department of Defense standard methods and assigns unique usernames and passwords to users accessing PHI. CalViva Health enforces security measures in several ways:

1. **Use of System Security Controls –** CalViva Health will ensure computer systems automatically timeout after no more than 20 minutes of inactivity. CalViva Health will make sure all systems containing PHI display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. CalViva Health's systems will include system-logging functions, access controls, transmission encryption and host-based intrusion detection. Logs and user activities are maintained by CalViva Health in accordance with the Plan's document and data retention policy and procedures.

2. **Use of Audit Controls –** CalViva Health will conduct system security reviews of all systems processing and/or storing PHI. The audit controls in place include reviewing systems logs for unauthorized access and ensuring there is a documented change control procedure in place.

3. **Use of Paper Document Controls –** CalViva Health's paper document controls includes protection of data by making sure PHI in paper form is locked in a file cabinet rather than left unattended. CalViva Health also escorts visitors to areas in which PHI is housed. CalViva Health confidentially shreds and destroys PHI in paper form and never removes PHI from the premises except for routine business purposes or with the express written permission of a state and/or federal agency. Faxes containing PHI are never left unattended and outgoing faxes include a confidentiality statement notifying the recipient receiving to destroy faxes received in error. PHI is mailed using secure means and for large volume mailings of PHI, CalViva Health uses a bonded courier with signature required on receipt.

4. **Use of a Contingency Plan –** CalViva Health's contingency plan includes an ability to enable continuation of critical business processes and protection of the Security of electronic PHI in the event of an emergency. CalViva Health makes sure all sensitive data including PHI is backed up regularly. Data backups are stored offsite, which allows for restoration of data in the event of an outage.

C. **Notification and Investigation of Incidents and/or Breaches -** CalViva Health is committed to compliance with HIPAA and state health information compliance laws and to correcting violations. Upon discovery of a suspected Security incident and/or Breach, CalViva Health notifies the applicable state and federal agencies without unreasonable delay. CalViva Health takes prompt corrective action to mitigate any risks or damages involved with the Breach. Refer to the Plan's Privacy and Security policies and procedures for detailed descriptions of the Breach investigation and notification processes.

1. **Investigation and Corrective Action -** If there is a report of noncompliance, the Privacy and Security Officer, a member of the Compliance Committee or a Plan employee/associate discovers credible evidence of a violation, an investigation will immediately ensue. When CalViva Health substantiates a reported violation, it is the policy to institute corrective action.

2. **Initiating Systemic Changes to Correct Problems** - After a problem has been identified and corrected, the Privacy and Security Officer and Compliance Committee will review the circumstances to determine 1) whether similar problems have been uncovered elsewhere and 2) whether modifications of the policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy and Security Officer will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

4. Education and Training Programs:

CalViva Health will ensure that training is provided to all employees and business associates. All employees with access to Protected Health Information are required to attend and participate in privacy and security training sessions. Adherence to the provisions of this plan, such as attending training sessions, will be a factor in the annual evaluation of each employee. All new employees will be provided training within a reasonable period after orientation.

5. Risk Analysis and Risk Management:

CalViva Health understands a Risk Analysis is the first step in identifying and implementing safeguards that comply with and carry out the standards and implementation specifications in the Security rule. CalViva Health works to ensure an accurate and thorough assessment of the potential risks and vulnerabilities to the Confidentiality, integrity and availability of PHI held by the Plan.

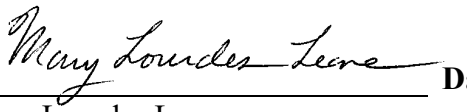
CalViva Health implements these steps when conducting a Risk Analysis:

a. Step 1: System Characterization
b. Step 2: Threat Identification
c. Step 3: Vulnerability Identification
d. Step 4: Control Analysis
e. Step 5: Likelihood Determination
f. Step 6: Impact Analysis
g. Step 7: Risk Determination
h. Step 8: Control Recommendations
i. Step 9: Results Documentation

The steps referenced above are consistent with the methodologies described in the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-30 Risk Management Guide for Information Technology Systems and NIST SP 800-66 An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security rule.

Along with risk analyses, CalViva Health maintains a Risk Management protocol which provides a structure for the evaluation, prioritization, and implementation of risk-reducing Security measures. CalViva Health has a team of individuals in place who are knowledgeable about the organization's Privacy and Security policies, procedures, training program, computer system set up, and technical Security controls.

APPROVAL:

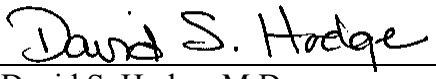


Date: **February 15~~6~~, 2024~~3~~**

Name: Mary Lourdes Leone
Title: Chief Compliance Officer

Date: **February 15~~6~~, 2024~~3~~**

Name: Jeffrey Nkansah
Title: Chief Executive Officer



Date: **February 15~~6~~, 2024~~3~~**

Name: David S. Hodge, M.D.
Title: RHA Commission Chairperson

Program Description History		
Date	**Section #**	**Comment(s)**
1/1/2012		New Program Description
3/1/2013		Updated entire document to properly reflect Privacy and Security Measures
2/6/2014		Changes to the Breach and Protected Health Information definition to align with the HIPAA FINAL Rule published on January 17, 2013; added language pertaining to the Risk Management Team; clarification to identify the Chief Compliance Officer is also the Privacy and Security Officer and other minor changes to clarify current contractual relationships and activities; comply with new regulations and Medi-Cal contract requirements
1/5/2015		Annual Review; No Changes Needed
2/18/2016		Annual Review; Updated the contact information for the Compliance Officer. Minor edits to clarify current practices.

2/16/2017		Annual Review; Updated overview clarify current contractual relationships and activities. Updated the name of document from Privacy and Security Program to Privacy and Security Plan.
2/15/2018		Annual Review; Updated the officer responsible for the Privacy and Security Plan, added a reference to comply with California's Data Breach Security Reporting Requirements, Updated the Department Responsible for the Plan and the reference to the name of the report which would be provided to the RHA Commission. Re-arranged sections for readability.
2/21/2019		Annual Review; No Changes Needed
2/20/2020		Annual Review; Added language referencing new policy HI-031 Member Communications under Telephone Consumer Protections Act (TCPA). Clarified a definition and a publishing date for a previously released regulatory law.
2/18/2021		Annual Review; No Changes Needed
2/3/2022		Annual Review; Updated the CCO to Mary Lourdes Leone and the CEO to Jeffery Nkansah
2/16/2023		Annual Review; Updated language to capture Assembly Bill 1184 surrounding requests for confidential communication, added definition of protected individual and sensitive services.
2/15/2024		Annual Review; Updated language to capture Assembly Bill 352 surrounding privacy of personal reproductive decisions, Assembly Bill 254 reproductive or sexual health information, and Senate Bill 107 surrounding gender-affirming care and mental health care for children. Updated/added definition of ~~updated/added definition of~~ PHI, ~~and~~ Social Needs Data, reproductive/sexual health information, and medical information.~~.~~

Item #14
Attachment 14.A-14.C

Finance

- 14.A Financials as of 12/31/23
- 14.B Revised FY 2024 Budget
- 14.C Moss Adams, LLP Audit Proposal

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of December 31, 2023

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	165,909,593.96
5	Total Bank Accounts	$ 165,909,593.96
6	Accounts Receivable	
7	Accounts Receivable	133,282,933.39
8	Total Accounts Receivable	$ 133,282,933.39
9	Other Current Assets	
10	Interest Receivable	444,552.67
11	Investments - CDs	0.00
12	Prepaid Expenses	1,030,533.92
13	Security Deposit	23,662.50
14	Total Other Current Assets	$ 1,498,749.09
15	Total Current Assets	$ 300,691,276.44
16	Fixed Assets	
17	Buildings	5,844,931.88
18	Computers & Software	45,111.08
19	Land	3,161,419.10
20	Office Furniture & Equipment	88,058.30
21	Total Fixed Assets	$ 9,139,520.36
22	Other Assets	
23	Investment -Restricted	303,000.73
24	Lease Receivable	2,926,694.91
25	Total Other Assets	$ 3,229,695.64
26	TOTAL ASSETS	$ 313,060,492.44
27	LIABILITIES AND EQUITY	
28	Liabilities	
29	Current Liabilities	
30	Accounts Payable	
31	Accounts Payable	127,189.62
32	Accrued Admin Service Fee	4,749,173.00
33	Capitation Payable	118,646,044.74
34	Claims Payable	19,755.85
35	Directed Payment Payable	3,768,442.06
36	Total Accounts Payable	$ 127,310,605.27
37	Other Current Liabilities	
38	Accrued Expenses	883,748.73
39	Accrued Payroll	72,805.13
40	Accrued Vacation Pay	344,908.05
41	Amt Due to DHCS	30,568,417.71
42	IBNR	75,992.01
43	Loan Payable-Current	0.00
44	Premium Tax Payable	0.00
45	Premium Tax Payable to BOE	1,446,886.65
46	Premium Tax Payable to DHCS	0.00
47	Total Other Current Liabilities	$ 33,392,758.28
48	Total Current Liabilities	$ 160,703,363.55
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	$ 160,729,270.34
54	Deferred Inflow of Resources	$ 2,492,418.53
55	Equity	
56	Retained Earnings	141,338,556.42
57	Net Income	8,500,247.15
58	Total Equity	$ 149,838,803.57
59	TOTAL LIABILITIES AND EQUITY	$ 313,060,492.44

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2023 - December 2023

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Income	4,015,566.99	1,800,000.00	2,215,566.99
3	Premium/Capitation Income	705,802,197.53	639,260,406.00	66,541,791.53
4	**Total Income**	**709,817,764.52**	**641,060,406.00**	**68,757,358.52**
5	Cost of Medical Care			
6	Capitation - Medical Costs	665,972,143.62	601,854,235.00	64,117,908.62
7	Medical Claim Costs	692,825.13	799,999.98	(107,174.85)
8	**Total Cost of Medical Care**	**666,664,968.75**	**602,654,234.98**	**64,010,733.77**
9	**Gross Margin**	**43,152,795.77**	**38,406,171.02**	**4,746,624.75**
10	Expenses			
11	Admin Service Agreement Fees	28,831,209.00	26,886,750.00	1,944,459.00
12	Bank Charges	0.00	3,600.00	(3,600.00)
13	Computer/IT Services	68,782.50	128,982.00	(60,199.50)
14	Consulting Fees	32,800.00	199,999.98	(167,199.98)
15	Depreciation Expense	163,768.20	180,000.00	(16,231.80)
16	Dues & Subscriptions	118,304.25	117,000.00	1,304.25
17	Grants	2,367,727.25	2,382,275.00	(14,547.75)
18	Insurance	175,534.24	226,560.00	(51,025.76)
19	Labor	1,815,015.55	2,257,839.00	(442,823.45)
20	Legal & Professional Fees	42,616.21	100,000.02	(57,383.81)
21	License Expense	632,523.49	698,755.98	(66,232.49)
22	Marketing	566,174.44	835,000.00	(268,825.56)
23	Meals and Entertainment	8,781.61	17,350.00	(8,568.39)
24	Office Expenses	33,956.02	45,600.00	(11,643.98)
25	Parking	109.00	780.00	(671.00)
26	Postage & Delivery	1,102.04	2,400.00	(1,297.96)
27	Printing & Reproduction	933.65	2,460.00	(1,526.35)
28	Recruitment Expense	842.13	56,250.00	(55,407.87)
29	Rent	0.00	6,000.00	(6,000.00)
30	Seminars and Training	4,449.14	14,400.00	(9,950.86)
31	Supplies	6,932.88	6,499.98	432.90
32	Taxes	(446.53)	0.00	(446.53)
33	Telephone	15,247.80	21,000.00	(5,752.20)
34	Travel	9,479.02	13,099.98	(3,620.96)
35	**Total Expenses**	**34,895,841.89**	**34,202,601.94**	**693,239.95**
36	**Net Operating Income/ (Loss)**	**8,256,953.88**	**4,203,569.08**	**4,053,384.80**
37	Other Income			
38	Other Income	243,293.27	300,000.00	(56,706.73)
39	**Total Other Income**	**243,293.27**	**300,000.00**	**(56,706.73)**
40	**Net Other Income**	**243,293.27**	**300,000.00**	**(56,706.73)**
41	**Net Income/ (Loss)**	**8,500,247.15**	**4,503,569.08**	**3,996,678.07**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2024 vs FY 2023

		Total	
		July 2023 - Dec 2023 (CY)	July 2022 - Dec 2022 (PY)
1	Income		
2	Interest Income	4,015,566.99	1,916,442.59
3	Premium/Capitation Income	705,802,197.53	662,549,693.84
4	**Total Income**	**709,817,764.52**	**664,466,136.43**
5	Cost of Medical Care		
6	Capitation - Medical Costs	665,972,143.62	531,530,000.77
7	Medical Claim Costs	692,825.13	687,699.66
8	**Total Cost of Medical Care**	**666,664,968.75**	**532,217,700.43**
9	**Gross Margin**	**43,152,795.77**	**132,248,436.00**
10	Expenses		
11	Admin Service Agreement Fees	28,831,209.00	27,316,641.00
12	Computer/IT Services	68,782.50	103,580.96
13	Consulting Fees	32,800.00	10,625.00
14	Depreciation Expense	163,768.20	143,374.14
15	Dues & Subscriptions	118,304.25	103,497.76
16	Grants	2,367,727.25	2,955,909.10
17	Insurance	175,534.24	95,785.49
18	Labor	1,815,015.55	1,623,760.24
19	Legal & Professional Fees	42,616.21	48,342.33
20	License Expense	632,523.49	587,891.32
21	Marketing	566,174.44	618,453.30
22	Meals and Entertainment	8,781.61	14,733.31
23	Office Expenses	33,956.02	44,572.25
24	Parking	109.00	120.39
25	Postage & Delivery	1,102.04	1,507.08
26	Printing & Reproduction	933.65	595.85
27	Recruitment Expense	842.13	36,009.73
28	Rent	0.00	0.00
29	Seminars and Training	4,449.14	4,786.93
30	Supplies	6,932.88	5,232.32
31	Taxes	(446.53)	91,437,253.47
32	Telephone	15,247.80	15,020.88
33	Travel	9,479.02	10,142.55
34	**Total Expenses**	**34,895,841.89**	**125,177,835.40**
35	**Net Operating Income/ (Loss)**	**8,256,953.88**	**7,070,600.60**
36	Other Income		
37	Other Income	243,293.27	261,716.75
38	**Total Other Income**	**243,293.27**	**261,716.75**
39	**Net Other Income**	**243,293.27**	**261,716.75**
40	**Net Income/ (Loss)**	**8,500,247.15**	**7,332,317.35**

	Fresno Kings Madera Regional Health Authority dba CalViva Health								
	REVISED FY 2024 PROPOSED BUDGET								
			<A>		**<B>**		**<C>** = <B> - <A>		**<D>** = <C>/<A>
			FY 2024 Approved Budget		**REVISED Proposed FY 2024 Budget**		**REVISED Proposed FY 2024 vs FY 2024 Budget Difference**		**% Change from Revised Proposed FY 2024 Budget vs FY 2024 Approved Budget**
1	Medical Revenue		1,265,478,182		**1,731,790,682**		466,312,500		36.85%
2	Interest Income		3,600,000		**3,600,000**		-		0.0%
3	**Total Revenues**		1,269,078,182		**1,735,390,682**		466,312,500		36.7%
4	**Medical Cost Expense**		1,129,334,874		**1,129,334,874**		-		0.0%
5	**Gross Margin**		139,743,308		**606,055,808**		466,312,500		333.7%
	Expenses								
6	Administrative Services Fee		51,397,610		**51,397,610**		-		0.0%
7	Salary,Wages & Benefits		4,546,256		**4,546,256**		-		0.0%
8	Bank Charges		7,200		**7,200**		-		0.0%
9	Consulting		400,000		**400,000**		-		0.0%
10	Computer & IT		257,960		**257,960**		-		0.0%
11	Depreciation		360,000		**360,000**		-		0.0%
12	Dues & Subscriptions		234,000		**234,000**		-		0.0%
13	Grants		3,925,000		**3,925,000**		-		0.0%
14	Insurance		403,683		**403,683**		-		0.0%
15	Legal & Professional		200,000		**200,000**		-		0.0%
16	License		1,397,512		**1,397,512**		-		0.0%
17	Marketing		1,500,000		**1,500,000**		-		0.0%
18	Meals		27,450		**27,450**		-		0.0%
19	Office		91,200		**91,200**		-		0.0%
20	Parking		1,560		**1,560**		-		0.0%
21	Postage & Delivery		4,800		**4,800**		-		0.0%
22	Printing & Reproduction		4,920		**4,920**		-		0.0%
23	Recruitment		112,500		**112,500**		-		0.0%
24	Rent		12,000		**12,000**		-		0.0%
25	Seminars & Training		28,800		**28,800**		-		0.0%
26	Supplies		13,000		**13,000**		-		0.0%
27	Telephone/Internet		42,000		**42,000**		-		0.0%
28	Travel		26,200		**26,200**		-		0.0%
29	**Total Expenses**		64,993,651		**64,993,651**		-		0.0%
30	**Income before Taxes**		74,749,657		**541,062,157**		466,312,500		623.8%
31	**Taxes-MCO**		66,500,000		**532,812,500**		466,312,500		701.2%
32	**Excess Revenue (Expenses)**		8,249,657		**8,249,657**		-		0.0%
33	**Other Income**		600,000		**600,000**		-		0.0%
34	**Net Income/(Loss)**		8,849,657		**8,849,657**		-		0.0%
35	**Capital Expenditure Budget**		400,000		**400,000**		-		0.0%

MOSSADAMS

T (415) 956-1500
F (415) 956-4149

101 Second Street
Suite 900
San Francisco, CA 94105

October 20, 2023

Fresno Kings Madera Regional Health Authority
dba CalViva Health
c/o Mr. Daniel Maychen Chief Financial Officer
7625 North Palm Ave., Suite 109
Fresno, CA 93711

Subject: Fee Proposal for Audit and Nonattest Services

Dear Daniel,

Thank you for the opportunity to provide services to Fresno Kings Madera Regional Health Authority dba CalViva Health. In our engagement, we will audit the Company's statement of net position as of and for the years ending June 30, 2025; June 30, 2026; and June 20, 2027, and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended. In addition, we will provide the Company with the following nonattest services:

Assist management in drafting the financial statements and related footnotes as of and for each of the years ending June 30, 2025; June 30, 2026; and June 20, 2027.

Rianne Suico is responsible for supervising the engagement and authorizing the signing of the report. Our fees for audit services will be:

Service Description	FY 2025	FY 2026	FY 2027
Annual Financial Statement Audit	$69,500	$69,500	$69,500
Presentation of the audit results and Management Letter to the Finance Committee and Board of Commissioners		Included	
Total	$69,500	$69,500	$69,500

You will also be billed for expenses at our cost as they are incurred.

The fee estimates are based on anticipated level of preparation and cooperation from your management and staff, your completion of the year-end closing and adjusting process prior to our arrival to begin fieldwork and the expectation that the records will be in good order. We may experience delays in completing our service due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

MOSSADAMS

Our fees are also based on accounting and auditing standards currently in effect and on the assumption there will be minimal changes to the scope of accounting entity.

We appreciate the opportunity to be of service to you. Please let us know if you need additional information.

Very truly yours,

Rianne Suico

Rianne Suico, Partner, for
Moss Adams LLP

Item #14
Attachment 14.D-14.H

Medical Management

- 14.D Appeals & Grievances Report
- 14.E Key Indicator Report
- 14.F QIUM Quarterly Report
- 14.G Credentialing Sub-Committee Quarterly Report
- 14.H. Peer Review Sub-Committee Quarterly Report

Attachment

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2023

Current as of End of the Month: December
Revised Date: 1/11/2024

CalViva - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	8	13	13	34	16	12	12	40	7	12	7	26	8	9	9	26	126	74
Standard Grievances Received	93	108	131	332	138	182	182	502	161	170	151	482	160	145	140	445	1761	1109
Total Grievances Received	**101**	**121**	**144**	**366**	**154**	**194**	**194**	**542**	**168**	**182**	**158**	**508**	**168**	**154**	**149**	**471**	**1887**	**1183**
Grievance Ack Letters Sent Noncompliant	0	1	0	1	1	1	1	3	0	0	0	0	0	1	5	6	10	5
Grievance Ack Letter Compliance Rate	**100.0%**	**99.1%**	**100.0%**	**99.7%**	**99.3%**	**99.5%**	**99.5%**	**99.4%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.3%**	**96.4%**	**98.7%**	**99.43%**	**99.5%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	7	12	13	32	17	13	12	42	7	11	8	26	8	6	12	26	126	74
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	1
Standard Grievances Resolved Compliant	93	79	116	288	118	157	182	457	162	173	173	508	141	173	135	449	1702	1105
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**99.8%**	**99.94%**	**99.9%**
Total Grievances Resolved	**100**	**91**	**129**	**320**	**135**	**170**	**194**	**499**	**169**	**184**	**181**	**534**	**149**	**180**	**147**	**476**	**1829**	**1180**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**65**	**68**	**100**	**233**	**102**	**134**	**158**	**394**	**136**	**153**	**151**	**440**	**114**	**164**	**123**	**401**	**1468**	**826**
Access - Other - DMHC	13	12	19	44	26	29	30	85	17	25	26	68	19	32	22	73	270	176
Access - PCP - DHCS	5	7	2	14	14	7	11	32	13	12	9	34	15	12	11	38	118	85
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	6	3	6	15	9	10	5	24	7	3	9	19	5	6	9	20	78	57
Administrative	10	6	13	29	5	18	19	42	15	30	21	66	11	20	18	49	186	119
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	5	5	10	20	9	8	13	30	9	11	19	39	10	15	8	33	122	102
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	12	19	42	20	28	42	90	35	37	39	111	32	36	28	96	339	101
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	9
Transportation - Access	9	14	13	36	12	10	22	44	23	19	15	57	11	21	6	38	175	81
Transportation - Behaviour	3	4	10	17	4	12	8	24	6	7	7	20	8	10	10	28	89	66
Transportation - Other	3	5	8	16	3	12	8	23	6	9	6	21	3	12	11	26	86	30
Quality Of Care Grievances	**35**	**23**	**29**	**87**	**33**	**36**	**36**	**105**	**33**	**31**	**30**	**94**	**35**	**16**	**24**	**75**	**361**	**354**
Access - Other - DMHC	0	0	0	0	0	1	0	1	0	0	1	1	0	1	0	1	3	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
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	1	1	1	3	1	0	0	1	0	0	0	0	4	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7	2	6	15	3	2	8	13	9	7	5	21	5	2	4	11	60	43
PCP Care	8	9	6	23	8	13	6	27	9	7	7	23	14	2	5	21	94	93
PCP Delay	12	5	13	30	11	10	10	31	9	11	11	31	7	8	9	24	116	104
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	6	4	2	12	9	6	10	25	2	4	5	11	5	3	4	12	60	66
Specialist Delay	2	3	2	7	1	3	1	5	3	2	1	6	4	0	2	6	24	33
Exempt Grievances Received	144	208	218	**570**	163	199	132	**494**	145	176	103	**424**	114	155	128	**397**	**1885**	2429
Access - Avail of Appt w/ PCP	1	3	5	**9**	1	1	0	**2**	0	2	1	**3**	0	1	0	**1**	**15**	53
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**	1
Access - Wait Time - wait too long on telephone	0	0	1	**1**	1	1	1	**3**	0	0	1	**1**	1	1	0	**2**	**7**	25
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	**2**	10
Access - Panel Disruption	3	3	2	**8**	3	1	0	**4**	0	0	0	**0**	0	1	2	**3**	**15**	25
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Geographic/Distance Access PCP	0	1	0	**1**	1	0	0	**1**	0	0	1	**1**	0	0	0	**0**	**3**	5
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	**2**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	1	2	3	**6**	0	0	1	**1**	2	1	1	**4**	0	1	2	**3**	**14**	6
Attitude/Service - Provider	1	2	3	**6**	4	9	4	**17**	5	7	0	**12**	1	4	3	**8**	**43**	198
Attitude/Service - Office Staff	0	4	0	**4**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**5**	0
Attitude/Service - Vendor	0	0	2	**2**	0	0	0	**0**	0	0	0	**0**	2	0	0	**2**	**4**	15
Attitude/Service - Health Plan	0	2	0	**2**	0	1	2	**3**	2	2	1	**5**	0	1	1	**2**	**12**	5
Authorization - Authorization Related	0	0	1	**1**	0	0	0	**0**	2	2	1	**5**	0	0	0	**0**	**6**	14
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	0	1	1	**2**	0	1	0	**1**	1	0	0	**1**	**4**	1

Eligibility Issue - Member not eligible per Provider	2	2	5	**9**	1	6	5	**12**	6	7	2	**15**	3	5	4	**12**	**48**	44
Health Plan Materials - ID Cards-Not Received	14	20	28	**62**	9	14	0	**23**	21	29	14	**64**	22	22	17	**61**	**210**	243
Health Plan Materials - ID Cards-Incorrect Information on Card	0	1	0	**1**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	7
Health Plan Materials - Other	1	2	0	**3**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	**4**	6
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	2	0	0	**2**	**2**	1
PCP Assignment/Transfer - Health Plan Assignment - Change Request	53	88	86	**227**	60	60	42	**162**	39	60	39	**138**	31	50	44	**125**	**652**	629
PCP Assignment/Transfer - HCO Assignment - Change Request	35	41	41	**117**	38	50	19	**107**	14	9	8	**31**	13	21	12	**46**	**301**	533
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	4
PCP Assignment/Transfer - PCP Transfer not Processed	0	1	2	**3**	0	2	2	**4**	1	6	2	**9**	3	9	9	**21**	**37**	20
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	4	3	**7**	**7**	2
PCP Assignment/Transfer - Mileage Inconvenience	1	0	2	**3**	3	5	0	**8**	0	1	2	**3**	0	0	0	**0**	**14**	32
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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**	0
Transportation - Access - Provider No Show	8	4	3	**15**	3	5	6	**14**	10	12	4	**26**	3	6	1	**10**	**65**	133
Transportation - Access - Provider Late	2	4	5	**11**	5	4	1	**10**	4	3	0	**7**	2	1	1	**4**	**32**	77
Transportation - Behaviour	13	10	14	**37**	10	3	2	**15**	10	10	1	**21**	1	1	1	**3**	**76**	139
Transportation - Other	0	2	1	**3**	1	5	16	**22**	2	6	11	**19**	1	4	4	**9**	**53**	12
OTHER - Other	0	1	1	**2**	1	0	1	**2**	0	3	0	**3**	2	4	1	**7**	**14**	7
Claims Complaint - Balance Billing from Provider	8	15	13	**36**	20	30	27	**77**	25	15	14	**54**	26	19	23	**68**	**235**	173

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	1	1	2	7	0	3	10	3	4	5	12	5	3	2	10	34	42
Standard Appeals Received	29	43	22	94	17	43	38	98	24	21	29	74	22	26	17	65	331	396
Total Appeals Received	**29**	**44**	**23**	**96**	**24**	**43**	**41**	**108**	**27**	**25**	**34**	**86**	**27**	**29**	**19**	**75**	365	**438**
Appeals Ack Letters Sent Noncompliant	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	2	3
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**95.5%**	**98.9%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**95.8%**	**100.0%**	**100.0%**	**98.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.40%**	**99.2%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	1	2	**3**	7	0	3	**10**	3	4	5	**12**	5	3	2	10	35	42
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Standard Appeals Resolved Compliant	21	29	40	90	19	21	46	86	29	26	19	74	28	24	23	75	325	414
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**96.6%**	**100.0%**	**100.0%**	**98.6%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.69%**	**99.8%**
Total Appeals Resolved	**21**	**30**	**42**	**93**	**26**	**21**	**49**	**96**	**33**	**30**	**24**	**87**	**33**	**27**	**25**	**85**	**361**	**457**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**21**	**30**	**39**	**90**	**25**	**21**	**48**	**94**	**33**	**29**	**23**	**85**	**32**	**27**	**25**	**84**	**353**	454
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	2	2	1	1	0	2	0	3	0	3	1	1	0	2	9	7
DME	2	5	4	11	3	0	2	5	6	2	2	10	1	2	8	11	37	49
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	1	1	0	0	0	0	1	2
Advanced Imaging	10	18	17	45	8	13	25	46	12	14	13	39	11	13	8	32	162	244
Other	2	0	2	4	2	1	8	12	3	2	1	6	5	4	4	13	35	33
Pharmacy/RX Medical Benefit	4	2	2	8	4	1	6	10	5	6	4	15	8	3	3	14	47	58
Surgery	3	5	12	20	7	5	7	19	7	2	2	11	6	4	2	12	62	61
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**3**	**3**	**1**	**0**	**1**	**2**	**0**	**1**	**1**	**2**	**1**	**0**	**0**	**1**	**8**	3
Consultation	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	2	2	1	0	1	2	0	1	1	2	1	0	0	1	7	2
Pharmacy/RX Medical Benefit	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	6	10	15	**31**	15	9	22	46	14	12	13	39	20	12	8	40	156	196
Uphold Rate	**28.6%**	**33.3%**	**35.7%**	**33.3%**	**57.7%**	**42.9%**	**44.9%**	**47.9%**	**42.4%**	**40.0%**	**54.2%**	**44.8%**	**60.6%**	**44.4%**	**32.0%**	**47.1%**	**43.2%**	**42.9%**
Overturns - Full	15	19	26	**60**	11	11	26	**48**	18	16	10	**44**	12	14	16	**42**	194	244
Overturn Rate - Full	**71.4%**	**63.3%**	**61.9%**	**64.5%**	**42.3%**	**52.4%**	**53.1%**	**50.0%**	**54.5%**	**53.3%**	**41.7%**	**50.6%**	**36.4%**	**51.9%**	**64.0%**	**49.4%**	**53.7%**	**53.4%**
Overturns - Partials	0	1	1	**2**	0	0	1	**1**	1	2	1	**4**	1	1	1	**3**	10	9
Overturn Rate - Partial	**0.0%**	**3.3%**	**2.4%**	**2.2%**	**0.0%**	**0.0%**	**2.0%**	**1.0%**	**3.0%**	**6.7%**	**4.2%**	**4.6%**	**3.0%**	**3.7%**	**4.0%**	**3.53%**	**2.8%**	**2.0%**
Withdrawal	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	0	**1**	8
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.8%**	**0.0%**	**1.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.3%**	**1.8%**
Membership	421,006	435,392	437,493		440,882	443,410	445,086		443,442	441,077	437,551		434,785	432,442	######			417,000
Appeals - PTMPM	0.05	0.07	0.10	0.07	0.06	0.05	0.11	0.07	0.07	0.07	0.05	0.07	0.08	0.06	0.06	0.07	0.07	0.09
Grievances - PTMPM	0.24	0.21	0.29	0.25	0.31	0.38	0.44	0.38	0.38	0.42	0.41	0.40	0.34	0.42	0.34	0.37	0.35	0.24

Fresno County - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	8	12	10	30	13	8	11	32	7	9	6	22	8	9	6	23	107	59
Standard Grievances Received	81	95	108	284	112	147	148	407	125	137	127	389	137	113	117	367	1447	929
Total Grievances Received	**89**	**107**	**118**	**314**	**125**	**155**	**159**	**439**	**132**	**146**	**133**	**411**	**145**	**122**	**123**	**390**	**1554**	**988**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	1	3	4	0	4
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.1%**	**100.0%**	**100.0%**	**99.8%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.1%**	**97.4%**	**98.9%**	**100.0%**	**99.57%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	7	11	10	28	14	9	11	34	7	8	7	22	8	6	9	23	107	59
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	1
Standard Grievances Resolved Compliant	71	70	103	244	96	127	147	370	130	135	139	404	117	148	106	371	1389	932
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.3%**	**100.0%**	**99.7%**	**99.9%**	**99.9%**
Total Grievances Resolved	**78**	**81**	**113**	**272**	**110**	**136**	**158**	**404**	**137**	**143**	**146**	**426**	**125**	**155**	**115**	**395**	**1497**	**992**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**51**	**60**	**86**	**197**	**80**	**107**	**129**	**316**	**109**	**119**	**122**	**350**	**97**	**139**	**95**	**331**	**1194**	**686**
Access - Other - DMHC	12	11	17	40	19	21	25	65	20	21	18	59	17	28	16	61	225	139
Access - PCP - DHCS	4	7	2	13	12	7	11	30	11	7	9	27	13	10	9	32	102	72
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	6	3	5	14	8	7	5	20	6	3	7	16	5	6	8	19	69	47
Administrative	7	6	12	25	4	16	19	39	12	28	16	56	8	16	16	40	160	97
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	2	4	8	14	7	6	10	23	9	8	15	32	8	13	7	28	97	90
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	9	9	18	36	16	18	34	68	28	30	34	92	30	33	24	87	283	83
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	6
Transportation - Access	7	11	9	27	8	9	15	32	14	13	11	38	7	18	4	29	126	65
Transportation - Behaviour	1	4	7	12	4	11	6	21	4	5	6	15	6	9	7	22	70	61
Transportation - Other	3	5	8	16	2	12	4	18	4	4	6	14	3	6	4	13	61	26
Quality Of Care Grievances	**27**	**21**	**27**	**75**	**30**	**29**	**29**	**88**	**28**	**24**	**24**	**76**	**28**	**16**	**20**	**64**	**303**	**306**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	1	2	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
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	1	1	1	3	1	0	0	1	0	0	0	0	4	3
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	2	6	13	3	1	6	10	8	7	4	19	3	2	4	9	51	35
PCP Care	4	9	6	19	8	11	6	25	7	5	5	17	10	2	5	17	78	76
PCP Delay	11	4	12	27	8	8	7	23	9	8	9	26	6	8	7	21	97	94
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	5	4	2	11	9	5	8	22	2	3	4	9	5	3	4	12	54	59
Specialist Delay	2	2	1	5	1	3	1	5	1	1	1	3	4	0	0	4	17	27

CalViva Health Appeals and Grievances Dashboard 2023 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	0	1	1	7	0	3	10	3	4	5	12	5	2	2	9	32	33
Standard Appeals Received	23	37	21	81	17	33	30	80	23	19	25	67	17	21	12	50	278	320
Total Appeals Received	**23**	**37**	**22**	**82**	**24**	**33**	**33**	**90**	**26**	**23**	**30**	**79**	**22**	**23**	**14**	**59**	310	**353**
Appeals Ack Letters Sent Noncompliant	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**95.2%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**95.7%**	**100.0%**	**100.0%**	**98.5%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.6%**	**99.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	1	1	7	0	3	10	3	4	5	12	5	2	2	9	32	33
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Standard Appeals Resolved Compliant	19	23	35	77	19	17	39	**75**	25	24	18	**67**	23	20	18	**61**	280	336
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.7%**
Total Appeals Resolved	**19**	**23**	**36**	**78**	**26**	**17**	**42**	**85**	**28**	**28**	**23**	**79**	**28**	**22**	**20**	**70**	**312**	**370**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**19**	**23**	**33**	**75**	**25**	**17**	**41**	**83**	**28**	**27**	**22**	**77**	**27**	**22**	**20**	**69**	**304**	**368**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	1	1	1	1	0	2	0	3	0	3	1	1	0	2	8	7
DME	2	5	4	11	3	0	2	5	5	2	2	9	1	2	8	11	36	40
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	1	1	0	0	0	0	1	2
Advanced Imaging	9	12	17	38	8	10	21	39	10	13	12	35	9	11	5	25	137	199
Other	2	0	0	2	2	2	8	12	3	2	1	6	5	4	3	12	32	29
Pharmacy/RX Medical Benefit	4	2	1	7	4	0	4	8	4	5	4	13	7	2	2	11	39	44
Surgery	2	4	10	16	7	4	6	17	6	2	2	10	4	2	2	8	51	47
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**3**	**3**	**1**	**0**	**1**	**2**	**0**	**1**	**1**	**2**	**1**	**0**	**0**	**1**	**8**	**2**
Consultation	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	2	2	1	0	1	0	0	1	1	0	1	0	0	1	3	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	5	7	12	**24**	15	7	21	**43**	14	11	13	**38**	19	10	5	**34**	139	164
Uphold Rate	**26.3%**	**30.4%**	**33.3%**	**30.8%**	**57.7%**	**41.2%**	**50.0%**	**50.6%**	**50.0%**	**39.3%**	**56.5%**	**48.1%**	**67.9%**	**45.5%**	**25.0%**	**48.6%**	**44.6%**	**44.3%**
Overturns - Full	14	16	23	**53**	11	10	21	**42**	14	15	9	**38**	9	11	14	**34**	167	189
Overturn Rate - Full	**73.7%**	**69.6%**	**63.9%**	**67.9%**	**42.3%**	**58.8%**	**50.0%**	**49.4%**	**50.0%**	**53.6%**	**39.1%**	**48.1%**	**32.1%**	**0.0%**	**0.0%**	**48.6%**	**53.5%**	**51.1%**
Overturns - Partials	0	0	1	**1**	0	0	0	**0**	0	2	1	**3**	0	1	1	**2**	6	9
Overturn Rate - Partial	**0.0%**	**0.0%**	**2.8%**	**1.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**7.1%**	**4.3%**	**3.8%**	**0.0%**	**4.5%**	**5.0%**	**2.9%**	**1.9%**	**2.4%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	8
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.2%**
Membership	338,835	349,660	351,313		353,806	355,821	357,098		355,405	353,005	350,061		348,373	346,709	345,319			**335572**
Appeals - PTMPM	0.06	0.07	0.10	0.08	0.07	0.05	0.12	0.08	0.08	0.08	0.07	0.07	0.08	0.06	0.06	0.00	0.06	0.07
Grievances - PTMPM	0.23	0.23	0.32	0.26	0.31	0.38	0.44	0.38	0.39	0.41	0.42	0.40	0.36	0.45	0.33	0.00	0.26	0.18

Kings County - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	0	1	2	3	1	3	0	4	0	0	0	0	0	0	2	2	9	3
Standard Grievances Received	4	7	14	25	10	20	11	41	14	15	7	36	12	22	15	49	151	76
Total Grievances Received	**4**	**8**	**16**	**28**	**11**	**23**	**11**	**45**	**14**	**15**	**7**	**36**	**12**	**22**	**17**	**51**	**160**	**79**
Grievance Ack Letters Sent Noncompliant	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0
Grievance Ack Letter Compliance Rate	**100.0%**	**85.7%**	**100.0%**	**96.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**93.3%**	**100.0%**	**99.3%**	**100.0%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	0	1	2	3	1	3	0	4	0	0	0	0	0	0	2	2	9	3
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	9	5	5	19	16	11	19	46	12	15	15	42	9	14	18	41	148	75
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**9**	**6**	**7**	**22**	**17**	**14**	**19**	**50**	**12**	**15**	**15**	**42**	**9**	**14**	**20**	**43**	157	**78**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**4**	**5**	**6**	**15**	**15**	**11**	**16**	**42**	**9**	**11**	**11**	**31**	**7**	**14**	**19**	**40**	**128**	**57**
Access - Other - DMHC	0	0	1	1	5	4	2	11	1	2	1	4	0	3	3	6	22	15
Access - PCP - DHCS	1	0	0	1	2	0	0	2	1	0	0	1	1	1	1	3	7	5
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	1	1	1	1	0	2	1	0	0	1	0	0	1	1	5	7
Administrative	2	0	1	3	0	0	0	0	1	1	2	4	1	2	1	4	11	4
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	0	0	0	0	2	1	1	4	0	2	3	5	0	1	0	1	10	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	2	0	2	3	5	5	13	2	2	3	7	0	0	3	3	25	8
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Transportation - Access	1	3	3	7	2	0	3	5	2	1	1	4	3	1	2	6	22	5
Transportation - Behaviour	0	0	0	0	0	0	1	1	0	0	1	1	2	0	2	4	6	4
Transportation - Other	0	0	0	0	0	0	4	4	1	3	0	4	0	6	6	12	20	3
Quality Of Care Grievances	**5**	**1**	**1**	**7**	**2**	**3**	**3**	**8**	**3**	**4**	**4**	**11**	**2**	**0**	**1**	**3**	**29**	**21**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	0	1	1	1	0	0	1	1	0	0	1	4	4
PCP Care	3	0	0	3	0	1	0	1	2	2	2	6	1	0	0	1	11	4
PCP Delay	1	1	0	2	2	1	1	4	0	1	1	2	0	0	1	1	9	6
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	1	1	2	0	1	1	2	0	0	0	0	4	6
Specialist Delay	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1

CalViva Health Appeals and Grievances Dashboard 2023 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Received	1	3	0	4	0	0	3	3	0	1	2	0	1	1	2	4	11	16
Total Appeals Received	**1**	**3**	**0**	**4**	**0**	**0**	**3**	**3**	**0**	**1**	**2**	**0**	**1**	**1**	**2**	**4**	11	**16**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**100.0%**	**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%**	**100.0%**	**0.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	2	0	3	5	0	0	0	0	1	1	0	2	2	1	1	4	11	14
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**2**	**0**	**4**	**6**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**2**	**2**	**1**	**1**	**4**	**12**	**14**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**0**	**4**	**6**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**2**	**2**	**1**	**1**	**4**	**12**	**14**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
DME	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	1	0	0	1	0	0	0	0	0	0	0	0	2	1	0	3	4	5
Other	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	1
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	1	2	3
Surgery	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	4
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	0	2	**3**	0	0	0	**0**	0	1	0	**1**	0	0	1	**1**	5	5
Uphold Rate	**50.0%**	**0.0%**	**50.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**100.0%**	**25.0%**	**41.7%**	**35.7%**
Overturns - Full	1	0	2	**3**	0	0	0	**0**	1	0	0	**1**	2	1	0	**3**	7	9
Overturn Rate - Full	**50.0%**	**0.0%**	**50.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**50.0%**	**100.0%**	**100.0%**	**0.0%**	**75.0%**	**58.3%**	**64.3%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Membership	36,388	38,617	38,772		39,184	39,372	39,665		39,611	39,697	39,366		38,824	38,583	38,436			**314148**
Appeals - PTMPM	0.05	-	0.10	0.05	-	-	-	0.00	0.03	0.03	-	0.02	0.05	0.03	0.03	0.03	0.03	0.03
Grievances - PTMPM	0.25	0.16	0.18	0.19	0.43	0.36	0.48	0.42	0.30	0.38	0.38	0.35	0.23	0.36	0.52	0.37	0.34	0.18

Madera County - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	0	0	1	1	2	1	1	4	0	3	1	4	0	0	1	1	10	12
Standard Grievances Received	8	6	9	23	16	15	23	54	22	18	17	57	11	10	8	29	163	104
Total Grievances Received	**8**	**6**	**10**	**24**	**18**	**16**	**24**	**58**	**22**	**21**	**18**	**61**	**11**	**10**	**9**	**30**	**173**	**116**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**93.3%**	**95.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**87.5%**	**96.6%**	**99.4%**	**100.0%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	0	0	1	1	2	1	1	4	0	3	1	4	0	0	1	1	10	12
Expedited Grievance Compliance rate	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	13	4	8	25	6	19	16	41	20	23	19	62	15	11	11	37	165	98
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**13**	**4**	**9**	**26**	**8**	**20**	**17**	**45**	**20**	**26**	**20**	**66**	**15**	**11**	**12**	**38**	**175**	**110**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**10**	**3**	**8**	**21**	**7**	**16**	**13**	**36**	**18**	**23**	**18**	**59**	**10**	**11**	**9**	**30**	**146**	**83**
Access - Other - DMHC	1	1	1	3	2	4	3	9	0	2	7	9	2	1	3	6	27	22
Access - PCP - DHCS	0	0	0	0	0	0	0	0	1	5	0	6	1	1	1	3	9	8
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	2	0	2	0	0	2	2	0	0	0	0	4	3
Administrative	1	0	0	1	1	2	0	3	2	1	3	6	2	2	1	5	15	18
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	3	1	2	6	0	1	2	3	0	1	1	2	2	1	1	4	15	8
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	1	1	4	1	5	3	9	5	5	2	12	2	3	1	6	31	10
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Transportation - Access	1	0	1	2	2	1	4	7	7	5	3	15	1	2	0	3	27	11
Transportation - Behaviour	2	0	3	5	0	1	1	2	2	2	0	4	0	1	1	2	13	1
Transportation - Other	0	0	0	0	1	0	0	1	1	2	0	3	0	0	1	1	5	1
Quality Of Care Grievances	**3**	**1**	**1**	**5**	**1**	**4**	**4**	**9**	**2**	**3**	**2**	**7**	**5**	**0**	**3**	**8**	**29**	**27**
Access - Other - DMHC	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	1	1	2	0	0	1	1	1	0	0	1	5	4
PCP Care	1	0	0	1	0	1	0	1	0	0	0	0	3	0	0	3	5	13
PCP Delay	0	0	1	1	1	1	2	4	0	2	1	3	1	0	1	2	10	4
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	2	3
Specialist Delay	0	1	0	1	0	0	0	0	2	1	0	3	0	0	2	2	6	2

CalViva Health Appeals and Grievances Dashboard 2023 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	1	2	9
Standard Appeals Received	5	2	1	8	0	10	5	15	1	1	2	4	4	4	3	11	38	60
Total Appeals Received	**5**	**3**	**1**	**9**	**0**	**10**	**5**	**15**	**1**	**1**	**2**	**4**	**4**	**5**	**3**	**12**	40	**69**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	1	0	1	0	0	0	0	4	0	0	4	0	1	0	1	6	9
Expedited Appeals Compliance Rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	0	6	2	8	0	4	7	**11**	0	1	1	**2**	3	3	4	**10**	31	64
Standard Appeals Compliance Rate	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**0**	**7**	**2**	**9**	**0**	**4**	**7**	**11**	**4**	**1**	**1**	**6**	**3**	**4**	**4**	**11**	**37**	**73**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**0**	**7**	**2**	**9**	**0**	**4**	**7**	**11**	**4**	**1**	**1**	**6**	**3**	**4**	**4**	**11**	**37**	**72**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	0	6	0	6	0	3	4	7	2	1	1	4	0	1	3	4	21	40
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	3
Pharmacy/RX Medical Benefit	0	0	1	1	0	0	2	2	1	0	0	1	1	1	0	2	6	11
Surgery	0	1	1	2	0	1	1	2	1	0	0	1	2	2	0	4	9	10
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	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	0	3	1	**4**	0	2	1	**3**	0	0	0	**0**	1	2	2	**5**	12	27
Uphold Rate	**0.0%**	**42.9%**	**50.0%**	**44.4%**	**0.0%**	**50.0%**	**14.3%**	**27.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**33.3%**	**50.0%**	**50.0%**	**45.5%**	**32.4%**	**37.0%**
Overturns - Full	0	3	1	**4**	0	1	5	**6**	3	1	1	**5**	1	2	2	**5**	20	46
Overturn Rate - Full	**0.0%**	**42.9%**	**50.0%**	**44.4%**	**0.0%**	**25.0%**	**71.4%**	**54.5%**	**75.0%**	**100.0%**	**100.0%**	**83.3%**	**33.3%**	**50.0%**	**50.0%**	**45.45%**	**54.1%**	**63.0%**
Overturns - Partials	0	1	0	**1**	0	0	1	**1**	1	0	0	**1**	1	0	0	**1**	4	0
Overturn Rate - Partial	**0.0%**	**14.3%**	**0.0%**	**11.1%**	**0.0%**	**0.0%**	**14.3%**	**9.1%**	**25.0%**	**0.0%**	**0.0%**	**16.7%**	**33.3%**	**0.0%**	**0.0%**	**9.1%**	**10.8%**	**0.0%**
Withdrawal	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	1	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**25.0%**	**0.0%**	**9.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.7%**	**0.0%**
Membership	45,783	47,115	47,408		47,892	48,217	48,323		48,426	48,375	48,124		47,588	47,150	46,762			**45377**
Appeals - PTMPM	-	0.15	0.04	0.06	-	0.08	0.14	0.08	0.08	0.02	0.02	0.04	0.06	0.08	0.09	0.08	0.06	0.14
Grievances - PTMPM	0.28	0.08	0.19	0.19	0.17	0.41	0.35	0.31	0.41	0.54	0.42	0.46	0.32	0.23	0.26	0.27	0.31	0.21

CalViva SPD only - 2023																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2023 YTD**	**2022**
Expedited Grievances Received	2	5	7	14	4	4	4	12	4	6	1	11	2	2	1	5	42	25
Standard Grievances Received	30	38	37	105	53	66	57	176	58	56	40	154	46	45	38	129	564	342
Total Grievances Received	**32**	**43**	**44**	119	**57**	**70**	**61**	**188**	**62**	**62**	**41**	**165**	**48**	**47**	**39**	**134**	**606**	**367**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	1	1	2	0	0	0	0	0	0	0	0	2	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.5%**	**98.2%**	**98.9%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.6%**	**99.71%**
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	2	3	8	13	5	4	4	13	4	6	1	11	2	1	2	5	42	25
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	24	27	38	89	34	57	69	160	51	60	56	167	41	52	41	134	550	356
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**26**	**30**	**46**	**102**	**39**	**61**	**73**	**173**	**55**	**66**	**57**	**178**	**43**	**53**	**43**	**139**	592	**381**
Grievance Descriptions - Resolved Cases	**26**	**30**	**46**	**102**	**39**	**61**	**73**	**173**	**55**	**66**	**57**	**178**	**43**	**53**	**43**	**139**	592	**381**
Access to primary care	0	4	2	6	4	0	8	12	6	5	3	14	4	4	1	9	41	51
Access to specialists	7	10	19	36	15	4	13	32	18	24	9	51	18	18	14	50	169	72
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	4	13	20	6	17	23	46	15	16	18	49	5	12	10	27	142	89
Out-of-network	0	6	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6	0
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	6	3	2	11	3	8	10	21	4	3	7	14	5	5	4	14	60	41
QOS Non Access	10	3	10	13	11	32	19	62	12	18	20	50	11	14	14	39	164	118
Exempt Grievances Received	10	15	7	**32**	4	9	4	**17**	0	15	6	**21**	10	0	8	**18**	**88**	180
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Panel Disruption	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	3
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Provider	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	15
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	0
Attitude/Service - Vendor	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	4
Attitude/Service - Health Plan	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	0
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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**	0
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	1	0	0	**1**	**2**	1
Health Plan Materials - ID Cards-Not Received	0	6	3	**9**	0	2	0	**2**	0	4	2	**6**	3	0	0	**3**	**20**	26
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	2
Health Plan Materials - Other	1	1	0	**2**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**3**	0
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Health Plan Assignment - Change Request	3	3	2	**8**	0	2	2	**4**	0	1	0	**1**	4	0	2	**6**	**19**	58
PCP Assignment/Transfer - HCO Assignment - Change Request	3	5	1	**9**	0	4	0	**4**	0	1	2	**3**	1	0	2	**3**	**19**	50
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
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**	0
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0

Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	0	0	0	**0**	0	0	1	**1**	0	4	0	**4**	0	0	0	**0**	**5**	0
OTHER - Other	0	0	0	**0**	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	**1**	0
Claims Complaint - Balance Billing from Provider	2	0	0	**2**	2	1	1	**4**	0	2	1	**3**	1	0	3	**4**	**13**	13

CalViva Health Appeals and Grievances Dashboard 2023 (SPD)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2022
Expedited Appeals Received	0	0	0	0	1	0	0	1	1	3	0	4	2	0	0	2	7	4
Standard Appeals Received	8	11	5	24	4	5	8	17	4	5	0	9	9	5	4	18	68	76
Total Appeals Received	**8**	**11**	**5**	**24**	**5**	**5**	**8**	**18**	**5**	**8**	**0**	**13**	**11**	**5**	**4**	**20**	75	**80**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**98.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	1	0	0	1	1	3	3	7	2	0	0	2	10	11
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**-600.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	7	9	8	24	6	4	6	**16**	5	2	3	**10**	6	8	2	**16**	66	89
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**7**	**9**	**8**	**24**	**7**	**4**	**6**	**17**	**6**	**5**	**6**	**17**	**8**	**8**	**2**	**18**	**76**	**93**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**7**	**9**	**8**	**24**	**7**	**4**	**6**	**17**	**6**	**5**	**6**	**17**	**8**	**8**	**2**	**18**	**71**	**96**
Continuity of Care	0	5	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5	0
Consultation	0	0	1	1	1	1	0	2	0	0	0	0	0	0	0	0	3	1
DME	0	1	4	5	1	0	1	2	1	1	2	4	0	1	1	2	13	26
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	5	0	0	5	1	0	3	4	2	1	1	4	3	6	0	9	22	43
Other	0	0	0	0	2	0	1	3	1	0	0	1	2	0	0	2	6	8
Pharmacy/RX Medical Benefit	2	1	1	4	0	0	0	0	1	2	3	6	2	1	1	4	14	6
Surgery	0	2	2	4	2	3	1	6	1	1	0	2	1	0	0	1	13	11
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	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	3	2	4	**9**	4	1	2	**7**	3	1	3	**7**	2	4	1	**7**	30	31
Uphold Rate	**42.9%**	**22.2%**	**50.0%**	**37.5%**	**57.1%**	**25.0%**	**33.3%**	**41.2%**	**50.0%**	**20.0%**	**50.0%**	**41.2%**	**25.0%**	**50.0%**	**50.0%**	**38.9%**	**39.5%**	**33.3%**
Overturns - Full	4	7	4	**15**	3	3	4	**10**	3	4	2	**9**	6	4	0	**10**	44	65
Overturn Rate - Full	**57.1%**	**77.8%**	**50.0%**	**62.5%**	**42.9%**	**75.0%**	**66.7%**	**58.8%**	**50.0%**	**80.0%**	**33.3%**	**52.9%**	**75.0%**	**50.0%**	**0.0%**	**55.6%**	**57.9%**	**69.89%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	0	1	**1**	2	3
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**16.7%**	**5.9%**	**0.0%**	**0.0%**	**50.0%**	**5.6%**	**2.6%**	**3.2%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.1%**
Membership	38,875	49,002	49,750		50,141	50,455	50,626		50,793	50,420	50,476		50,222	49,987	49,899			**109421**
Appeals - PTMPM	0.18	0.18	0.16	0.00	0.14	0.08	0.12	0.00	0.12	0.10	0.12	0.11	0.16	0.16	0.04	0.12	0.06	0.10
Grievances - PTMPM	0.67	0.61	0.92	0.00	0.78	1.21	1.44	0.00	1.08	1.31	1.13	1.17	0.86	1.06	0.86	0.93	0.52	0.51

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

Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).

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

Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 12/01/2023 to 12/31/2023

Report created 1/24/2024

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.con

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 12/01/2023 to 12/31/2023
Report created 1/24/2024

ER utilization based on Claims data	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
MEMBERSHIP																Quarterly Averages									Annual Averages		
Expansion Mbr Months	116,368		116,424	118,919	119,098	120,345	120,949	121,899	121,577	119,531	119,705	119,024	118,234	117,280		107,353	109,323	113,068	115,581	118,147	121,064	120,271	118,179		111,331	119,415	
Family/Adult/Other Mbr Mos	276,086		266,305	278,071	270,885	270,388	269,531	270,758	279,015	276,515	267,793	266,983	264,556	259,741		267,342	269,389	273,406	275,438	271,754	270,226	274,441	263,760		271,394	270,045	
SPD Mbr Months	37,496		39,224	50,115	50,616	51,132	51,364	51,614	51,647	51,138	51,531	51,390	51,118	50,871		35,754	36,067	36,697	37,283	46,652	51,370	51,439	51,126		36,450	50,147	
COUNTS																											
Admits - Count	2,210		2,306	2,630	2,446	2,355	2,469	2,294	2,407	2,405	2,235	2,223	2,220	2,337		2,142	2,177	2,333	2,278	2,461	2,373	2,349	2,260		2,233	2,361	
Expansion	610		661	630	729	729	768	735	777	805	722	679	702	690		633	685	730	663	673	744	768	690		678	719	
Family/Adult/Other	1,135		1,031	915	1,009	948	1,044	949	1,005	983	957	1,015	933	1,049		1,011	972	1,076	1,145	985	980	982	999		1,051	987	
SPD	463		610	1,083	703	671	655	605	621	614	552	525	578	595		493	518	522	468	799	644	596	566		500	651	
Admits Acute - Count	1,538		1,598	1,494	1,655	1,618	1,746	1,570	1,647	1,678	1,525	1,534	1,549	1,635		1,538	1,578	1,611	1,604	1,582	1,645	1,617	1,573		1,583	1,604	
Expansion	503		535	521	605	609	625	599	634	640	550	557	558	542		537	573	589	542	554	611	608	552		560	581	
Family/Adult/Other	596		566	495	546	499	594	482	520	523	507	537	515	600		543	522	537	621	536	525	517	551		556	532	
SPD	439		496	478	504	510	527	489	493	514	467	440	475	493		458	482	485	440	493	509	491	469		466	491	
Readmit 30 Day - Count	205		261	213	246	231	227	223	260	246	205	211	195	191		222	212	234	217	240	227	237	199		221	226	
Expansion	73		105	79	96	86	83	92	120	97	80	75	80	74		89	81	98	81	93	87	99	76		87	89	
Family/Adult/Other	30		48	39	60	41	49	36	32	41	31	37	37	28		42	40	40	43	49	42	35	34		41	40	
SPD	102		108	95	90	104	95	95	108	108	94	99	78	89		92	91	96	93	98	98	103	89		93	97	
**ER Visits - Count	14,533		12,891	13,139	14,878	14,785	16,101	14,194	14,144	14,191	13,586	13,346	10,049	5,615		13,183	15,274	14,362	14,948	13,636	15,027	13,974	9,670		14,442	13,077	
Expansion	3,585		3,499	3,430	3,806	3,803	4,076	3,762	4,017	3,968	3,543	3,592	3,214	1,928		3,515	3,953	3,974	3,664	3,578	3,880	3,843	2,911		3,777	3,553	
Family/Adult/Other	8,461		7,623	7,871	8,687	8,406	9,189	7,963	8,026	7,751	7,811	7,645	4,949	2,879		4,792	6,338	6,575	8,324	8,060	8,519	7,863	5,158		6,507	7,400	
SPD	1,528		1,518	1,570	1,757	1,821	2,033	1,932	1,957	1,987	1,718	1,625	1,549	671		1,047	1,377	1,464	1,599	1,615	1,929	1,887	1,282		1,372	1,678	
PER/K																											
Admits Acute - PTMPY	42.9		44.3	40.1	44.2	42.8	46.0	41.2	43.7	44.4	40.7	41.2	41.9	44.5		45.0	45.6	45.7	44.9	42.8	43.3	42.9	42.5		45.3	42.9	
Expansion	51.9		55.1	52.6	61.0	60.7	62.0	59.0	62.6	64.3	55.1	56.2	56.6	55.5		60.0	62.9	62.5	56.2	56.2	60.6	60.7	56.1		60.4	58.4	
Family/Adult/Other	25.9		25.5	21.4	24.2	22.1	26.4	21.4	22.4	22.7	22.7	24.1	23.4	27.7		24.4	23.3	23.6	27.1	23.7	23.3	22.6	25.1		24.6	23.6	
SPD	140.5		151.7	114.5	119.5	119.7	123.1	113.7	114.5	120.6	108.8	102.7	111.5	116.3		153.8	160.4	158.5	141.6	126.7	118.8	114.6	110.2		153.5	117.4	
Bed Days Acute - PTMPY	231.1		235.0	200.9	227.7	225.3	224.0	216.4	223.8	225.2	215.7	218.7	233.5	233.8		239.9	236.2	233.0	238.5	221.1	221.9	221.6	228.6		236.9	223.3	
Expansion	323.5		347.2	253.4	327.5	340.5	307.3	314.7	314.5	361.0	338.2	336.5	326.5	320.5		343.8	337.2	336.4	352.5	309.1	320.8	337.8	327.9		342.5	323.9	
Family/Adult/Other	98.0		87.7	79.7	90.7	88.3	108.0	88.1	86.2	84.2	77.3	91.8	84.5	104.2		94.0	93.7	81.6	98.3	86.0	94.8	82.6	93.4		91.9	89.1	
SPD	926.2		969.2	749.5	767.0	728.9	697.8	713.1	755.1	697.2	693.0	645.9	834.1	755.3		1,018.6	1,000.1	1,043.9	921.0	817.4	713.3	715.2	744.9		995.4	746.0	
ALOS Acute	5.4		5.3	5.0	5.2	5.3	4.9	5.3	5.1	5.1	5.3	5.3	5.6	5.3		5.3	5.2	5.1	5.3	5.2	5.1	5.2	5.4		5.2	5.2	
Expansion	6.2		6.3	4.8	5.4	5.6	5.0	5.3	5.0	5.6	6.1	6.0	5.8	5.8		5.7	5.4	5.4	6.3	5.5	5.3	5.6	5.8		5.7	5.5	
Family/Adult/Other	3.8		3.4	3.7	3.7	4.0	4.1	4.1	3.9	3.7	3.4	3.8	3.6	3.8		3.9	4.0	3.5	3.6	3.6	4.1	3.7	3.7		3.7	3.8	
SPD	6.6		6.4	6.5	6.4	6.1	5.7	6.3	6.6	5.8	6.4	6.3	7.5	6.5		6.6	6.2	6.6	6.5	6.4	6.0	6.2	6.8		6.5	6.4	
Readmit % 30 Day	9.3%		11.3%	8.1%	10.1%	9.8%	9.2%	9.7%	10.8%	10.2%	9.2%	9.5%	8.8%	8.2%		10.4%	9.7%	10.0%	9.5%	9.8%	9.6%	10.1%	8.8%		9.9%	9.6%	
Expansion	12.0%		15.9%	12.5%	13.2%	11.8%	10.8%	12.5%	15.4%	12.0%	11.1%	11.0%	11.4%	10.7%		14.1%	11.8%	13.4%	12.2%	13.9%	11.7%	12.9%	11.1%		12.8%	12.4%	
Family/Adult/Other	2.6%		4.7%	4.3%	5.9%	4.3%	4.7%	3.8%	3.2%	4.2%	3.2%	3.6%	4.0%	2.7%		4.1%	4.1%	3.7%	3.8%	5.0%	4.3%	3.5%	3.4%		3.9%	4.0%	
SPD	22.0%		17.7%	8.8%	12.8%	15.5%	14.5%	15.7%	17.4%	17.6%	17.0%	18.9%	13.5%	15.0%		18.6%	17.6%	18.4%	19.8%	12.2%	15.2%	17.3%	15.7%		18.6%	14.9%	
**ER Visits - PTMPY	405.4		357.0	352.5	397.1	391.4	424.0	372.2	375.1	375.6	362.9	358.3	271.7	152.8		385.3	440.9	407.0	418.6	369.0	395.8	371.2	261.4		413.1	349.8	
Expansion	369.7		360.6	346.1	383.5	379.2	404.4	370.3	396.5	398.4	355.2	362.1	326.2	197.3		392.9	433.9	421.8	380.4	363.4	384.6	383.4	295.6		407.1	357.1	
Family/Adult/Other	367.8		343.5	339.7	384.8	373.1	409.1	352.9	345.2	336.4	350.0	343.6	224.5	133.0		215.1	282.3	288.6	362.7	355.9	378.3	343.8	234.7		287.7	328.8	
SPD	489.0		464.4	375.9	416.5	427.4	475.0	449.2	454.7	466.3	400.1	379.5	363.6	158.3		351.5	458.0	478.8	514.6	415.4	450.5	440.3	300.8		451.6	401.6	
Services	TAT Compliance Goal: 100%		TAT Compliance Goal: 100%																TAT Compliance Goal: 100%							TAT Compliance Goal: 100%	
Preservice Routine	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%				
Preservice Urgent	100.0%		100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		99.3%	99.1%	99.1%	100.0%	100.0%	99.1%	100.0%	99.1%				
Postservice	100.0%		100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	100.0%		100.0%	95.7%	96.0%	100.0%	100.0%	100.0%	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	91.5%	98.8%	96.0%	96.9%	100.0%	98.9%	100.0%				
Deferrals - Urgent	N/A		N/A	100.0%	N/A	100.0%	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	NA		null	null	null	null	null	null	null	null	null	null	null	null		null	null	null	null	null	null	null	null				
	CCS ID RATE		CCS ID RATE																CCS ID RATE							CCS ID RATE	
CCS %	8.53%		8.50%	8.02%	7.98%	7.94%	7.90%	7.90%	7.90%	7.88%	7.83%	7.72%	7.77%	7.70%		8.69%	8.72%	8.31%	8.44%	8.17%	7.91%	7.87%	7.73%		8.54%	7.92%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand		Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand													Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand												
Births	16.3		14.3	12.0	13.2	12.8	12.8	13.1	13.9	13.9	13.2	13.6	12.7	13.7		14.2	14.0	17.0	15.7	13.2	-	-	-		15.2		
OB % Days	11.9%		5.3%	0.8%	2.8%	3.4%	4.6%	5.2%	5.5%	6.8%	7.0%	7.5%	7.1%	9.3%		10.1%	10.5%	11.9%	11.2%	3.0%	-	-	-		17.0%		
OB % Admits	26.5%		22.4%	17.1%	20.2%	20.6%	19.7%	21.8%	21.9%	21.9%	22.1%	22.7%	21.1%	21.5%		22.7%	22.2%	25.7%	24.7%	19.9%	-	-	-		30.0%		
	Perinatal Case Management		Perinatal Case Management																Perinatal Case Management							Perinatal Case Management	
Total Number Of Referrals	112		147	135	160	150	149	149	84	132	167	170	147	133		472	598	476	386	442	448	383	450		1,932	1,723	
Pending	21		0	0	0	0	0	0	0	0	0	0	0	0		0	2	1	21	0	0	0	0		24	0	
Ineligible	6		6	1	10	11	5	5	3	3	10	9	8	7		18	32	10	19	17	21	16	24		79	78	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 12/01/2023 to 12/31/2023
Report created 1/24/2024

ER utilization based on Claims data	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
Total Outreached	85		141	134	150	139	144	144	81	129	157	161	139	126		454	564	465	346	425	427	367	426		1,829	1,645	
Engaged	28		63	57	54	51	50	62	64	128	130	146	130	115		157	224	183	137	174	163	322	391		701	1,050	
Engagement Rate	33%		45%	43%	36%	37%	35%	43%	79%	99%	83%	91%	94%	91%		35%	40%	39%	40%	41%	38%	88%	92%		38%	64%	
Total Cases Managed	280		291	309	320	313	316	331	322	394	476	574	600	599		344	432	496	410	401	425	584	785		887	1276	
Total Cases Closed	51		39	41	57	47	47	70	57	48	58	90	116	127		136	154	182	180	137	164	163	333		652	797	
Cases Remained Open	224		242	258	261	258	267	251	261	341	419	478	495	469		199	263	263	224	261	251	419	469		224	469	
	Integrated Case Management																										
Total Number Of Referrals	150		220	211	368	343	239	258	198	220	194	161	114	132		288	503	622	529	799	840	612	407		1,942	2,658	
Pending	19		0	0	0	0	0	1	1	2	0	2	4	19		1	1	0	23	0	1	3	25		25	29	
Ineligible	10		48	78	68	56	56	52	32	37	32	35	16	22		16	26	42	32	194	164	101	73		116	532	
Total Outreached	121		172	133	300	287	183	205	165	181	162	124	94	91		271	476	580	474	605	675	508	309		1,801	2,097	
Engaged	98		93	96	154	173	115	134	116	124	98	81	72	62		185	341	445	328	343	422	338	215		1,299	1,318	
Engagement Rate	81%		54%	72%	51%	60%	63%	65%	70%	69%	60%	65%	77%	68%		68%	72%	77%	69%	57%	63%	67%	70%		72%	63%	
Total Screened and Refused/Decline	15		49	26	97	55	42	35	26	21	29	12	7	13		19	46	54	60	172	132	76	32		179	412	
Unable to Reach	8		30	11	49	59	26	36	23	36	35	31	15	16		67	89	81	86	90	121	94	62		323	367	
Total Cases Closed	123		110	113	102	105	188	122	128	132	137	107	102	94		181	238	333	395	325	415	397	303		1,147	1,440	
Cases Remained Open	411		382	371	399	464	406	415	399	384	354	336	302	262		267	368	471	411	399	415	354	262		411	262	
Total Cases Managed	540		505	491	522	609	616	560	547	538	503	441	403	362		458	622	900	818	746	848	769	591		1579	1723	
Complex Case	52		43	42	49	68	82	85	85	79	69	61	60	62		44	60	73	70	61	94	95	84		120	161	
Non-Complex Case	488		462	449	473	541	534	475	462	459	434	380	343	300		414	562	827	748	685	754	674	507		1459	1562	
	Transitions of Care																										
Total Number Of Referrals	105		88	98	110	166	301	283	261	338	228	278	277	130		252	326	436	363	296	750	827	685		1,377	2,558	
Pending	5		0	0	0	0	0	0	0	0	0	0	4	13		0	0	0	5	0	0	0	17		5	17	
Ineligible	8		8	9	16	9	11	6	10	11	7	13	19	18		21	24	21	18	33	26	28	50		84	137	
Total Outreached	92		80	89	94	157	290	277	251	327	221	265	254	99		231	302	415	340	263	724	799	618		1,288	2,404	
Engaged	65		68	72	76	128	275	270	241	322	220	256	217	52		158	213	375	264	216	673	783	525		1,010	2,197	
Engagement Rate	71%		85%	81%	81%	82%	95%	97%	96%	98%	100%	97%	85%	53%		68%	71%	90%	78%	82%	93%	98%	85%		78%	91%	
Total Screened and Refused/Decline	11		1	3	3	4	1	2	6	0	0	6	10	14		4	12	18	25	7	7	6	30		59	50	
Unable to Reach	16		11	14	15	25	14	5	4	5	1	3	27	33		69	77	22	51	40	44	10	63		219	157	
Total Cases Closed	82		70	55	70	62	146	268	185	248	212	230	191	79		138	220	338	301	195	476	645	500		997	1,816	
Cases Remained Open	45		30	29	19	59	96	73	80	96	69	61	50	12		71	56	87	45	19	73	69	12		45	12	
Total Cases Managed	135		113	107	112	147	339	443	357	452	380	382	310	125		214	297	579	372	265	695	901	654		1,127	2,248	
	Palliative Care																										
Total Number Of Referrals	15		11	10	12	15	15	9	9	6	5	10	14	7		24	32	51	39	33	39	20	31		146	123	
Pending	3		0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	3	0	0	0	0		3	0	
Ineligible	6		6	3	5	1	1	1	1	2	2	2	6	6		11	7	17	11	14	3	5	14		46	36	
Total Outreached	6		5	7	7	14	14	8	8	4	3	8	8	1		13	25	34	25	19	36	15	17		97	87	
Engaged	6		5	6	5	9	9	6	3	1	1	5	8	1		9	19	23	19	16	24	5	14		70	59	
Engagement Rate	100%		100%	86%	71%	64%	64%	75%	38%	25%	33%	63%	100%	100%		69%	76%	68%	76%	84%	67%	33%	82%		72%	68%	
Total Screened and Refused/Decline	0		0	1	2	2	4	2	3	2	1	2	0	0		2	2	5	4	3	8	6	2		13	19	
Unable to Reach	0		0	0	0	3	1	0	2	1	1	1	0	0		2	4	6	2	0	4	4	1		14	9	
Total Cases Closed	3		7	4	8	4	4	3	4	12	3	7	6	90		23	12	15	19	19	11	19	103		69	152	
Cases Remained Open	92		88	91	88	89	86	98	101	91	89	86	87	0		73	82	92	92	88	98	89	0		92	0	
Total Cases Managed	95		99	97	98	99	104	106	106	103	92	93	95	90		99	97	114	111	109	113	108	103		167	152	
	Behavioral Health Case Management																										
Total Number Of Referrals	79		70	76	89	46	59	61	37	51	40	26	40	38		295	318	270	214	235	166	128	104		1,097	633	
Pending	8		0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	8	0	0	0	0		8	0	
Ineligible	4		4	6	11	6	4	6	3	4	3	1	5	10		25	18	13	6	21	16	10	16		62	63	
Total Outreached	67		66	70	78	40	55	55	34	47	37	25	35	28		270	300	257	200	214	150	118	88		1,027	570	
Engaged	51		47	49	43	28	34	46	27	37	36	25	21	12		164	203	175	140	139	108	100	58		682	405	
Engagement Rate	76%		71.0%	70.0%	55.0%	70.0%	62.0%	84%	79%	79%	97%	100%	60%	43%		61%	68%	68%	70%	65%	72%	85%	66%		66%	71%	
Total Screened and Refused/Decline	1		1	2	3	4	6	2	1	2	1	0	1	4		11	12	13	9	6	12	4	5		45	27	
Unable to Reach	15		18	19	32	8	15	7	6	8	0	0	13	12		95	85	69	51	69	30	14	25		300	138	
Total Cases Closed	32		43	61	50	31	48	43	41	46	41	34	26	27		134	142	217	148	154	122	128	87		641	491	
Cases Remained Open	160		167	154	149	146	131	138	126	109	106	95	89	75		149	212	171	160	149	138	106	75		160	75	
Total Cases Managed	199		215	221	203	179	182	180	164	160	149	129	118	104		293	359	444	316	307	264	237	170		809	572	
Complex Case	7		7	9	11	16	16	15	16	16	15	12	15	15		18	15	17	12	13	17	20	18		30	32	
Non-Complex Case	192		208	212	192	163	166	165	148	144	134	117	103	89		275	344	427	304	294	247	217	152		779	540	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 12/01/2023 to 12/31/2023
Report created 1/24/2024

ER utilization based on Claims data	2022-12	2022-Trend	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Qtr Trend	CY- 2022	YTD-2023	YTD-Trend
	First Year of Life CM		First Year of Life CM																	First Year of Life CM						First Year of Life CM	
Total Number Of Referrals	0		0	0	0	0	1	7	15	19	26	28	18	27		0	0	0	0	0	8	60	73		0	141	
Pending	0		0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0		0	0	
Ineligible	0		0	0	0	0	1	0	0	0	0	0	2	1		0	0	0	0	0	1	0	3		0	4	
Total Outreached	0		0	0	0	0	0	7	15	19	26	28	16	26		0	0	0	0	0	7	60	70		0	137	
Engaged	0		0	0	0	0	0	3	15	19	26	28	16	21		0	0	0	0	0	3	60	65		0	128	
Engagement Rate	0		0.0%	0.0%	0.0%	0.0%	0.0%	43.0%	100.0%	100.0%	100.0%	100.0%	100%	81%		0.0%	0.0%	0.0%	0.0%	0.0%	43.0%	100.0%	93%		0.0%	93.0%	
Total Screened and Refused/Decline	0		0	0	0	0	0	2	0	0	0	0	0	2		0	0	0	0	0	2	0	2		0	4	
Unable to Reach	0		0	0	0	0	0	2	0	0	0	0	0	3		0	0	0	0	0	2	0	3		0	5	
Total Cases Closed	0		0	0	0	0	0	0	0	2	1	8	4	4		0	0	0	0	0	0	3	16		0	19	
Cases Remained Open	0		0	0	0	0	0	3	18	33	56	74	91	108		0	0	0	0	0	3	56	108		0	108	
Total Cases Managed	0		0	0	0	0	0	3	18	37	61	88	95	113		0	0	0	0	0	3	62	125		0	128	

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: February 15th, 2024

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 4 2023 (Feb 2024)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Case Management and Population Health Management performance, programs, and regulatory activities in Quarter 4 2023.

I. Meetings

Two QI/UM Meetings were held in Quarter 4, in October and November. On October 19th and November 16th, 2023, the QI/UM Committee met, and the following **guiding documents** were approved:

a. The Program Documents that were approved were:
1. 2023 Health Equity Work Plan Mid-Year Evaluation & Executive Summary
2. 2023 Health Education Work Plan Mid-Year Evaluation & Executive Summary
3. Health Equity Language Assistance Program Mid-Year Report
4. Health Equity Geo Access Report
5. Quality Improvement Health Equity Transformation Program 2023

b. Other General Documents approved were:
1. Medical Policies Update Q3
2. Clinical Practice Guidelines
3. Public Health Policies & Procedures
4. Updates to Select UMCM and A & G Policies
5. Appeals Review Job Description
6. Preventive Health Guidelines
7. UMCM Policies and Procedures Annual Review

II. QI Reports - The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance (A & G) Dashboard** for September 2023 tracks volumes, turn-around times, and case classifications. Results demonstrate that the total number of grievances through September 2023 has increased compared to previous years. Trends associated with this increase have been identified and are being addressed.
   - The highest volume of grievances is Quality of Service (QOS). QOS cases related to Access (Prior Authorizations), Administrative, Other (Balanced Billing), and Transportation continue to represent most of these grievances.

- The volume of Quality of Care (QOC) grievances decreased in August and September compared to the previous month, and Q3 totals have decreased compared to Q2.
- Exempt Grievances have decreased in Q3 compared to Q2.
- Balanced Billing related Grievances have begun to decline.

2. **MHN Performance Indicator Report for Behavioral Health** was reviewed in the October meeting with Q2 data presented. Fifteen out of the fifteen metrics met or exceeded their targets this quarter.
    a. CalViva Membership increased 1.8% from Q1 2023, utilization is approximately 2.3%.
    b. There were two (2) Life-Threatening Emergent cases and two (2) Non-Life-Threatening Emergent cases, and the appointment access standards were met.
    c. There were ten (10) Urgent cases, and the appointment access standard was met for all cases.
    d. Both Non-ABA and ABA were 100% compliant on timeliness.
    e. There were seven (7) PQIs, with no quality issues found.
    - MHN is also working on improving communication with members through a targeted provider newsletter, sent on 9/11/23 based upon member recommendations for improved communication.
3. **Facility Site & Medical Record & PARS Review Report** provides a summary of Facility Site and Medical Record Reviews in Q1 & Q2 2023. New FSR/MRR tools and standards were implemented on July 1st, 2022.
    a. There were twenty-four (24) Facility Site Reviews (FSR) and twenty-four (24) Medical Record Reviews (MRR) completed in the 1st and 2nd Quarters of 2023.
    b. The mean rate FSR score for Fresno, Kings, and Madera Counties was 97% for the 1st and 2nd Quarters of 2023.
    c. The mean rate MRR score for Fresno, Kings, and Madera Counties was 92% for the 1st and 2nd Quarters of 2023 with 250 records reviewed.
    d. The Pediatric Preventive Care section's mean score was 88%.
    e. The Adult Preventive Care section's mean score was 91%.
    f. Lead Screening & Initial Health Appointment compliance are monitored through the Medical Record Review portion of these audits providing important validation of the status of these measures at the point of service.
    g. Forty-two (42) Physical Accessibility Review Surveys (PARS) were completed in the 1st and 2nd Quarters 2023. Twenty-nine (29) of the forty-two (42) PARS have Basic level access.
4. **Additional Quality Improvement Reports** including Provider Preventable Conditions, County Relations Quarterly, PQI Report. IHA Quarterly Audit, and Lead Screening Quarterly Report were presented in Q4.

III. **Access Related Reporting** for Quarter 4 included **Provider Appointment Availability & After-Hours Access Survey Results (Provider Update) and the Access Work Group minutes from July 25th, 2023 and the Access Workgroup Quarterly Report for Q3.**

1. **The 2022 annual Provider Appointment Availability Survey (PAAS) and Provider After-Hours Access Survey (PAHAS)** results are used to monitor provider compliance with timely access and after-hours regulations and evaluate the effectiveness of the network to meet the needs and preferences of CalViva Health members. The following DMHC and DHCS appointment access metrics **did not meet** the performance goal of **70%**:
    a. Urgent care appointment with PCP within 48 hours.
    b. Urgent care appointment with Specialist that requires prior authorization within 96 hours.
    c. Non-urgent appointment with PCP within 10 business days.
    d. Non-urgent appointment with Specialist within 15 business days.
    e. Preventive health or well-child appointment with PCP within 2 weeks.
    f. Physical exam/wellness check appointment with PCP within 30 calendar days.
    g. Initial prenatal appointment with PCP/specialist within two weeks.

A Corrective Action Plan (CAP) is issued to contracted PPGs and provider offices that fail any of the urgent or non-urgent metrics. PPGs and providers who receive a CAP are required to submit a written improvement plan (IP) within 30 days.

2. **Other Access-related** reporting included the Standing Referrals Report, Specialty Referrals Report, and Provider Office Wait Time Report.

IV. UMCM Reports - The following is a summary of some of the reports and topics reviewed:

1. **The Key Indicator Report (KIR)**, **Concurrent Review Report and Case Management Report** provided data through September 2023. A quarterly comparison was reviewed with the following results:
    a. Membership demonstrated a decline for all populations associated with redeterminations and the unwinding of the Public Health Emergency.
    b. For Acute Admissions (adjusted PTMPY), the Expansion population had a slight decrease. TANF and SPDs remained consistent.
    c. Bed Days (adjusted PTMPY) for Expansion, TANF and SPD there was a slight decrease for all.
    d. Acute Length of Stay (adjusted PTMPY) slight decrease for all populations.
    e. Readmits within 30 days (adjusted PTMPY) decreased slightly for all three populations.
    f. Turnaround Time (TAT) rates were all reported at 100%.
    g. Perinatal Case Management had an increase in referrals and their engagement rate in August.
    h. Integrated Case Management (CM) and Transitional CM have seen an increase in referrals and the engagement rate increased for Transitional CM. A new process has been implemented to refer all members to TCM initially and then they are referred to other programs as indicated.
    i. Palliative Care shows a decrease in referrals this month but an increase in their engagement rate.
    j. The Behavioral Health CM shows a 30% drop in volume of referrals in Q3.
    k. The First Year of Life Program was restructured to increase member compliance.
    l. Case Management Outcomes: members who participate have lower readmission rates, fewer ED claims/utilization, and a reduction in pregnancy-related complications.
2. **Additional Utilization Management/Case Management Reports** presented were the TurningPoint Musculoskeletal Utilization Review, CCS Quarterly Report, Concurrent Review IRR Report, NIA/Evolent, SPD HRA Outreach Report (Q2).

V. Pharmacy quarterly reports include Pharmacy Operations Metrics, Top Medication Prior Authorization (PA) Requests, and Inter-rater Reliability Review Report which were all reviewed for Quarter 3. The target for all metrics is to be within 5% of the standard or goal. All metrics were within 5% of the goal this quarter with an average turn-around time compliance rate of 99.5%. Prior authorization volumes were higher for Q3 compared to Q2 and will be monitored to ensure TATs remain within standard.
Inter-rater Reliability results identified *Criteria Application* to be the main issue in Q3. A more detailed review and QA on cases in Q4 will be performed and results will be shared with PA management to address any concerns.

VI. HEDIS® Activity

In Q4 HEDIS® related activities were focused on continued analysis of the results for RY2022 under the Managed Care Accountability Set (MCAS) measures and the minimum performance level (MPL) of 50th percentile and initiating activities to address opportunities for improvement. DHCS has established new guidelines and tiering for MCPs that will be implemented in 2024. We are awaiting further guidance and a new All Plan Letter outlining the details of the new standards.

1. **SWOT Project:**
    a. Improve Well-Child Visits and Childhood Immunizations for children under 2 years.

b. Worked with two FQHCs to test improvement strategies.
c. Final Report Submitted to DHCS 11/30/23 was approved. SWOT Closed.

2. Two New Performance Improvement Projects (PIP) include:

a. **Clinical**- Well Child Visits W30-6+ (0-2yrs). Received initial feedback from HSAG on September PIP Submission. Revised PIP submission form addressing HSAG recommendations was submitted on November 29th. Steps 1-6 approved in December with score of 100%.
b. **Non-Clinical**-Follow up after ED Visit for mental health or SUD within 7 days. Received initial feedback from HSAG on September PIP submission. TA Call with DHCS in November and decided to revise PIP topic to focus on Provider Notifications for this same population. Resubmission completed 12/15/23.

New HEDIS® season has begun for MY2023. HSAG has shared a timeline for this season including timeframe for completing the HEDIS® Audit, initial and final data submission dates, Roadmap due date, etc. We have received our auditor assignment for this year as well. Data and information are currently being gathered for completion of the HEDIS® Roadmap MY2023 due January 2024.

VII. **Oversight Audit** status for Medical Management.

Medical Management is responsible for performing a number of Oversight Audits of our delegate, HealthNet, to ensure adequate oversight of delegated functions and the identification of opportunities for improvement. Through our weekly QI/UM Work Group Medical Management reviews a wide range of reports on an ongoing basis following an annual, semi-annual, quarterly, or monthly schedule as applicable. In addition, we perform annual Oversight Audits for the following functional areas (including their status):

1. **Appeals & Grievances –** Closed Dec 2023, no CAP. This audit was initiated in June. Several different types of files are reviewed.
2. **Continuity of Care –** In progress. This audit was initiated in October. We are awaiting documents.
3. **Credentialing** – This audit was initiated in December 2023. Awaiting documents and files.
4. **Emergency Services –** In progress. This audit was initiated in October. Documents in review.
5. **Pharmacy** – Completed in October, no CAP.
6. **Quality Improvement** – This audit was initiated in December 2023. In progress.
7. **Utilization Management/Case Management –** In progress. This audit was initiated in September 2023 with a new audit tool. Extensive file and document review. Also awaiting final documentation in order to close last year's CAP.
8. **Behavioral Health –** Not started. New standalone audit to be initiated in February 2024.

The performance of Oversight Audits is a formal one in which Medical Management submits a Letter of Notification of Audit Initiation to HealthNet to identify the functional area, communication process and start date for the audit. Our established audit tools, including tools for conducting case file reviews are also provided and the specific documents that are requested as evidence of compliance are identified. After requested evidence is received and confirmed to meet or not meet regulatory and accreditation requirements a final assessment is made in the form of a summary report. The summary report will indicate whether corrective actions are necessary and a timeline for a corrective action plan (CAP) submission. The CAP is followed to conclusion when evidence of compliance has been provided.

VIII. Findings/Outcomes

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

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: February 15th, 2024

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 4 2023

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 4th Quarter 2023 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on October 19th, 2023. At the October meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the second quarter for 2023 were reviewed for delegated entities and third quarter 2023 for Health Net and MHN. A summary of the second quarter data is included in the table below.

III. Table 1. Quarter 2 2023 Credentialing/Recredentialing

	Sante	ChildNet	MHN	HN	LaSalle	ASH	Envolve	IMG	CVMP	Adventist	Totals
Initial credentialing	30	20	12	3	17	0	2	6	26	23	**139**
Recredentialing	118	42	32	24	8	1	6	8	36	0	**275**
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	**148**	**62**	**44**	**27**	**25**	**1**	**8**	**14**	**62**	**23**	**414**

IV. **Credentialing Adverse Actions** for Q3 for CalViva from Health Net Credentialing Committee was presented. There were no (0) cases for July, August, or September for CalViva Health.

V. **The 2023 Adverse Events Report** is a new report for the Credentialing Sub-Committee this year. This report provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period.

- There were no (0) cases identified in Q3 that met the criteria for reporting in which an adverse outcome was associated with a contracted practitioner. There were no reconsiderations or fair hearings during the third quarter of 2023.
- There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of access to care issues.
- There were no (0) cases identified outside of the ongoing monitoring process this quarter. (NCQA CR.5.A.4)

VI. **Credentialing Policies & Procedures:** There were two Credentialing Policies reviewed by the committee with edits:

Policy CR-110 Credentialing and Recredentialing:

- Updated references to the sub-committees from, “Credentialing/Peer Review Sub Committee” to “Peer Review Sub-Committee and Credentialing Sub-Committee” to clearly distinguish as two separate committees throughout policy. This does not reflect an organizational change, only language clarification.
- Added information regarding the Credentialing Committee Process and the Chairperson's responsibilities.
- Updated Attachment A, C, D, E, and F.

Policy CR-160 Appeal Process:

- Updated references to the sub-committees from, “Credentialing/Peer Review Sub Committee” to “Peer Review Sub-Committee and Credentialing Sub-Committee” to clearly distinguish as two separate committees throughout policy. This does not reflect an organizational change, only language clarification.
- Clarified reference to provider notices.

VII. **Practitioner Right of Review Evidence Letter:** The **Practitioner Right of Review Evidence Letter (CR.1.B)** was presented and reviewed. Template letters for 2022 and 2023 approval letters for initial credentialing and inclusion in the provider network were presented to the committee for review and adoption. The templates provided included the attachments regarding Practitioner Right of Review as distributed to practitioners upon completion of the initial credentialing process. This includes the Right of Review/Current Network Status, Notification of Discrepancy, and Correction of Erroneous Information. The documents were explained, discussed, and adopted by committee members present.

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	February 15th, 2024
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 4 2023

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 October 19th, 2023. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 3 2023 were reviewed for approval. There were no significant cases to report.

II. The 2023 Adverse Events Report is a new report for the Peer Review Sub-Committee in 2023. This report provides a summary of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period.

- There were thirteen (13) cases identified in Q3 that met the criteria for reporting and were submitted to the Peer Review Committee. Seven (7) of these cases involved a practitioner and six (6) cases involved organizational providers (facilities).
- Of the thirteen (13) cases, two (2) were tabled, one (1) was tabled with a letter of education, one (1) was placed on a CAP, one (1) was closed with a letter of concern, and eight (8) were closed to track and trend.
- There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of access to care issues.
- There were no (0) cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4)

- There were 38 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management.

III. Quarter 3, 2023 Peer Count Report was presented at the meeting with a total of twenty (20) cases reviewed. The outcomes for these cases are as follows:
    - There were thirteen (13) cases closed and cleared. There were four (4) cases tabled for further information. There was one (1) case with CAP outstanding and two (2) were pending closure for CAP compliance.

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

Item #14
Attachment 14.I

Executive

- 14.I Executive Dashboard

	2022	2023	2023	2023	2023	2023	2023	2023	2023	2023	2023	2023	2023
Month	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
CVH Members													
Fresno	336,359	338,835	349,660	351,313	353,806	355,821	357,098	355,405	353,005	350,061	348,373	346,709	345,319
Kings	36,208	36,388	38,617	38,772	39,184	39,372	39,665	39,611	39,697	39,366	38,824	38,583	38,436
Madera	45,484	45,783	47,115	47,408	47,892	48,217	48,323	48,426	48,375	48,124	47,588	47,150	46,762
Total	418,051	421,006	435,392	437,493	440,882	443,410	445,086	443,442	441,077	437,551	434,785	432,442	430,517
SPD	36,848	38,875	49,002	49,750	50,141	50,455	50,626	50,793	50,616	50,476	50,222	49,987	49,899
CVH Mrkt Share	68.23%	68.10%	67.08%	67.14%	67.21%	67.26%	67.28%	67.36%	67.44%	67.46%	67.51%	67.59%	67.65%
ABC Members													
Fresno	142,820	144,993	157,415	157,746	158,447	158,902	159,464	158,068	156,328	155,030	154,141	152,908	151,942
Kings	24,185	24,323	25,683	25,797	25,854	25,987	26,085	25,976	25,952	25,737	25,319	25,075	24,901
Madera	27,692	27,897	30,593	30,579	30,831	30,902	30,915	30,793	30,642	30,333	29,752	29,339	29,018
Total	194,697	197,213	213,691	214,122	215,132	215,791	216,464	214,837	212,922	211,100	209,212	207,322	205,861
Default													
Fresno													
Kings													
Madera													
County Share of Choice as %													
Fresno													
Kings													
Madera													
Voluntary Disenrollment's													
Fresno													
Kings													
Madera													

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	**5 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communication and Systems.		

Member Call Center CalViva Health Website		**Year**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**
		Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	(Main) Member Call Center	**# of Calls Received**	**26,747**	**24,875**	**35,660**	**34,897**	**34,897**	**34,875**
		# of Calls Answered	**26,495**	**24,707**	**35,418**	**34,625**	**34,595**	**34,533**
		Abandonment Level (Goal < 5%)	**0.90%**	**0.70%**	**0.70%**	**0.80%**	**0.90%**	**1.00%**
		Service Level (Goal 80%)	**88%**	**96%**	**94%**	**87%**	**88%**	**83%**
	Behavioral Health Member Call Center	**# of Calls Received**	**1,082**	**602**	**813**	**940**	**860**	**1,436**
		# of Calls Answered	**1,066**	**596**	**808**	**930**	**848**	**1,426**
		Abandonment Level (Goal < 5%)	**1.50%**	**1.00%**	**0.60%**	**1.10%**	**1.40%**	**0.70%**
		Service Level (Goal 80%)	**86%**	**92%**	**91%**	**89%**	**89%**	**95%**
	Transportation Call Center	**# of Calls Received**	**8,062**	**9,278**	**12,407**	**12,107**	**12,554**	**8,239**
		# of Calls Answered	**8,014**	**9,241**	**12,394**	**12,083**	**12,466**	**8,181**
		Abandonment Level (Goal < 5%)	**0.50%**	**0.20%**	**0.10%**	**0.00%**	**0.50%**	**0.50%**
		Service Level (Goal 80%)	**85%**	**88%**	**94%**	**93%**	**87%**	**86%**
	CalViva Health Website	**# of Users**	**32,000**	**27,000**	**54,000**	**42,000**	**40,000**	**45,000**
		Top Page	**Provider Search**	**Do You Qualify?**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (60%)**	**Mobile (57%)**	**Mobile (60%)**	**Mobile (60%)**	**Mobile (61%)**	**Mobile (61%)**
		Session Duration	**~ 2 minutes**	**~ 1 minute**	**~ 2 minutes**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	Q3 and Q4 2023 numbers are available. A new functionality to allow CalViva Health members an opportunity to request a change to their Primary Care Physician online has been implemented on the CalViva Health website effective November 2023.							

Provider Network & Engagement Activities	**Year**	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**155**	**156**	**156**	**156**	**157**	**157**	**156**
	PCP	**387**	**395**	**400**	**398**	**407**	**392**	**383**
	PCP Extender	**318**	**324**	**324**	**328**	**330**	**332**	**357**
	Specialist	**1431**	**1451**	**1453**	**1463**	**1471**	**1470**	**1493**
	Ancillary	**236**	**238**	**235**	**239**	**243**	**243**	**244**
	Year	**2022**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	Behavioral Health	**497**	**530**	**472**	**507**	**593**	**598**	**592**
	Vision	**39**	**25**	**30**	**37**	**104**	**110**	**104**
	Urgent Care	**10**	**11**	**11**	**12**	**14**	**14**	**16**
	Acupuncture	**6**	**4**	**4**	**4**	**4**	**4**	**3**
	Year	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**	**2023**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	% of PCPs Accepting New Patients - Goal (85%)	**95%**	**95%**	**92%**	**97%**	**97%**	**97%**	**98%**
	% Of Specialists Accepting New Patients - Goal (85%)	**97%**	**98%**	**97%**	**97%**	**98%**	**98%**	**98%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**97%**	**97%**	**97%**	**96%**	**96%**	**97%**	**96%**
	Year	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**	**2023**
	Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	Providers Touched by Provider Relations	**704**	**550**	**517**	**439**	**560**	**507**	**480**
	Provider Trainings by Provider Relations	**1,185**	**1,492**	**1,735**	**986**	**1,195**	**1,698**	**1,028**
	Year	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
	Total Providers Touched	**2,786**	**2,552**	**1,932**	**3,354**	**1,952**	**1,530**	**5,554**
	Total Trainings Conducted	**762**	**808**	**1,353**	**257**	**3,376**	**5,754**	**11,238**
Message From the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network & Engagement Activities.							

Claims Processing	**Year**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**	**2023**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	95% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	96% / 99% N/A	98% / 99% N/A	99% / 99% N/A	99% / 99% N/A	94% / 95% N/A	99% / 99% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / NA NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	97% / 99% YES	99% / 100% YES	96% / 99% NO	99% / 100% NO	99% / 99% NO	100% / 100% NO	87% / 100% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	80% / 95% NO	78% / 87% YES	81% / 89% YES	90% / 94% YES	82% / 91% YES	91% / 97% NO	95% / 98% NO
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	95% / 99% YES	79% / 95% YES	55% / 89% NO	95% / 100% YES	90% / 100% YES	83% / 98% YES	68% / 92% NO
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	97% / 100% NO	88 / 100% YES	98% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	97% / 97% NO	98% / 100% NO	100% / 100% NO	98% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	84% / 89% NO	100% / 100% NO	99% / 100% YES	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	91% / 96% NO	94% / 100% YES	99% / 99% NO	99%/100% NO	99%/100% NO	99% / 100% NO	100% / 100% YES
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	89% / 96% NO	99% / 99% NO	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
Message from the CEO	Q4 2023 numbers are available. Most areas met Goal. Management is working with PPG1 and PP3 on improving performance.							

Provider Disputes	**Year**	**2022**	**2022**	**2022**	**2022**	**2023**	**2023**	**2023**
	Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	99%	98%	97%	96%	98%	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%	N/A	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	100%	100%	100%	100%	100%	78%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	84%	11%	31%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	97%	45%	85%	71%	40%	66%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	99%	41%	55%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	97%	97%	86%	98%	100%	43%	65%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	N/A	100%	100%	47%	63%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	91%	43%	96%	98%	N/A	100%	67%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	100%	100%	99%
Message from the CEO	Q3 2023 data is available. Most areas did not meet goal. Management is working with PPGs 2-7 to improve performance.							