Population Health Management Strategy Program Description

HEALTH NET – CALVIVA HEALTH

2025

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Introduction

The CalViva Health robust population health framework leverages community partnerships, clinical programming, and data analytics to strategically deploy resources to enhance the Member and provider experience, improve whole-person care, mitigate social determinants of health (SDoH), and match Members with clinical programs designed to serve their unique clinical, cultural, social, functional, and behavioral health needs.

This document describes the strategy for managing the health of the CalViva Health enrolled population. It provides an overview of how the needs of the population are identified and stratified for intervention, summarizes the population health management (PHM) programs used to address the needs of the population across the entire health and wellness continuum, and explains enabling strategies used to promote the transition to value-based care in its contracted network. We contract with providers to conduct assessments and integrate the results with care and care management processes.

Background

CalViva Health is contracted with Health Net Community Solutions, Inc. (Health Net) to provide and arrange for population health 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.

Population Needs Assessment (PNA)

We evaluate the needs of the enrolled population and use that information to assess whether current programs need modification to better address the needs of our Membership. We examine data to evaluate the needs of Member subpopulations, including:

- Evaluation of the characteristics and needs of the Member population, including an analysis of the impact of relevant SDoH:
    - We assess the SDoH impacting our Membership through a geographic analysis using external data sources
    - We use an external SDoH tool, The California Healthy Places Index to create a custom selection using counties where we have Members.
    - We use the Healthy Places Index to determine regional SDoH performance on the following categories:
        - Economics
        - Education
        - Transportation
        - Social
        - Neighborhood
        - Clean Environment
        - Housing
        - Healthcare Access

- Evaluation of health status and risks by using utilization data broken out into cohorts based on NCQA and DHCS age-based stratification guidance.
- Evaluation of the needs of Members with disabilities:

  - Annually, a cohort of Members with disabilities are identified and assessed for needs to determine the appropriateness and adequacy of available clinical programs. A disabled Member is defined as needing assistance with Activities of Daily Living (ADL).
  - Identification criteria example: Members with one or more of the following: 1) Power Wheelchair 2) Home Hospital Bed 3) Hoyer Lift 4) In Home Supportive Services.
  - Analysis of this cohort consists of diagnostic categories and utilization trends for acute inpatient admits, readmits, and emergency department utilization.
- Evaluation of the needs of Member with Severe and Persistent Mental Illness:
  - Annually, a cohort of Members with severe and persistent mental illness are identified and assessed for needs to determine the appropriateness and adequacy of the available clinical programs. Severe and persistent mental illnesses are defined as diagnosis such as schizophrenia, psychosis, and bipolar disorder.
  - Identification criteria example: Members prescribed one or more of the medications on the Health Effectiveness Data and Information Set (HEDIS) schizophrenia, schizoaffective disorder (SSD) National Drug Code (NDC) list (See attachment in "Appendix A").
  - Analysis of this cohort consists of diagnostic categories and rates of acute inpatient readmits, emergency department utilization, and those receiving at least 2 outpatient medication management visits in 12 months.

PNA Activities

When the data analysis is complete, it is used to determine if changes are required to population health management programs or resources to meet the unique needs of our population and offer timely services and supports. In addition, there is an evaluation of the extent to which PHM programs facilitate access and connection to community resources that address Member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

Stakeholder Engagement

Public Policy Committee (PPC) participants help serve as advisors to PNA development, and implementation of the PNA action plans. CalViva will continue to employ multiple approaches to inform contracted providers of PNA highlights and recommendations. Communication channels may include:

- Provider Updates: Provider Updates extend immediate information to the provider network, which include Physicians, Participating Physician Groups, Hospitals, and Ancillary Providers. Provider Updates are also available online through the provider portal.

- Provider On-Site Outreach: The Provider Engagement team conducts site visits regularly, allowing opportunities to discuss with providers PNA findings and recommendations.

- Community Provider Lunch and Learns: Lunch and Learn sessions bring together multiple providers in a community setting, planned regularly throughout the year. Hosted by Provider Engagement, these events provide important health plan program updates and information to support providers in better servicing their patients. PNA findings will be shared with those in attendance. Provider feedback about the PNA and/or proposed action plans will be considered for further enhancement.
- Public Policy Committee (PPC): CalViva Health maintains a Public Policy Committee as one way for members to participate in establishing the public policy of the plan, to obtain feedback and guidance in the delivery of culturally and linguistically appropriate health care, and to establish and maintain

community linkages. The Public Policy Committee meets four times a year. The PPC empowers members to ensure the Plan is actively driving interventions and solutions to build more equitable care. The Plan will ensure that PPC meetings are accessible to PPC members and that PPC feedback is meaningfully incorporated in the Plan's operations and governance. Information provided by the PPC members is included in the development of Health Equity Department materials, health education materials and programs, and Quality Improvement Projects. The Committee includes a culturally diverse group including CalViva Health members, member advocates (supporters), Commissioner of CalViva Health's governing board, the Fresno-Kings-Madera Regional Health Authority (RHA) Commission, and health care providers. We incorporate county or region-specific Population Needs Assessment per PHM Policy Guide to build community partnerships and improve Member participation to fully understand the barriers preventing all populations from receiving care and preventive services as well as social drivers of health.

• Available Online: For easy access to our members and community stakeholders, the PNA report will be available on the health plan's website.

Population Stratification

Population stratification is performed to support clinical decision making both at the point of care, as part of resource allocation and healthcare management to improve patient outcomes. PMH risk stratification segmentation and tiering (RSST) algorithms include clinical and sociodemographic variables, bias testing using Delta (quantitative method), and measures of healthcare utilization. Data sources, clinical criteria, and stratification tiers are reviewed periodically to ensure the PHM approach incorporates feedback from different departments including medical directors, provider and member engagement teams which allows for continuous improvement. Data elements and standards used in RSST are compliant with NCQA PHM standards.

The RSST approach and Health Equity Improvement Model (HEIM) is designed to avoid and reduce biases to prevent the exacerbation of health disparities and address inequities in a variety of ways, including urban versus rural; race, ethnicity, and language; and the unhoused and special needs population. We combine data from multiple sources and multiple data points (like race, ethnicity, primary language, disability data, social risk information, social determinants of health, comorbidities, and mental health issues) for RSST of the population and obtain a 360 view of population needs and strengths. Our bias tested PHM model considers:

- Screening or assessment data
    - Screenings and assessments data is captured by our Health Information Form and additional screening conducted by the Plan including SDoH survey, CalViva Pregnancy Program (perinatal/postpartum program including maternal risk: history, age, or SUD) screening data etc. The inputs from the form are incorporated into member level data to assign members based on RSST model as well as at an aggregate population health level data set.
- Claims and Encounter data, including Fee-For-Service data
    - Claims and encounter data, including Fee-For-Service data is captured by various sources of data and based on member's utilization pattern (High Utilizer, Prospective High Utilizer) members are assigned into appropriate category and that flows into our RSST model.

- Available social needs data
    - CalFresh, WIC, CalWORKs, In Home Services, Z-Codes and Supports (IHSS), Safety risk factors (e.g., available caregiver support and environment) are captured from various sources of data and incorporated into our RSST model.
- Electronic health records
    - Electronic Health Record (EHR) data is captured by EHR integration as well as other data feeds and using that information members are assigned to appropriate category; this data feeds into and informs our RSST model.
- Referral data
    - Referral data is captured by Find Help/Community Connect, customer contact center data, provider portal, authorization data, and other sources. Referral data is being used for identifying individuals who are at higher risk for adverse health outcomes or high healthcare costs. Using referral data, the model identifies members who have been referred to specialists or specialty services for high-risk conditions such as cancer, heart disease, or chronic illnesses. Subsequently, based on frequency and intensity of healthcare services need, the members are assigned to certain category including members who require more coordinated and managed care of PHM model. Referral data combined with other member data, such as demographics, claims history, and clinical data is being used for risk stratification.
- Behavioral Health data (including SBIRT and other SUD data)
    - Behavioral Health data is captured by data exchange agreement to establish secure data exchange with all contracted counties to obtain Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health Services (SMHS) data available through the Short-Doyle/Medi-Cal claims system by use of HIE, secure file transfer protocol (SFTP), or other means to then be incorporated into RSST. We are also capturing Behavioral Claims from our Behavioral Health administrator to capture mental health needs of our members and assigning members to a PHM category based on their need.
- Pharmacy data
    - Pharmacy data is captured via data feed from Magellan/Okta portal. Pharmacy data helps to determine a member's adherence to prescribed medications. Poor medication adherence is associated with adverse health outcomes. Using pharmacy data, we identify individuals who are non-adherent to their medications, which may indicate a higher risk for future health complications or hospitalizations and this information is being used for the RSST model. In addition to medication adherence data, pharmacy data is also being used to identify members with chronic diseases who are prescribed specific medications for disease management. By analyzing medication usage patterns, we are identifying individuals with suboptimal disease control, escalating medication needs, or frequent medication changes. These members may require additional support and care management to optimize their disease management and reduce the risk of complications. This information is also being used in the RSST model.
- Utilization data
    - Utilization data is captured via claims and encounters data. Utilization data helps to identify individuals with frequent or intensive healthcare service utilization. This includes emergency department visits, hospital admissions, and outpatient utilization. Members with high utilization patterns are often at a higher risk of future

healthcare utilization or adverse health events. Utilization data provides us insights into the level of care coordination and management required for individuals.

Utilization data highlight the extent to which individuals engage in preventive services such as vaccinations, screenings, or wellness visits. Low utilization of preventive services may indicate an increased risk of undiagnosed or unmanaged health conditions. Targeting interventions towards individuals with low preventive service utilization helps us identify and address potential health risks earlier. Utilization data helps to identify individuals who utilize high-cost healthcare services, such as expensive procedures, specialty medications, or complex surgeries. Individuals with high-cost service utilization are more likely to have higher healthcare costs and may require targeted interventions to manage costs and improve outcomes.

- Disengaged Member reports (e.g., assigned Members who have not utilized any services)
    - Disengaged member reports are captured via our zero encounters (zero encounter / no office visit / no utilization members) report. The monthly Zero Encounter enables the Plan to reconnect members to care, tracking disengagement with PCP.
- Lab results data
    - Lab results data is captured via EMR integration, quality data, among other sources.
- Admissions, Discharge and Transfer (ADT) data
    - ADT data is captured via HIE connections with various facilities and providers.
- Race/ethnicity data
    - Race/ethnicity data including disparity data is captured from various sources of data including but not limited to member enrollment data, customer contact center data.
- Sexual orientation and gender identity (SOGI) data
    - SOGI data is collected from our customer contact center data and we are in the process of identifying sources for collection of SOGI data.
- Oral health data:
    - We receive a data feed from DHCS that includes dental claims.

Our algorithms include bias testing and stratify our entire membership into a Risk Tier (low, medium, and high) and CM level (Level-1 to Level-5) to assign appropriate resources, interventions, and programs. To identify SDoH need, we have used:

- ICD 10 Z-Code from Claim,
- Encounter data,
- Admission discharge and transfer (ADT) data;
- TruCare Assessment including health risk assessment (HRA),
- SdoH Mini-screen;
- Other data feed including State eligibility data, (San Diego (SD)211 etc.)

The SdoH report allows to drill down into the SdoH needs of selected geographies and/or subsets of membership.

In addition to Risk Tier and level, PHM also include information from Impact Pro, a predictive modeling tool that uses multiple data sources that are stored in the data warehouses (EDW and ODW or Snowflake). In addition to Impact Pro, a web-based customizable report generating system, Micro Strategy®, is used to produce adjunctive analytical reports that support tracking of goals of clinical

programs. The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: medical and behavioral claims/encounters, pharmacy claims, laboratory results, health appraisal results, electronic health records, data from health plan utilization management (UM) and/or care management (CM) programs and advanced data sources such as all-payer claims databases or regional health information.

Additionally, we use our system, Impact Pro, to segment and risk stratify the entire enrolled population into meaningful subsets for targeted interventions. These subsets, or levels, are listed below with detailed descriptions in the appendix. This system is used on a regular basis (weekly or monthly) to identify, enroll, track and coordinate eligible Members for clinical programs. Information about the process used is defined in the description of specific programs in the sections which follow.

We conduct continuous improvement evaluation and the incorporation of inputs that explicitly aim to reduce bias or existing disparities that may exist in basic cost or utilization data (e.g., care gaps, ambulatory care sensitive conditions, underutilization of primary care). We have found and rectified biases in utilization data, for example: prioritization based solely on high utilization, access to care by zip code, or homeless members with no utilization.

Upon enrollment, the Health Information Form (HIF)/Member Evaluation Tool (MET) is completed within 90 days of enrolling new members. Enrolled populations are further broken out into Population Health Analytic Groups designed to segment the entire population into mutually exclusive categories based on their utilization pattern (institutional, pharmacy, behavioral health), acute events, co-morbidity, risk scores and any clinical indications use the Member's most recent 12 months of claims and pharmacy history and care gap information. With each monthly refresh of the Population Health Analytic Grouping, each Member is reassessed based on the most up-to-date utilization information and may be re-classified to a new grouping. The Risk Stratification, Segmentation, Tiering (RSST) methodology identifies significant changes in Members' health status or level of care and in this way, Members are monitored to ensure appropriate re-stratification.

We will provide DHCS, upon request, our processes to identify significant changes in member's health status and appropriate re-stratification via this Strategy Description.

We monitor the penetration rate of PHM Programs and Services by Tier including the number of members by risk tier who need further assessment and received it, and who were enrolled in eligible programs.

We define a significant change in health status and/or a change in a member's level of care monthly. Each Member is re-assessed based on the most up-to-date utilization information and therefore may be re-classified to a new grouping. We also deploy industry leading SdoH data analytics to inform our PNA and PHM interventions. The PNA will be similar to previous years and will include information spanning the needs of our entire Member population.

The goals of PHM are to improve health conditions of current patients, understand patient needs that might have been overlooked, design better health services, make better use of resources, prevent diseases and predict future health issues. To achieve the goal and effect on outcomes, we monitor PHM performance using a Key Performance Indicators (KPI) report. The KPI includes:

- Admit/K,
- Emergency room (ER)/K,

- Readmission %,
- Ambulatory Care Sensitive Admissions (ACSA) %,
- Average Length of Stay (ALOS),
- Days/K,
- Avoidable ER%,
- Per member per month (PMPM) Cost,
- PMPM Cost by Service Category, and
- Pharmacy (Rx) Utilization
- DHCS PHM Monitoring Plan KPI requirements

Along with that we also use SdoH dashboard to track and trend Member SdoH needs and we align our health equity goals with DHCS' Health Equity Framework within the Comprehensive Quality Strategy (CQS) Report, and stratify DHCS selected MCAS measures by demographics.

We use these reports to set benchmarks, identify outliers and high performing Providers, address performance issues, share best practices, and invest in additional capacity.

- Members are assessed/re-assessed who are/have:
  - Seniors and Persons with Disabilities (SPD)
  - Receiving: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) Services
  - LTSS needs
  - Entering Enhanced Care Management (ECM), Complex Care Management (CCM)
  - Children with Special Health Care Needs (CSHCN)
  - Residing in acute hospital
  - Hospitalized w/in 90 days or 3 + hospitalizations in last year
  - 3 + ER visits in last year w/ high utilization of services (e.g., multiple Rx for chronic diseases)
  - BEH dx or developmental disability and > 1 chronic medical diagnoses or social need (e.g., homelessness)
  - Multiple Outpatient Surgeries
  - Readmission risk
  - Preventable Admit
  - Avoidable Emergency Use
  - Multiple prevalence conditions including end stage renal disease (ESRD), acquired immunodeficiency syndrome (AIDS), or recent organ transplant, Cancer, Asthma, Diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), serious and persistent mental illness (SPMI), serious emotional disturbance (SED), Opioid use etc.,
  - Pregnancy state
  - On antipsychotic medication
  - On 15 or more prescriptions in the past 90 days
  - Self-report of a deteriorating condition
  - Other conditions as determined based on local resources.

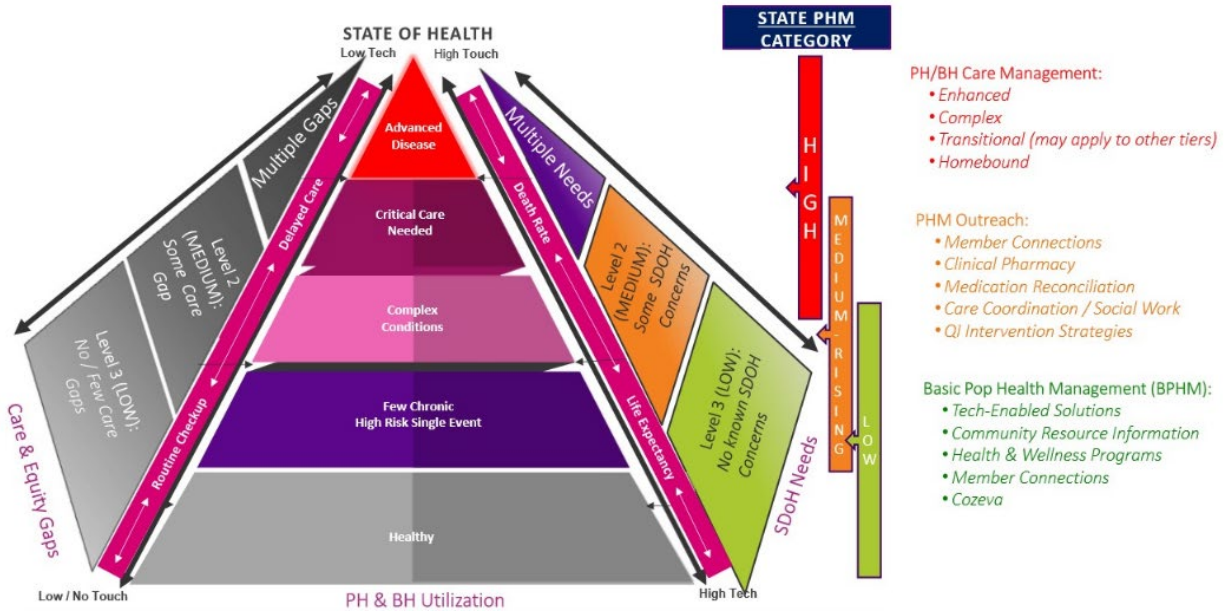
- We work with network providers for shared decision making with the members about the services a member needs, including through use of real-time information.

Once the statewide RSST and risk tiers are available through the PHM Service, at a minimum Members who are identified as high-risk through the PHM Service will be assessed.

ImpactPro Population Health Categories* consist of the following:

- 01: Healthy
- 02: Acute Episodic
- 03: Healthy, At-Risk Level and
- 04A: Chronic Big 5 Stable
- 04B: Chronic Other Condition Stable
- 04C: BH Primary Stable
- 05A: Health Coaching
- 05B: Physical Health CM
- 05C: Behavioral Health CM
- 06: Rare High-Cost Condition
- 07A: Catastrophic: Dialysis
- 07B: Catastrophic: Active Cancer
- 07C: Catastrophic: Transplant
- 08A: Dementia
- 08B: Institutional (custodial care)
- 09A: LTSS and Medicare-Medicaid Plan (MMP) – Service Coordination
- 09B: LTSS and MMP – High Needs Care Management
- 10: End of Life

* Definition of each category appears in "Appendix C".



A description of subsets and the type of intervention offered to Members is described in the PHM Programs and Services portion of this document below.

PHM Programs and Services Overview

Basic Population Health Management (BPHM)

Health equity is a guiding principle. Population Health Management (PHM) is the framework to achieve health and wellness for all, free from barriers, using the Health Equity (HE) Improvement Model to identify and design community-anchored interventions. We offer BPHM services that promote health equity and aligns with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A multi-pronged, non-delegated, empanelment approach is used for BPHM which directly facilitates connections to primary care. New Member welcome packets are sent to ask Members to schedule their initial health appointment (IHA), and conduct new Member outreach to facilitate appointment scheduling, and survey Members to ensure they are satisfied with their assigned providers. Primary care providers (PCPs) are also notified of new Member enrollment within 10 days of assignment to facilitate PCPs seeing their patients within 120 days of assignment. Members who don't select a PCP within 30-days of enrollment are auto-assigned a PCP within 40-days of enrollment. (Full-benefit dual-eligible Members are not required to select a PCP).

A proactive outreach to Members without a PCP visit in the past year is used to assist in arranging appointments, transportation, or interpreters, if needed. Hard-to-reach Members, including those with unstable housing or no phone, are assigned to the MemberConnections® Field Team for in-person outreach. The MemberConnections Representatives (MCR) also assist with PCP selection or change. Members are informed that they can select a variety of providers in lieu of a PCP (e.g., Nurse Practitioner, Certified Nurse Midwife, Physician Assistant). Native American Members can select an Indian Health Services (IHS) Provider within the 'network as their PCP. SPD Members may select a Specialist or Clinic as a PCP if they are qualified. PCPs are notified of Member assignments within 10-days from selection/assignment by file sharing and provider web portal.

We use KPIs (e.g., encounters, Member engagement, HEDIS care gaps) and stratifications to address disparities in PCP engagement including identifying Members with open HEDIS care gaps for targeted outreach campaigns. Our Modeling Engagement project predicts levels of Member engagement, stratifies Members into 4-categories of likeliness-to-engage based on engagement history and tracks both PCP and Member engagement. This project informs the 'outreach approach, including monthly Care Gap reports distributed to provider, which helps prioritize and adapt outreach. The monthly Zero Encounter enables us to reconnect Members to care, tracking disengagement with PCP. We also stratify data to identify health disparities and are excited to leverage community health workers and doulas to ensure outreach is targeted with a focus on advancing health equity, and that post-partum Members are supported for their newborn pediatrician visits into the first year of life.

On a monthly basis, we review disengaged Member reports to proactively identify Members who have not established care with their PCP in the last 12 months. Then, we match Members to the level of support needed leveraging our Population Health telephone outreach teams to connect Members to PCP, or MemberConnections Field Team (our field-based team that performs proactive home visits), assigning continuous support, reporting disengaged Member who have not received their IHA to providers, and introducing Member engagement strategies such as Cozeva, quality improvement projects, and discussions during Joint Operations Meetings (JOM). Support is available over the phone, through self-service tools, and in the field, leveraging Member Services, Care Management, Community Engagement, and Health Education staff.

Key aspects of member navigation support include:

- Establishing a relationship with a usual source of care through their PCP that meets Member's geographic, clinical, and cultural needs.
- Ensuring PCPs have successfully engaged Members in ongoing care and are familiar with the holistic needs of the Member, through systematic monitoring of the initial health appointment, ambulatory or preventive visits every 12 months, vaccinations and immunizations (e.g., COVID-19, Flu, Pneumococcal), care gaps, and sharing insights with PCPs. Our provider engagement teams, who perform onsite and virtual meetings with providers, regularly encourage providers to leverage engagement strategies, provide them disengaged Member lists with contact information, engage ability scores, and provide routine progress on how well engaged their Member are with required care. Providers can request funding to address specific barriers to engaging Members.
    - As part of the implementation of the Community Health Worker (CHW) benefit, providers are encouraged to leverage new ways to support Members who have significant clinical needs, health equity or SDoH barriers, or are lost to follow up
    - Members and their family are supported with community resources and carved-out services
- The Quality Improvement Team supports systematic evaluations to assess why Members are not engaged with their PCP or other healthcare needs and provide findings to the engagement team and providers for intervention. Providers are not delegated responsibilities, however, are provided with incentive and support tools to engage and outreach to Members.
- We use a quality and health equity framework to ensure all Members under age 21 receive all screening, preventive and medically necessary diagnostic treatment services and immunizations required by early periodic screening, diagnosis and treatment (EPSDT), American Academy of Pediatrics (AAP) Bright Futures periodicity schedule and the ACIP Childhood Immunization Schedule. Our strategy includes 1) service tracking and early identification, 2) connecting to services, and 3) meaningful innovation to continuously improve outcomes with a focus on the life course perspective. To achieve this, we:
    - Invest in preventive programs, coordinate/collaborate with Local Health Departments (LHDs), Local Government Agencies (LGAs), and local organizations to address SDoH and identified health disparities.
    - Support Members with culturally relevant health education, Member incentives; reminder outreach programs; and community engagement to promote prevention, screening, remove SDoH barriers.
    - Activate our plan CHW model to work with families with historical gaps in screenings to proactively outreach and remove barriers.
    - Prioritize partnerships with Providers to support our effective EPSDT program. Our pediatric Providers receive training and support tools to help identify care gaps timely and are audited for adherence to medical record requirements including EPSDT services. We incentivize providers for quality care and provision of preventive services, including EPSDT.
    - Track and report EPSDT screenings, AAP Bright Futures and ACIP Childhood Immunization periodicity adherence and monitor follow-up service needs. Tracking and stratification are at the population, community, subpopulation, and individual Member level. KPIs include annual and monthly HEDIS metrics (e.g., W30 (Well-Child Visits in the First 30 Months of Life), WCV (Child and Adolescent Well-Care Visits), CIS (Childhood Immunization Status), IMA (Immunizations for Adolescents), AAP (Adults' Access to Preventive/Ambulatory Health Services), IHA). Additional claims/encounters codes are evaluated for specific assessments and screenings (e.g., Oral Evaluation, Dental Services (OED), topical fluoride for children (TFC)).

We monitor utilization patterns including preventive services, ER/admissions, PCP visits, ambulatory/preventative visits, and the use of behavioral health services, as well as condition/situation specific outcomes by race/ethnicity to evaluate and improve the effectiveness of ECM, CHWs and other PHM programs in improving health outcomes, reducing disparities, and achieving health equity.

We are working with Local Health Jurisdictions (LHJs) in the service area to develop SMART goals that align with the Bold Goals from DHCS Comprehensive Quality Strategy as well as to promote meaningful participation in the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process.

In 2024, CalViva Health representatives established a collaborative partnership with Fresno, Madera, and Kings counties' LHJs/LHDs to begin "meaningful participation" in their current or future CHA/CHIP cycles. Plan will work with LHJs to determine what combination of funding and/or in-kind staffing the plan will contribute to the LHJ CHA/CHIP process, which includes attending CHA/CHIP meetings and serving on the CHA/CHIP governance structure. CalViva Health representatives are also engaging with these LHJs to co-develop joint SMART goals. This collaborative work includes CalViva Health/Health Net partnering and aligning with the other Managed Care Plans (Anthem and Kaiser) providing Medi-Cal services in these three counties.

Plan will partner with LHJ in the service area to identify priority areas for plan to share data with LHJ. In 2025, the Plan will begin to share data agreed upon in 2024 with the LHJs in a timely manner. Plan will engage our community advisory committees (CACs) as part of our participation in the LHJ's CHA/CHIP process. Plan will publish CHA/CHIP on our website and complete the MCP/LHJ collaboration worksheet by deadline.

Plan will submit our annual PHM strategy deliverable using the DHCS template for the service area.

Transitional Care Services

The purpose of the Transitional Care Services (TCS) program is to provide a comprehensive, integrated transition process that supports members during movement between levels of care.Care Transition Interventions may include 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 Care Manager works to create a smooth transition from one setting to another and to reduce re-hospitalization risks and other potentially adverse events. Using a Member-centric approach, the model incorporates three evidenced based care elements of inter-disciplinary communication and collaboration, Member/participant engagement and enhance post-acute care follow-up.

TCS includes:

- Conducting an initial outreach call within 72 hours of inpatient referral to complete an inpatient discharge risk assessment
- A minimum of two follow-up calls are made to the Member within 15 days of discharge

- Initiating Community Support referrals as appropriate
- Focus on 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 of how to respond
- Preparation for discussions with other health care professionals and use of a personal health record to support member collaboration with the inter-disciplinary team to enhance post-discharge follow up care
- Supporting the Member's self-management role
- Educating the Member to follow up with the PCP and/or specialist within 7 days of discharge, and providing scheduling assistance if not listed on the post-discharge instructions
- Ensuring Member transition is successful and needs are met
- Actively engages the Member in medication reconciliation including how to respond to medication discrepancies

During the post discharge period, staff evaluates 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.

PHM Programs and Services

We offer several PHM programs and services to our enrolled Members to provide comprehensive wellness, prevention, and self-management tools:

Program Name	Eligible Population
Improve Preventive Health: Flu Vaccinations	Members 18 years and older, especially high-risk populations
Improve Preventive Health: Breast Cancer Screening	Women ages 50-74 years
Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
CalViva Pregnancy Program	Pregnant Members at risk for complications of pregnancy as determined by having an NOP score >34 and/or provider determination
Care Management	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health.
Transitional Care Services	Members with high complexity profile: Member is inpatient with anticipated discharge or recently discharged, hospital readmissions risk, 2 or more admissions within the past 6 months, 3+ emergency department visits within the past 6 months, multiple medications/high cost medications/high-risk medications, recent catastrophic event or

Program Name	Eligible Population
	illness, unmanaged/poorly managed chronic or behavioral health issues, psychosocial issues/barriers impacting access to care and/or services, history of non-compliance and/or complexity of anticipated discharge
Chronic Condition Disease Management	Members with Asthma, COPD, Diabetes, Cardiovascular Conditions, and Sickle Cell Disease
Chronic Condition Management: Substance Use Disorder-Opioid (SUD-O) Program	SUD-O program timely/effective care in collaboration with providers for members on dangerous combinations (benzodiazepines, opioids, muscle relaxants, other), high doses and prolonged use.
Tobacco Cessation – Kick It California	Members 13 years and older
Diabetes Prevention Program	Members 18 years and older with BMI > 25 (BMI >23 if Asian) and have one of the following within 12 months: HbA1c between 5.7% and 6.4%, Fasting plasma Glucose 100-125 mg/dL. 2-hour plasma glucose of 140-199 mg/dL
Diabetes Management Program	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Cardiac + Diabetes	Members that have diabetes with hypertension and/or cardiovascular disease
Health Information Form	All Members
Initial Health Appointment	All Members
Teladoc Mental Health Digital Platform (formerly myStrength)	Ages 13 years and above - Mental health and substance use (behavioral health) educational support for depression, anxiety, substance use, pain management, and insomnia/sleep health
Behavioral Health Care Management	All members
Chronic Condition: Respiratory Conditions (Chronic Obstructive Pulmonary Disease (COPD) and Asthma)	Members with Chronic Obstructive Pulmonary Disease or Asthma diagnosis with pharmacy claims who are either not adherent to their medications, have ER visits in the last 12 months, or both
Emergency Room Diversion Program	High-frequency emergency department utilizers
Chronic Condition: Oncology	Members with diagnosis of breast, prostate,colon cancer, or other cancers with pharmacy claims who are either not adherent to their medications, have ER/IP visits in the last 12 months, or both
Telemedicine	All Members

Focus Areas

Programs related to the four focus areas are described in greater detail below.

Improve Preventive Health: Flu Vaccinations	
Eligible population:	Members 18 yearsand older, especially high-risk populations
Focus area:	Keeping Members healthy
Program goal(s):	Reach or maintain Medicaid 25% MPL for AIS-E (Adult Immunization Status) measure
Program services:	Member education promoting flu vaccination through: ○ Emails ○ Proactive Outreach Manager (POM) messaging ○ Interactive Voicemail Response (IVR) messaging ○ ProviderFlu Flyer ○ Web landing page and web pop-up/notification banner
Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations, enrollment data
Relevance	The flu vaccine can prevent contracting the flu and other illness and can decrease health care utilization by reducing risk of going to the doctor or hospital, and keeping the community healthy. It is an important preventative tool for people with chronic health conditions. The ability to get the flu shot can also be an indicator of any health plan/network access barriers.

Tobacco Cessation	
Eligible population:	Members 13 years and older
Focus area:	Keeping Members Healthy
Program goal(s):	Increase member participation in smoking cessation programs by 5% from prior year.
Program services:	CalViva Health will cover a minimum of two separate quit attempts per year, without prior authorization, with no mandatory break between quit attempts. Please refer to the Medi-Cal RX contract drug list for individual products and any restrictions to coverage. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_OTC_FINAL.pdf. CalViva Health also offers no cost individual, group and telephone counseling without prior authorization for members of any age regardless of if they opt to use tobacco cessation medications. Kick It California is a no-cost, statewide tobacco cessation program that addresses smoking and vaping behaviors. Services include: • tailored one-on-one telephonic coaching in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), • a texting program in English or Spanish, • a website chat function, and • mobile apps on smoking and vaping.

Methods and data sources used to identify the eligible population	Data extraction from eligible Member populations using ICD-10 identifiers. Program is opt-in. Members can also be referred by their PCP, or Care Management.
Relevance	Tobacco use is the leading cause of preventable death and disease in the U.S., making it critically important that prevention and cessation programs are available to help people break their tobacco addiction for good. In 2021, an estimated 1.8 million adults reported current cigarette smoking in California and 1.2 million reported current vape use. The cost of smoking in California totaled $43.54 billion in health care costs and lost productivity from illness and premature death.Tobacco cessation is critical to improve members' health outcomes and reduce health care costs by decreasing the rate of tobacco users among CVH membership. Source: CDPH Tobacco Facts and Figures 2022

Improve Preventive Health: Breast Cancer Screening	
Eligible population:	Women ages 40-74 years
Focus area:	Managing Members with Emerging Risk
Program goal(s):	Meet/exceed the Quality Compass national 50th percentile for reporting year (RY)
Program services:	Member education promoting breast cancer screenings through: • Mobile mammography events • Multi-gap call outreach to members • Identify opportunities to collaborate with community based organizations Provider education and partnership to promote breast cancer screenings through: • Tipsheets on the Breast Cancer Screening HEDIS measure • Provide Breast Cancer Screening HEDIS measure specific best practices, coding practices, and clinic processes practices in the Provider Best Practices guide • Collaboration with priority Providers to identify opportunities to improve breast cancer screening utilization rates • Host office hours for internal Provider-Facing teams to provide measure specific education on updated recommendations, guidelines, and best practices
Methods and data sources used to identify the eligible population	HEDIS care gap reports, enrollment data
Relevance	The American Cancer Society cites breast cancer as the second leading cause of cancer-related deaths and the second most common cancer among women in the US.[2] Regular breast cancer screenings (also known as a mammogram) can help detect the cancer while it is still in early stages, which is also when the cancer treatment is most likely to be successful. Breast cancer screening is an

	important preventative tool that can help keep members healthy and decrease health care utilization.

Diabetes Management Program	
Eligible population:	Members 18-75 years of age with diabetes (type 1 and 2) with care gaps
Focus area:	Managing Members with emerging risk
Program goal(s):	Meet directional improvement of 1-5% from prior year or ≥ 50th percentile benchmark for the following MCAS-MPL measure: • Glycemic Status >9
Program services:	Member education on diabetes management: o Digital Health Education QR Codes on diabetes-related resources. o Access to comprehensive diabetes webpages on member portal site. o Targeted Community Health Workers (CHW) outreach to members with SDOH barriers. o Pharmacy medication adherence outreach by phone. o Availability of A1c home kits and follow-up email and/or follow-up calls to encourage completion. o Multi-gap live calls encourage members to complete A1c screening and assist in scheduling appointments with provider; bi-directional texting to accompany live calls for targeted populations to promote trust and improve health outcomes. Provider partnerships on diabetes management: o Targeted outreach to high-volume, low-performing PPGs/PCPs utilizing root cause analysis for uncontrolled A1c to segment population follow-up. o Provider tipsheets on HEDIS Diabetes measures: GSD (Glycemic Status Assessment for Patients with Diabetes), EED (Eye Exam for Patients With Diabetes), BPD (Blood Pressure Control for Patients With Diabetes) and KED (Kidney Health Evaluation for Patients With Diabetes).
Methods and data sources used to identify the eligible population	HEDIS care gap reports, pharmacy claims
Relevance	According to the Centers for Disease Control and Prevention (CDC), 38.4 million people have diabetes (11.6% of the US population), and 1 in 5 individuals have undiagnosed diabetes.[3] Individuals with diabetes face an increased risk of developing serious health complications and co-morbidities such as blindness, amputation, kidney failure, heart disease, stroke, and early mortality. Diabetes is the eighth leading cause of death in the United States. Disadvantaged and underserved communities experience higher disease rates

	and worse health outcomes. In 2023, African American adults were 1.4 times more likely than white adults to be diagnosed with diabetes, and more likely admitted to the hospital for uncontrolled diabetes. Early detection and comprehensive management of diabetes can significantly prevent, reduce, and delay complications of the disease, ultimately improving patient health outcomes, while greatly reducing costs. Diabetes control is achieved through effective whole-person approach to care and management, addressing SDOH barriers and clinical preventive care practices that achieve optimal rates for the HEDIS diabetes-related measures, specifically blood sugar control, retinal eye exam, and kidney health evaluation.

CalViva Pregnancy Program (CPP) / High-Risk Obstetrics (OB) CM	
Eligible population:	Pregnant Members at risk for complications of pregnancy as determined by having a notification of pregnancy (NOP) score >34 and/or provider determination
Focus area:	Patient safety or outcomes across settings
Program goal(s):	- Members managed in OB program have 8% greater completion of the 1st pre-natal visit within the 1st trimester or 42 days of enrollment than pregnant Members not managed. - Members managed in OB program have 10% greater completion of the post-natal visit between 7-84 days post-delivery than pregnant Members not managed. - High-risk Members managed have 2% lower rate of pre-term delivery than high-risk Members not managed. - Member experience survey – each question and overall >90%
Program services:	Care manager completes the CPP OB CM Assessment, Edinburgh Depression Screen, Post-Partum Assessment with Member. - Education Materials are sent to Member - Members who received a medium or high score receive outreach to be enrolled in High-Risk OB Program - The OB Care manager coordinates care with the BH Care manager for Members with behavioral health needs.
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims
Relevance	Pregnancy complications can be harmful for mom and baby. Early and regular prenatal care helps identify conditions and behaviors that can result in preterm and low weight births. Early identification of pregnant women and their risk factors is an important factor in improving birth outcomes. Interventions are aimed at increasing pre-natal visits thereby improving health outcomes and resulting in reducing utilization costs.

	Pregnancy complications can be harmful for mom and baby. Post-natal care is important in preventing and addressing the health of mom and baby after pregnancy. Interventions are aimed at improving health outcomes and resulting in reduced utilization costs. Pregnancy complications can be harmful for mom and baby. Preterm birth is the leading cause of US infant morbidity and mortality and low birth weight can cause serious and long-term health problems. Interventions are aimed at reducing pre-term deliveries thereby improving health outcomes and resulting in reduced utilization cost. Measuring member experience evaluated the effectiveness of the services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement.

Improve Behavioral Health: Severe and Persistent Mental Illness (SPMI) and Follow-Up Care after Mental Health Emergency Department Visits	
Eligible population:	Members ages 6 years and older as of the date of the Emergency Department visit for mental illness or intentional self-harm.
Focus area:	Patient safety or outcomes across settings
Program goal(s):	Achieve or exceed the 50th percentile for HEDIS® Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Program services:	Behavioral Health clinical staff live calls to members with a very recent ED visit for Mental illness or Intentional self-harm to conduct assessments and support timely follow-up to outpatient care for members in Fresno, Kings and Madera counties. Clinical staff are able to identify depressive symptoms and provide additional counseling and resources to assist with stress management and avoidance of at-risk alcohol and substance use.
Methods and data sources used to identify the eligible population	Hospital admissions, discharges, and transfers (ADT), claims or encounter, and membership data
Relevance	Major depression is one of the most prevalent and treatable mental health disorders. Although antidepressants are considered effective treatment, non-adherence to antidepressants significantly hinders successful treatment of depression. Symptoms associated with major depression can last for years and has been linked to poor treatment outcomes (e.g., relapse occurrence) if left untreated. Conversely, many can improve through treatment with appropriate medications. Measuring antidepressant medication adherence for 84 days (12 weeks) among individuals diagnosed with depression evaluates the impact of the recommended treatment monitoring during the acute phase, during which remission (reduction of depressive symptoms) is induced. This measure ensures patients successfully adhere to treatment plans.

	Successful treatment of patients with major depressive disorder is promoted when patients adhere to the treatment plan through the continuation phase of treatment (six months), the period in which remission is preserved. Ultimately, adherence through the continuation and maintenance phase protects the patient against the recurrence of a subsequent major depressive episode.

Cardiac + Diabetes (formerly Cardio-Protective Bundle Project – SHAPE)	
Eligible population:	Members that have diabetes with hypertension and/or cardiovascular disease.
Focus area:	Managing multiple chronic illnesses
Program goal(s):	Improve cardio-protective bundle medication adherence by performing successful outreach to high risk members who were flagged for non-adherence, utilization (ER/IP), or both and provide education/counseling to encourage compliance
Program services:	Member education and outreach through - o A "live call" by health care coaches to engage the Member and help ensure that they are compliant with their medications. The health care coaches, consisting of pharmacists, diabetes educators, nutritionists, or dieticians, can conduct follow-up visits as needed to address Members' chronic conditions and healthy weight (BMI) maintenance, encouraging physical activity and healthy eating o Multimodal communications: online newsletters and mailings. o Connecting Members with care management and disease management.
Methods and data sources used to identify the eligible population	Medical claims, encounter data, pharmacy claims
Relevance	Diabetes was the eighth leading cause of death in the United States in 2021.[5] If not properly managed, it can lead to renal, vision, hearing impairment and cardiovascular disease. If complicated with other chronic comorbid conditions like hypertension and CAD, the utilization is very high affecting the quality of life and the challenges to navigate through the healthcare system. In 2022, the total cost of diagnosed diabetes in the United States was $412.9 billion.[5] The utilization is primarily around pharmacy, inpatient and emergency room costs. Timely intervention, focus on prevention and developing wellness into the lifestyles, and implementation of evidence-based strategies to incorporate best practices are the goals of the initiative.

Care Management	
Eligible population:	Members fitting within clinical analytics population health groups 05d, 05c, 07a, 07b derived from ImpactPro with other designated criteria, complex conditions and other designated health factors and/or social determinants of health. A predictive modeling tool, reports and health risk screening are used to identify Members who have higher risk and more complex health needs. Members may self-refer and/or be referred to the program by other internal and external entities. The person-centered approach allows us to link Members to a tailored variety of Complex Care Management (CCM) programs and interventions

	(inclusive of BPHM) to address Members' unique needs. Types of interventions and conditions the Program addresses include: health promotion, disease management, maternal and child health, Behavioral Health (BH), telehealth, transitional care services, palliative care, oncology, nursing facilities, and ED diversion. Depending on the Member's preferences, the CCM program uses a variety of communication modalities to initiate and sustain Member support (e.g., in-person contacts, face-to-face virtually, calls, texts, email).
Focus area:	Managing multiple chronic illnesses
Program goal(s):	• Member experience survey – each question and overall > 90% • Reduce Non-Emergent ER Visits > 10% annual • Reduce Readmissions > 5%
Program services:	**Care coordination:** Typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor health concerns arise. Services included at this level of coordination include outreach to Member, assistance scheduling appointments, assistance securing authorizations and follow up to ensure compliance. In addition, this level of care management is used for continuity of care transitions and supplemental support for Members managed by the county. **Care management (CM):** Services included at this level of care management include the level of coordination along with identification of Member agreed upon goals and progress towards meeting those goals. If the CM program is delegated to the Participating Physician Group (PPG) and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up. **Complex Care management:** Services at this level of complex care management include all coordination and care management services from above, along with a more frequent outreach to the Member to assess compliance with their treatment plan and progress towards meeting goals. Care managers will monitor Members' key indicators of disease progress, e.g., HgbA1c levels and medication adherence. If the CM program is delegated to the PPG and the Member is identified as potential candidate for CM, the health plan refers the Member to the PPG for follow up
Methods and data sources used to identify the eligible population	Medical and behavioral claims or encounter, health appraisal results, pharmacy claims and laboratory claims, focused Population Health Management reports, referrals

Relevance	One element of the Care Management program evaluation is to assess member satisfaction. Measuring member experience evaluated the effectiveness of Care Management services and satisfaction with Care Managers. Gauging a member's experience or perception of care is important as it can help provide insight into whether the program is meeting the member's needs and identify trends for areas of improvement. Use of the emergency room may prevent or interrupt the receipt of coordinated services by the primary care physician. Readmission may reflect a failure of transition of care after hospital discharge. Readmissions not only increase health care costs, but also can signal a setback in member recovery after hospitalization. There are many factors which increase the potential for a readmission including member and caregiver understanding of discharge instructions, member and caregiver understanding of red flags and when to contact a physician and lack of medication reconciliation.

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Care Coordination

We provide care coordination to our members from each of the following populations based on the member needs that address all their health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs.

- Mental Health Plans (or specialty mental health system): We coordinate care through interdisciplinary care team (ICT) discussions with MH resources and with the county Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) to address the holistic needs of members including transitioning between SMHS and NSMHS. CM provides education on and referrals to SMHS and NSMHS. For members who are medically and BH complex, we perform an ICT round, and work with the county to coordinate care. We monitor individual cases, and we also have enhanced and global reporting on trends across cases for provision to providers. We can now track how many members have been linked to BH Therapist and/or Psychiatrist, as well as how many members we facilitated ICT meetings with county Mental Health Providers for SMI services.

- Drug Medi-Cal or a Drug-Medical Organized Delivery System: CM and Clinical Pharmacy refers members to appropriate level of care/provider for SUD needs. CM staff outreach to Drug Medical provider to ensure member needs are being addressed. ICT meetings scheduled as needed.
- Long Term Services and Supports (LTSS), including 1915(c) waivers and In-Home Supportive Services: CM staff will refer to our dedicated Public Programs team who specialize in supporting LTSS members. In addition, CM staff educate the Member on IHSS and refer the member to the Public Programs team who will support the Member through the IHSS application process. Finally, we outreach to the Member's PCP or specialist to help advocate for member and encourage the provider to complete the remaining components of the IHSS forms as necessary. In 2023 we implemented additional KPIs to improve monitoring and tracking of care coordination outcomes (e.g., coordination with providers, facilitating referrals, linkage to services).
- CBAS: We measure completion of Face-to-Face assessment within 30 days of notification for CBAS and we review the reassessments completed by CBAS every 6 months to determine program eligibility.
- LTC: We review the assessments at least annually or when the Member experiences a significant change in condition completed by LTC to determine appropriateness and eligibility.
- Waiver Programs: We make referrals to waiver programs, as appropriate, and partner with waiver agencies for all care coordination opportunities.
- Overarching CM supporting: CM staff complete Health Risk Screenings with members to help identify when additional support may be needed. CM staff refer members to any of the programs above including ECM or CS (if member meets criteria and is identified in the population of focus). CM staff outreach to providers to coordinate care, share assessment information as needed, and case conference as appropriate. CM provides members with information for community and social services based on recommendations from the Interdisciplinary Care Team (ICT). CM also assists the members with 3-way calls to those entities or submits referrals on the member's behalf. The CM team primarily interfaces with providers and outside entities telephonically and by secure email.

External partnerships

Entity	Description:
Departments of Social Services and In-Home Supportive Services (IHSS)	CalViva Health will maintain MOUs with Local Departments of Social Services and In-Home Supportive Services (IHSS) programs in all services areas and will meet with these departments/programs quarterly at minimum, as is required under the new State contract.
Departments of Behavioral Health and Substance Use Disorder Services (SUDs)	CalViva Health will maintain MOUs with Local Departments of Behavioral Health and Substance Use Disorder Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Regional Centers	CalViva Health will maintain MOUs with the Regional Center(s) for all services areas and will meet with the Regional Center(s) quarterly at minimum, as is required under the new State contract.
Local Health Departments	CalViva Health will maintain MOUs with Local Health Departments (LHDs) in all services areas and will meet with LHDs quarterly at minimum, as is required under the new State contract. Example of how Plan and LHDs work together include but are not limited to:

	Collaborating to ensure COVID-19 vaccinations were/are available to homebound members; Collaborating to deliver provider trainings (e.g., CPSP); Collaborating to deliver certain member-facing events (e.g., breastfeeding mom's lunch and learn).
Departments of Child Welfare Services	CalViva Health will maintain MOUs with Local Departments of Child Welfare Services in all services areas and will meet with the departments quarterly at minimum, as is required under the new State contract.
Women, Infants and Children (WIC) Supplemental Nutrition Programs	CalViva Health has an MOU in place with Fresno Economic Opportunity Commission (EOC) concerning the arrangement and coordination of Women, Infant, and Children Supplemental Nutrition Program (WIC) services to CalViva members who are enrolled in Fresno County. CalViva Health will also maintain MOUs with the local WIC programs in all services areas and will meet with the WIC programs quarterly at minimum, as is required under the new State contract.
County Targeted Case Management Programs	CalViva Health will maintain MOUs with Local County Targeted Case Management (TCM) programs *(where applicable)* in all services areas and will meet with the TCM programs quarterly at minimum, as is required under the new State contract.
First Five programs and providers	CalViva Health will maintain MOUs with the local First Five programs in all services areas and will meet with these programs quarterly at minimum, as is required under the new State contract. We participate in coalitions and help establish processes for local programs. We provide First Five with sponsorships as needed or requested.
Justice Departments & Correctional Facility Partners and Programs	CalViva Health will maintain MOUs with the local Justice Departments/Correctional Facility partners and program in all services areas and will meet with the JI/CI partners quarterly at minimum, or as directed by DHCS, as is required under the new State contract.
Schools and Local Education Agencies	CalViva Health has agreements in place with three Local Education Agencies (LEAs), Fresno County Office of Education (FCOE), Fresno Unified School District (FUSD) and Clovis Unified School District (CUSD). We will be working to execute memorandum of understandings (MOUs) with LEAs in all service areas under the new State contract requirements. We meet regularly with FCOE, FUSD and CUSD, and will maintain, at minimum, quarterly engagement with LEA partners in all service areas under the new State contract requirements as well. CalViva Health partnership activities with schools and LEAs include, but are not limited to, participation in on-site health fairs, support for back-to-school events and trainings, etc. We also provide grant support to schools and LEAs for workforce training and development, as well as infrastructure and support for the expansion of telehealth services in schools. We do not currently participate on any School or LEA boards, but this is something in which will look to more involved in the future.

Early Start	Plan works with Early Start through local health departments. We participate in coalitions and help establish processes for local programs. We meet on an as-needed basis. We provide Early Start with sponsorships as needed or requested.
California Work Opportunity and Responsibility to Kids (CalWorks)	Plan provides warm-handoffs and referrals to support our members who can benefit from CalWorks services. Example of warm-handoff: While speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalWorks program, we will 3-way call the CalWorks Customer Service number (California Department of Social Services) and connect our members to a CalWorks representative to ensure our member is connected to CalWorks benefits.
CalFresh	Plan provides warm-handoffs when possible and referrals to support our members who can benefit from CalFresh services. Example of warm-handoff: While we are speaking to a member on the phone, and we identify through listening to our member that they might benefit from the CalFresh program, we will 3-way call the California Department of Social Services and connect our member to a CalFresh representative to ensure our member is connected to CalFresh benefits.
Supplemental Security Income (SSI)	Plan provides warm-handoffs and referrals to support our members who can benefit from SSI services. Warm hand-off Example: While we are speaking to a member on the phone, and we identify through listening to our member that they might be eligible for SSI, we will 3-way call the Social Security Administration and make an appointment for our member to apply for SSI. 2. We do not provide financial support or investments to SSI. 3. We do not have involvement with SSI boards or governance structures.

Activities Which Support PHM Programs and Services

In order to support network providers as they strive to achieve their population health management goals, we provide the following:

Delivery System Supports

Data and information sharing with practitioners

We share an extensive amount of data with providers partners. Data shared with providers includes pharmacy, enrollment, care gaps, claim/encounters, financial, and various utilization (inpatient, outpatient and ED) information. In addition, disease management program enrollment reports are also shared with our strategic provider partners. Data is shared at various frequencies (daily, weekly, monthly, yearly) via the Plan provider portal, secure email, SFTP, fax or mail. The method of data transmission varies based on the data being shared as well as provider preference. We exchange admission, discharge transfer (ADT), Observation Result (ORU), and consolidated clinical document architecture (C-CDA) data through Health Information Exchanges (HIEs).

We implemented additional bidirectional data exchange processes with other CoCs as well as exchanging Behavioral Health data with various counties across California.

We have improved our IT Capabilities under the umbrella of our Cal AIM program including:

1. We've invested CalAIM Incentive Payment Program (IPP) funding in our ECM and Community Supports (CS) providers to:
    1) increase the number of contracted Enhanced Care Management (ECM) providers that engage in bi-directional Health Information Exchange (HIE);
    2) ensure our contracted ECM providers have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan; and
    3) ensure our contracted ECM and Community Supports providers have the ability to submit a claim or invoice to the Plan or have access to a system or service that can process and send a claim or invoice to the Plan with the information necessary for the MCP to submit a compliant encounter to DHCS.
2. We are connected to the local Homeless Management Information Systems (HMIS) for member matching and receiving timely alerts when a Member experiences a change in housing status. We also support data sharing with housing-related services Community Supports providers on Member's housing status information.
3. ECM is an end-to-end solution that provides a whole-person approach to care that are medically appropriate and addresses the clinical and non-clinical needs of the member. ECM providers receive a monthly member information file (MIF) and are required to submit a return transmission file (RTF) of enrolled members.
4. Findhelp is an online platform with a network of social programs across the state. We are creating a closed-loop referral system to appropriate Community Supports and other community and social services including financial assistance, food pantries, medical care, transportation, and other free or reduced-cost services. The referral process ensures a seamless experience for the provider and member.

A Closed-Loop Referral (CLR) is a referral initiated on behalf of a member that is tracked, supported, monitored and results in a known closure. A known closure occurs when a member's initial referral loop is completed with a known closure reason such as the member receiving services. The goal of CLRs is to increase members successful connection to the services they need by identifying and addressing gaps in referral practices and service availability. The Plan is taking steps to collect and report CLR data for ECM and Community Supports by 7/1/2025 to ensure more members are connected to needed services.

Exchange of member information and medical records is done in accordance with professional standards and state and federal privacy laws and regulations.

Value-based payment arrangements

We encourage providers to participate in value-based payment arrangements. Our value-based incentive programs reward both professional and hospital providers who achieve program goals in areas critical to the success of PHM such as quality outcomes, care coordination, access to care, overall medical costs and patient satisfaction. Data used to inform provider performance within incentive programs align with industry standard benchmarks/metrics and is sourced from health plan data. Below you will find incentive program components detail.

Incentive Payments

Description: The Plan offers incentives to network providers who achieve program goals in one or more of the below areas.

Capitation: Pre-paid PMPM payments for professional or professional and hospital services place responsibility for cost management on the providers and hospitals.

Incentive Program Components

- Quality – Providers delivering high value, quality care, and not just a high volume of care, are eligible to earn an incentive payment for meeting Medicaid thresholds for HEDIS clinical quality measures.
- Encounter Data – Sharing patient encounter data is an essential aspect of assessing patient risk for subsequent clinical intervention as well as assessing providers for the quality of care they are delivering. Providers earn an incentive by meeting encounter data delivery thresholds.
- Access to care – the Plan offers incentives to PPGs to ensure their primary care providers and specialists have appointment availability for both urgent and non-urgent visits.

Ability to view evidence-based practice guidelines on demand

We provide clinical practice guidelines to network providers via access to the Plan's provider portal. The clinical practice guidelines are recommendations intended to optimize patient care for specific clinical circumstances to all network providers. They are based on professionally recognized standards and systemically developed through a formal process with input from practitioners and based on authoritative sources including clinical literature, studies, and expert consensus. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based. Board-certified practitioners who will utilize the guidelines are given the opportunity to review and give advice on the guidelines through the Centene Corporate Clinical Policy Committee (CPC). Guidelines are updated at least every two years or upon significant new scientific evidence or changes in national standards.

Providing practice transformation support

We offer provider communication and webinars to support the sharing of updates and best practices. In addition, we offer 1-to-1 training with providers, clinics and medical groups and design integrated workflows to streamline transition of care. We share population health risk data with Medical Groups to support the identification of Member needs. Ultimately, all of this fosters care collaboration, provider engagement and holistic care. Enhancing provider engagement can have a dramatic impact on health plan performance, lead to improved clinical outcomes, quality ratings, member retention, member satisfaction, and overall efficiency.

Coordination of Member programs

We use the following tactics to coordinate across Member programs and services, including programs Members may receive through their provider care team:

Copy of care plan and/or interventional program description sent to Member's practitioner inviting them to participate in the development of the care plan and attend interdisciplinary care team meetings as needed.

- Defining a program hierarchy so Members don't receive outreach from multiple programs. The following hierarchy is used to determine which entity will be the primary point of contact, unless Member specific evaluation demonstrates otherwise:

1. Delegated Participating Physician Group (PPG) Concurrent Review and Care Management
    a. Example: To avoid duplicative outbound calls, a data analyst reviews potential care management list in Impact Pro and excludes Members who are assigned to a Delegated PPG as well as those already enrolled and engaged with Care Management
2. Health Plan Concurrent Review (e.g., Inpatient Concurrent Review)
3. Plan Complex Care Management
4. Plan Care Management
5. Special or Disease Specific Clinical Programs (e.g., Transitional Care Services, First Year of Life)
6. Disease Management
7. Auxiliary services may run concurrently as coordinated and requested by the primary Care Manager with the consent of the Member.
    a. Examples: Wellness Coaching (smoking cessation, weight management), Life Solutions evaluation for home safety, field-based Member Connection outreach for difficult to engage Members, Licensed Clinical Social Worker (LCSW) assessments, special PPG programs, ECM providers, Doulas and CHWs, etc.

EXAMPLE OF HIERARCHY IMPLEMENTATION:

- Care Management participates in Utilization Management inpatient concurrent review rounds to determine if Care management services are needed post discharge.
- Participating Physician Groups (PPGs) and Providers may submit referral directly (via fax/email referral form) to plan CM. If care management is delegated to the PPG, the plan refers the Member to the PPG for follow up.
- While the Member is enrolled in CM, the care manager will look at open care gaps and assist the Member to fulfill them.
- If an enrolled Member enters an inpatient setting the Concurrent Review staff identifies the Care manager involved and keeps the CM updated on status and discharge.

- Clinical program documentation processes are in a single medical management system platform (TruCare): Members actively enrolled in clinical programs are flagged in the common documentation platform to avoid duplication of outreach calls.

  EXAMPLES:
  - Alerts placed Member record in the Medical Management System are visible to staff when the Member record is accessed.
  - Tasks generated within the system from one process to another informing the recipient of activity to complete.
  - Inbound and outbound calls related to CM programs, tasks, notes, assessments, and correspondence are captured and dated within the medical management system and are visible to associates with access to the Member record.
- Assigning a single care coordinator and/or Co-Management to address all of the Member's needs:
  - Integrated Care Management: Integrated Care involves managing the Member's physical, behavioral, and psychosocial needs (including SDoH needs) with the care manager as the primary point of contact for the Member. This holistic approach lessens the complexity for our Members and aligns with our overall population health program.
  - Behavioral Health (BH) and Physical Health (PH) Care Management Coordination: for new BH CM referrals of Members enrolled in open PH CM, the PH Care manager coordinates with

the referring party and BH CM to determine which CM staff will be the primary Care manager. Co-management may occur between BH and PH during CM rounds, and by documentation in a common platform. With Member's express permission, both BH and PH CM may work with Member, but always coordinating outreach and discussing during rounds.
    - The BH CM coordinates with Regional Centers to coordinate services falling within their domain.
    - The Care Manager coordinates with county programs and other external entities to facilitate services and programs available to the Member.

- Multi-disciplinary, cross functional rounds and/or workgroups to develop and maintain strategies for efficient clinical program coordination:
    - Preventative Health Work group QI, Health Education, Medical Management, Health Programs, Care Management, Member Services, Community Grants, Provider Relations, HEDIS, Enrollment Services, Member Experience, Health Equity, and Practice Transformation departments meet regularly to review Member outreach for various health measures, coordinate efforts and minimize duplication.

- Interdisciplinary/Integrated Care Management Team Rounds:
    - Care Management rounds are routinely conducted with a team-based approach, using Care Managers, Social Workers, Registered Dietitian, Pharmacists, Behavioral Health, and Medical Directors to coordinate between departments for specific Members, and develop and/or support a comprehensive care plan. Reports are shared with key internal stakeholders for care coordination.
    - On an annual basis, we report on population health metrics including a population health summary and risk factor analysis based on a Initial Health Appointment.

- CalViva Pregnancy Program:
    - Care Managers may discuss the Member during utilization or care management rounds, the Member will be referred as appropriate when it is identified a Member may benefit from information in another program and/or when care coordination is required across processes.

- Disease Management Reports:
    - Key operational and clinical measures for each Disease Management program are reported annually which summarize key enrollment and engagement metrics by program and describe utilization performance and quality measures for the Disease Management population and population health metrics including a population health summary.

- Sharing of Member outreach data:
    - Information regarding our preventive health programs, such as influenza immunizations, and documentation of member outreach/activities is provided to our Customer Contact Center (CCC) via notification and available in our internal database (Central Point) in order to increase awareness so that Customer Service Representatives can answer incoming questions from our members and direct members to the available resources.

- Standardized Protocols for Unable to Reach Members: Each clinical program follows a standard protocol for the number and frequency of outbound attempts to reach Member to avoid multiple or intrusive calls to Members. All outreach is documented in the common platform.

- Integrated Care Management: A standard number of outbound call attempts are followed by a letter.
- Disease Management: Establishes a set number of call attempts for Members with a valid phone number, then sends an outreach letter.
- Disengaged/housing insecure or homeless member support: Street Medicine providers support in reaching the most difficult to reach populations and provide basic care coordination and connection to PCP.

- Standardized Protocols for Members opting out of clinical programs:
  - Members wishing to opt out of clinical programs are flagged and set for future outbound calls according to protocol, respecting their wishes while adhering to regulatory compliance guidelines.

Informing Members about Available PHM Programs

We provide Members with information about all available PHM programs and services through the following:

- New Member Welcome letter sent via United States (US) Postal Mail
- Unsolicited Phone Call Outreach based on identified health needs post risk stratification
- Solicited Phone Calls for Members who agree to be actively enrolled in programs
- E-mail
- Plan Website
- Annual Plan Newsletter
- Face to face visits

Informing Members about PHM Programs – Interactive Contact

Staff engage Members that are eligible for programs which include interactive contact with the Plan to notify them of the following key information: See Appendix C

Key Program Attributes Communication Check list

- To inform Member of how they became eligible to participate in the specific program
- How they can opt-in the individual program
- How they can opt-out of the individual program

Key Modes of Communicating Program Information

- Welcome letter to welcome the Member to get them oriented with the program and all of the available program benefits, including all of the aforementioned key program elements.
- Unsolicited Phone Call Outreach based on identified health needs post risk stratification.
- Solicited Phone Calls for Members who agree to be actively enrolled in programs and are identified as eligible for other potential beneficial programs.
- On occasion the CM staff may request a MemberConnections Representative make a face-to-face visit with the Member.
- Members may opt in to an automated texting program to receive reminders, and pregnancy health education.

Appendix A

This table contains guidance to determine specific HEDIS SSD NDC list

HEDIS SSD NDC list	HEDIS SSD NDC List.xlsx

Appendix B

This table contains guidance to PHM Level and KPI tools Overview

PHM Level and KPI tools Overview	PHM Level and KPI tools Overview.pdf

Appendix C

This table contains guidance to determine specific medical conditions that are included within each population health category

Level 01: Healthy	Includes Members that meet *ALL* of the following criteria: No chronic conditions See Attachment Chronic Conditions.docx No behavioral health conditions See Attachment Behavioral Health Conditions.docx Risk of future costs for the next 12 months: • When age <65 then risk of future costs < 2 ○ When age >= 65 then risk of future costs < 4 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits regardless of the reason in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.doc No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities.

	No drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx
Level 02: Acute Episodic	Includes Members that meet both of the following criteria: No chronic conditions See Attachment  Chronic Conditions.docx No behavioral health conditions See Attachment  Behavioral Health Conditions.docx AND *one* or more of the criteria below 1 or more emergency room visits regardless of the reason in the last 12 months 1 or more inpatient stays regardless of reason in the last 12 months
Level 03: Healthy, At Risk	Includes Members that meet both of the following criteria: No chronic conditions See Attachment  Chronic Conditions.docx No behavioral health conditions See Attachment  Behavioral Health Conditions.docx AND NOT in any of the following categories 01: Healthy 02: Acute Episodic
Level 04a: Chronic, Big 5: Stable	Includes Members that meet *all* of the following criteria: Diabetes or COPD or Asthma or CHF or CAD Risk of future costs for the next 12 months: ○ When age <65 then risk of future costs < 2 ○ When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits with a primary diagnosis of diabetes, CAD, CHF, asthma or COPD in the last 12 months No medication adherence gaps: See Attachment

	Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx AND NOT in any of the following categories: 04b: Chronic, other condition, stable 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 04b: Chronic, Other Condition: Stable	Includes Members that meet *all* the following criteria: 1 or more non big 5 chronic conditions See Attachment Chronic Conditions.docx Risk of future costs for the next 12 months: ○ When age <65 then risk of future costs < 2 ○ When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No "True" emergency room visits in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment

	Clinically Important Care Opportunities. No drug safety care opportunities See Attachment Drug Safety Care Opportunities.docx AND NOT in any of the following categories: 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 04c: BH Primary: Stable	Includes Members that meet *all* of the following criteria: 1 or more behavioral health conditions that are not flagged as high needs See Attachment Behavioral Health Conditions.docx Risk of future costs for the next 12 months: • When age <65 then risk of future costs < 2 • When age >= 65 then risk of future costs < 4 Behavioral Health Risk Score < 20 Risk of an admission in the next 12 months < 10% No inpatient stays regardless of reason in the last 12 months No emergency room visits regardless of reason in the last 12 months No medication adherence gaps: See Attachment Medication Adherence Gaps.do No 'clinically important' care opportunities See Attachment Clinically Important Care Opportunities. No drug safety care opportunities See Attachment

	Drug Safety Care Opportunities.docx OR A behavioral health condition that is not flagged as high needs AND NOT in any of the following categories: 04a: Chronic Big 5, Stable 04b: Chronic, other condition, stable 05a: Health Coaching 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05a: Health Coaching	Includes Members that meet both the following criteria: Diabetes or COPD or Asthma or CHF or CAD or HbA1c over 9 Behavioral Health Risk Score < 20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: ○ When age <65 then risk of future costs between 2 ○ When age >= 65 then risk of future costs between 4 Risk of an admission in the next 12 months between 10% 1 or more inpatient stays with a primary diagnosis of diabetes, CAD, CHF, asthma, or COPD in the last 12 months 1 or more “True” emergency room visits in the last 12 months 1 or more emergency room visits with a primary diagnosis of diabetes, CAD, CHD, asthma or COPD in the last 12 months 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.doc 1 or more ‘clinically important’ care opportunities See Attachment Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment

	Drug Safety Care Opportunities.docx A Big 5 condition with 1 or more diagnosis of: • Atherosclerosis • Hyperlipidemia • Obesity • Hypertension AND NOT in any of the following categories: 05b: Physical Health Care Management 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05b: Physical Health Care Management	Includes Members that meet both the following criteria: 1 or more non big 5 chronic conditions See Attachment Chronic Conditions.docx Behavioral Health Risk Score <20 AND meet 1 or more of the following criteria: Risk of future costs for the next 12 months: • When age <65 then risk of future costs greater than or equal to 2 • When age ≥ 65 then risk of future costs greater than or equal to4 Risk of an admission in the next 12 months greater than or equal to10% 1 or more inpatient stays regardless of reason in the last 12 months 1 or more “True” emergency room visits in the last 12 months 1 or more medication adherence gaps: See Attachment Medication Adherence Gaps.doc 1 or more ‘clinically important’ care opportunities See Attachment

	 Clinically Important Care Opportunities. 1 or more drug safety care opportunities See Attachment  Drug Safety Care Opportunities.docx PRG risk greater than 10 AND NOT in any of the following categories: A Big 5 condition with 1 or more diagnosis of: • Atherosclerosis • Hyperlipidemia • Obesity • Hypertension 05c: Behavioral Health Care Management 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 05c Behavioral Health Care Management	Includes Members that meet the following criteria: Flagged as having a high behavioral health needs status based on either having: • High mental health risk • High substance-use disorder risk AND NOT in any of the following categories: 06: Rare High Cost Conditions 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL

Level 06: Rare High Cost Condition	1 or more rare, high cost conditions See Attachment  Rare High Cost Conditions.docx AND NOT in any of the following categories: 07a: Catastrophic: Dialysis 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07a: Catastrophic: Dialysis	1 or more claims indicating dialysis services in the most recent 12 months AND NOT in any of the following categories: 07b: Catastrophic: Active Cancer 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07b: Catastrophic: Active Cancer	1 or more episodes of care indicating active cancer treatment in the most recent 12 months AND NOT in any of the following categories: 07c: Catastrophic: Transplant 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 07c: Catastrophic Transplants	1 or more of the following transplants in the most recent 12 months: • Bone Marrow • Heart • Liver • Lung

	• Pancreas • Renal AND NOT in any of the following categories: 08a: Dementia 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 08a: Dementia	2 or more claims indicating dementia in the most recent 12 months AND NOT in any of the following categories: 08b: Institutional (custodial care) 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 08b: Institutional (custodial care)	1 or more claims with a place of service code=33 (Custodial Care Facility) AND NOT in any of the following categories: 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management 10: EOL
Level 09a: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – Service Coordination	Includes Members that meet *one* or more of the criteria below: Be enrolled in an LTC or MMP product, that do not have a high-needs condition AND NOT in: 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High-Needs Care Management
Level 09b: Long-Term Supportive Services and Medicare-Medicaid Plan and DSNP – High Needs Care Management	Includes Members that meet *one* or more of the criteria below: Be currently enrolled in at least one of the LTSS/MMP products 1 or more claims in the last 12 months with any of the following diagnoses in any position ○ Traumatic Brain Injury (TBI) ○ Cystic Fibrosis ○ Multiple Sclerosis ○ Hip or Pelvic Fracture ○ Ulcers

	○ Spinal Cord Injury ○ Acute Myocardial Infarction (AMI) ○ Muscular Dystrophy ○ Learning Disabilities ○ Spina Bifida ○ Fibromyalgia ○ Intellectual Disabilities ○ Other Developmental Delays ○ Migraine Please refer to attachment for a list of diagnosis codes that correspond to the above clinical groups. LTSS High Needs Codes.xlsx
Level 10: End of Life (Non-LTSS)	Includes Members that meet one or more of the criteria below: 1 or more claims in last 12 months indicating hospice care OR Metastatic Cancer AND NOT in any of the following categories: 09a: Long-Term Supportive Services and Medicare-Medicaid Plan – Service Coordination 09b: Long-Term Supportive Services and Medicare-Medicaid Plan – High Needs Care Management

References

Oversight	Reference	Cross Reference
DHCS	APL 22-024	
NCQA	PHM.1.A.1	Four Focus Areas
	PHM.1.A.2	Focus Areas Programs or Services Offered
	PHM.1.A.3	Activities Which Support PHM Programs and Services
	PHM.1.A.4	Coordination of Member programs
	PHM.1.A.5	Informing Members about Available PHM Programs
	PHM.1.A.6	Basic Population Health Management (BPHM) (Health Equity Improvement Model)
	PHM.1.B	Informing Members about PHM Programs – Interactive Contact
	PHM.2.A	Population Stratification
	PHM.2.B	Population Needs Assessment (PNA)
	PHM.2.C	PNA Activities
	PHM.2.D	Population Stratification, Focus Areas,
	PHM.3.A	Activities Which Support PHM Programs and Services

Fresno-Kings-Madera Regional Health Authority Commission Approval

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

David S. Hodge

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

March 20, 2025
Date

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

March 20, 2025
Date