FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Sal Quintero
Board of Supervisors

Joyce Fields-Keene
At-large

Soyla Reyna-Griffin
At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn, Director
Public Health Department

Lisa Lewis, Ph.D.
At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

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

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

DATE: July 12, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Cheryl Hurley, Commission Clerk

RE: Commission Meeting Materials

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

Thursday, July 18, 2024
1:30 pm to 3:30 pm

Where to attend:

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

Meeting materials have been emailed to you.

Currently, there are **10** Commissioners who have confirmed their attendance for this meeting. At this time, a quorum has been secured. Please advise as soon as possible if you will not be in attendance to ensure a quorum can be maintained.

Thank you

AGENDA

Fresno-Kings-Madera Regional Health Authority
Commission Meeting
July 18, 2024
1:30pm - 3:30pm
Meeting Location: **1)** CalViva Health
7625 N. Palm Ave., Suite 109
Fresno, CA 93711

Item	Attachment #	Topic of Discussion	Presenter
1		**Call to Order**	D. Hodge, MD, Chair
2		**Roll Call**	C. Hurley, Clerk
3 Action	Attachment 3.A Attachment 3.B Attachment 3.C Attachment 3.D Attachment 3.E Attachment 3.F Attachment 3.G Attachment 3.H Attachment 3.I Attachment 3.J	**Consent Agenda:** • Commission Minutes dated 5/16/24 • Finance Committee Minutes dated 3/21/24 • QIUM Committee Minutes dated 3/21/24 • Public Policy Committee Minutes dated 3/6/24 • Finance Committee Charter • Credentialing Committee Charter • Peer Review Committee Charter • Quality Improvement/Utilization Management Charter • Public Policy Committee Charter • Compliance Report *Action: Approve Consent Agenda*	D. Hodge, MD, Chair
4 Action	No attachment	**Closed Session:** **The Board of Directors will go into closed session to discuss the following item(s)** **A. Public Employee Appointment, Employment, Evaluation, or Discipline** Title: Chief Executive Officer Annual Review Per Government Code Section 54957(b)(1)	
5 Information	No attachment	**Promotores Network 10 year anniversary**	C. Shapiro, Director, Community Relations & Marketing
6 Information	Attachment 6.A	**Review of Fiscal Year End 2024 Goals** • BL 24-006 Review of Fiscal Year End Goals 2024	J. Nkansah, CEO

7 Action	Attachment 7.A	**Goals and Objectives for Fiscal Year 2025** • BL 24-007 Goals and Objectives FY 2025 *Action: Approve Goals for FY 2025*	J. Nkansah, CEO
8 Action	Attachment 8.A	**FKM RHA Revised Bylaws** • Review of revised Bylaws *Action: Approve revised Bylaws*	J. Nkansah, CEO
9 Information	No attachment	**Update on Existing Litigation: Case #21CV381776**	J. Nkansah, CEO
10 Action	Attachment 10.A Attachment 10.B	**Revised Annual Delegation Oversight of Health Net** • BL 24-008 Annual Delegation Oversight of HN • 2023 Annual Delegation and Oversight Monitoring Report *Action: Approve Revised Annual Delegation Oversight Report*	J. Nkansah, CEO
11 Information	No attachment	**Quality Improvement** • HEDIS® Update	P. Marabella, MD, CMO
12 Information	Attachment 12.A	**Case Management** • 2023 Program Evaluation & Executive Summary	P. Marabella, MD, CMO
13 Action		**Standing Reports**	
	Attachment 13.A	**Finance Report** • Financials as of May 31, 2024	D. Maychen, CFO
	Attachment 13.B Attachment 13.C Attachment 13.D Attachment 13.E Attachment 13.F	**Medical Management** • Appeals and Grievances Report • Key Indicator Report • Quarterly Summary Report • Credentialing Sub-Committee Quarterly Report • Peer Review Sub-Committee Quarterly Report	P. Marabella, MD, CMO
	No attachment	**Health Equity Report** • Equity update	Sia Xiong-Lopez, EqO
	Attachment 13.G	**Executive Report** • Executive Dashboard *Action: Accept Standing Reports*	J. Nkansah, CEO
14		**Final Comments from Commission Members and Staff**	D. Hodge, MD, Chair

15	**Announcements**	D. Hodge, MD, Chair
16	**Public Comment** *Public Comment is the time set aside for comments by the public on matters within the jurisdiction of the Commission but not on the agenda. Each speaker will be limited to three (00:03:00) minutes. Commissioners are prohibited from discussing any matter presented during public comment except to request that the topic be placed on a subsequent agenda for discussion.*	D. Hodge, MD, Chair
17	**Adjourn**	D. Hodge, MD, Chair

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

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

Next Meeting scheduled for September 19, 2024 in Fresno County
CalViva Health, 7625 N. Palm Ave., Ste. 109, Fresno, CA 93711

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

Item #3
Attachment 3.A-J

Consent Agenda

A. Commission Minutes dated 5/16/24
B. Finance Committee Minutes dated 3/21/24
C. QIUM Committee Minutes dated 3/21/24
D. Public Policy Committee Minutes dated 3/6/24
E. Finance Committee Charter
F. Credentialing Committee Charter
G. Peer Review Committee Charter
H. Quality Improvement/Utilization Management Charter
I. Public Policy Committee Charter
J. Compliance Report

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
Commission
Meeting Minutes
May 16, 2024

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

	Commission Members		
✓	**Sara Bosse**, Director, Madera Co. Dept. of Public Health	✓	**David Luchini**, Director, Fresno County Dept. of Public Health
	David Cardona, M.D., Fresno County At-large Appointee	✓	**Aftab Naz,** M.D., Madera County At-large Appointee
	Aldo De La Torre, Community Medical Center Representative	✓	**Joe Neves**, Vice Chair, Kings County Board of Supervisors
✓*	**Joyce Fields-Keene,** Fresno County At-large Appointee	✓	**Lisa Lewis**, Ph.D., Kings County At-large Appointee
✓	**John Frye**, Commission At-large Appointee, Fresno	✓	**Sal Quintero**, Fresno County Board of Supervisor
	Soyla Griffin, Fresno County At-large Appointee	✓	**Rose Mary Rahn**, Director, Kings County Dept. of Public Health
	David Hodge, M.D., Chair, Fresno County At-large Appointee	✓	**Jordan Wamhoff (*alternate*)**, Madera County Board of Supervisors
✓*	**Kerry Hydash**, Commission At-large Appointee, Kings County	✓	**Jennifer Armendariz**, Valley Children's Hospital Appointee
		✓	**Paulo Soares**, Commission At-large Appointee, Madera County
	Commission Staff		
✓	**Jeff Nkansah**, Chief Executive Officer (CEO)	✓	**Mary Lourdes Leone**, Chief Compliance Officer
✓	**Daniel Maychen**, Chief Financial Officer (CFO)	✓	**Amy Schneider**, R.N., Senior Director of Medical Management
✓	**Patrick Marabella, M.D.,** Chief Medical Officer (CMO)	✓	**Cheryl Hurley**, Commission Clerk, Director Office/HR
	General Counsel and Consultants		
✓	**Jason Epperson**, General Counsel		
✓= Commissioners, Staff, General Counsel Present			
* = Commissioners arrived late/or left early			
● = Attended via Teleconference			

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#1 Call to Order	The meeting was called to order at 1:30 pm. A quorum was present.		
#2 Roll Call Cheryl Hurley, Clerk to the Commission	A roll call was taken for the current Commission Members.		*A roll call was taken*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#3 FKM RHA Appointment/ Reappointments Action J. Neves, Co-Chair	The Commission voted unanimously to ratify and reappoint the following Commissioners: • Ratify Soyla Reyna-Griffin, Fresno County At-large BOS Commissioner • Ratify Aldo De La Torre, CRMC reappointed Commissioner • Ratify official appointment of Department of Public Health, David Luchini, Fresno County • Ratify official appointment of Department of Public Health, Rose Mary Rahn, Kings County • Ratify Jennifer Armendariz, Valley Children's Hospital		***Motion**: All appointments / reappointments were approved* *11 – 0 – 0 – 6* *(Soares / Frye)*
#4 Consent Agenda • *Commission Minutes dated 3/21/24* • *Finance Committee Minutes dated 2/15/24* • *QI/UM Committee Minutes dated 2/15/24* Action J. Neves, Co-Chair	All consent items were presented and accepted as read.		***Motion**: Consent Agenda was approved.* *12 – 0 – 0 – 5* *(Naz / Lewis)*
#5 Closed Session	Jason Epperson reported out of Closed Session. The report out of closed session, the Commission discussed in closed session the items agendized for closed session discussion, specifically #5.A Public Employee, title Equity Officer, pursuant to Government section code 54957(b)(1); and item #5.B conference report involving trade secret pursuant to Government code 54954.5. The Commission discussed these items, gave direction to staff, and took no other reportable actions. Closed session recessed at 2:00 pm.		***No Motion***
#6 Chair and Co-Chair Nominations for FY 2025	The Commissioners nominated and subsequently re-elected David Hodge, MD as chair and Supervisor Joe Neves as Co-Chair to serve during Fiscal Year 2025.		***Motion:** Consent Agenda was approved.* *12 – 0 – 1 – 4*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
Action J. Nkansah, CEO			*(Naz / Fields-Keene)*
#7 CEO Annual Review Ad-Hoc Committee Selection Action J. Neves, Co-Chair	Commission members selected for the CEO Annual Review ad-hoc committee are Dr. Hodge, Dr. Naz, John Frye, and Paulo Soares.		***Motion:*** *Commissioners selected and approved ad-hoc committee for CEO annual review.* *13 – 0 – 0 – 4* *(Soares / Rahn)*
#8 Sub-Committee Members for FY 2025 Information J. Neves, Co-Chair	No changes in Commission members were made for FY 2025 to the following committees, as described in BL 24-004: • Finance Committee • Quality Improvement/Utilization Management Committee • Credentialing Sub-Committee • Peer Review Sub-Committee • Public Policy Committee		***No Motion***
#9 Community Support Funding Action J. Nkansah, CEO	The Community Support Grant Recommendations were presented to the Commission with funding at $4,325,000 for 2024-2025 fiscal year. The ad-hoc committee reviewed the funding recommendations on April 16, 2024, and April 29, 2024, and voted to move to full Commission for approval. Commissioner Sara Bosse and Commissioner David Luchini stated they both have a conflict of interest with EPU and will abstain their vote on this item at the recommendation of general counsel.		***Motion:*** *Approve Community Funding Grant Recommendations* *11 – 0 – 2 – 4* *(Frye / Fields-Keene)*
#10 Health Equity Program Description and Work Plan Evaluation • 2023 Exec Summary & Annual Evaluation • 2024 Change Summary & Program Description	Dr. Marabella presented the Health Equity Program Description and Work Plan Evaluation. Work Plan activities completed in four areas include: • Language Assistance Services ○ Newsletter informing members on how to access language services completed and disseminated.		***Motion****: See item #12 for motion.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
• 2024 Exec Summary & Work Plan Action P. Marabella, MD, CMO	○ 86 staff completed their bilingual assessment / re-assessment. ○ 28 translation reviews were completed in 2023. ○ Successfully integrated sexual orientation gender identity (SOGI) and preferred pronouns and name into OMNI. • Compliance Monitoring ○ HEQ reviewed 4 interpreter complaints and 45 grievance cases with 3 interventions identified. ○ 2 *findhelp* trainings were completed with 753 overall new programs added to the platform. • Communication, Training and Education ○ One (1) A&G training completed on coding and resolution of grievances. ○ Nine (9) Call Center trainings conducted, and training decks updated. ○ Language identification poster for provider offices was remediated and posted in provider library. • Health Literacy, Cultural Competency, & Health Equity ○ Completed 6 cultural competency trainings for 350 providers. Trainings include (2) Healthcare Barriers for Gender Diverse Populations, (2) Implicit Bias, (2) Special Needs and Cultural Competency. ○ Completed 3 live cultural competency trainings for staff; 191 staff attended live trainings. ○ Conducted annual Heritage/CLAS Month with 14 live attendees and 4,300 staff who read the newsletter. ○ Successfully co-led and supported the completion of quality projects. Projects targeting the following HEDIS® measures: CIS-10, WCV, and CDC. The Health Equity Program Description changes for 2024 include: • Expanded and added introduction to the Mission, Goals, and Objective section to align with the Health Equity Accreditation requirements. Added Vision to section. • Removed and enhanced mission and replaced with the following bullets: ○ Ensure language services meet regulatory requirements and achieve metric goals. ○ Achieve appropriate reading grade level requirements and cultural appropriateness at market and product levels.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	○ Complete staff and provider trainings for required topics. ○ Address health disparities through targeted cross-collaborative projects. ○ Implement social needs assistance strategies with integrated approaches for mitigating social risks. ○ Expanded on CLAS standards and the requirements it meets. ○ Added "Social needs and social risks all play into determining appropriate partners, selecting, engaging and taking initiatives with partners." ○ Expanded on the roles and objectives of the Governing Body and QI/UM Committee. ○ Broaden how data will be collected including SOGI data. ○ Added Equity Officer's role and responsibilities. The 2024 Work Plan is consistent with the 2023 Work Plan while incorporating and enhancing the following: • Added measurable objectives to Findhelp oversight based on Public Policy Committee's recommendation. • Updated the method for obtaining C&L materials to Provider Library. • Added "online" as way for staff to complete C & L training. • Expanded and consolidated cultural competency trainings. • Updated Quality Projects and included SUD/MH Non-clinical PIP. • Added IHI/DHCS Child Health Equity Sprint project. 2023 Language Assistance Program: • Spanish and Hmong are CalViva Threshold Languages. Spanish (97%) consistently has highest volume and Hmong was 3% of calls. • Interpretation was performed via the following: ○ 84% telephonic interpreters up from 74% in 2022 ○ 20% face-to-face – down from 24% in 2022 ○ 3% Sign language – up from 2% in 2022 ○ Video Remote Interpretation was zero (0) in 2023. • MHN results demonstrate similar language outcomes. • Limited English and non-English membership remain high for CVH population and therefore interpreter services are integral to maintaining safe, high-quality care.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
#11 Health Education Work Plan Evaluation • Executive Summary • 2023 Annual Evaluation **Action** P. Marabella, MD, CMO	Dr. Marabella presented the 2023 Health Education Executive Summary and 2023 Annual Work Plan Evaluation. The Plan is closing out the separate Health Education Program Documents as Health Education has been incorporated into the Quality Improvement Program Documents in 2024. The 2023 Annual Evaluation of Work Plan Summary of activities accomplished, and improvements made over the last calendar year consist of 15 initiatives with 40 measurable objectives. • Objective Outcomes: o 25 were attained as of the end of the year. o 1 was partially attained as of the end of the year. o 7 were not attained and did not meet the measurable objective as of the end of the year. o 2 were suspended given the Quality Department's quadrant analysis. o 5 were canceled. • Seven (7) initiatives were fully met: o Community Engagement o Behavioral Health o Preventive Health o Perinatal Education o Member Newsletter o Compliance o Department Promotion • Seven (7) initiatives did not meet, were suspended or canceled: o Chronic Disease Education-Asthma: Email and mailing campaigns were canceled because they have limited impact and are resource intensive. o Chronic Disease Education– Diabetes: outreach campaigns are in progress, and implementation will be contingent upon DHCS approval of the program.		***Motion:*** *See item #12 for motion.*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	○ Chronic Disease Education – Hypertension: the promotion of cardiovascular health resources is in progress. ○ Pediatric Education: call outreach to members via Concierge program for WCV Measure was not conducted. Family Unit HEDIS® outreach calls were completed for WCV measure. ○ Undocumented Outreach: this initiative has been canceled. ○ Obesity Prevention: This program had low enrollment, the team members are currently reviewing alternative ways to promote programs and health education resources through Providers and QR codes/links to program content. ○ Tobacco Cessation: this initiative was canceled due to email campaigns have limited impact, are resource intensive, and CVH has a low volume of emails provided by members. Continue to promote *Kick It California* program.	*Commissioner Dr. Naz stated there is a problem with finding Dieticians that accept Medi-Cal; and that this could potentially be a pilot project for CVH to develop.* *Dr. Marabella stated CVH did a project partnering with Clinica Sierra Vista a few years back for members with diabetes. The team partnered with a dietician that did outreach to members, provided virtual education, and then conducted individual follow up sessions with the members. This was a very successful program although the sample was small.*	
#12 Population Health Management **Action** P. Marabella, MD, CMO	Dr. Marabella presented the Population Health Management Strategy Program Description for 2024. The PHM Program is designed to ensure that all members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, which leads to longer, healthier, and happier lives, improved outcomes, and health equity. Core aspects of PHM program areas include: • Basic Population Health Management (BPHM) • Risk Stratification, Segmentation & Tiering (RSST) • Complex Care Management • Enhanced Care Management and Community Supports		***Motion:*** *See item #12 for motion.* *13 – 0 – 0 – 4* *(Neves / Naz)* *(Naz / Quintero)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Transitional Care Services The Risk Stratification, Segmentation & Tiering (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 vs rural • Race, ethnicity, language and • The unhoused and special needs population Algorithms include clinical and sociodemographic variables, bias testing, and UM data to stratify entire population (many data sources utilized). • Classify into Risk: Low, Medium, High and • Case Management Level: 1 to 5 Basic Population Health 2024 includes: • Access, Utilization, and Engagement with Primary Care. • Care Coordination, Navigation, and Referrals Across All Health and Social Services, including Community Supports. • Information Sharing and Referral Support Infrastructure. • Integration of Community Health Workers (CHWs) in PHM. • Wellness and Prevention Programs. • Programs Addressing Chronic Disease. • Programs to Address Maternal Health Outcomes. • PHM for Children. Highlights of Changes for 2024: • Updated Transitions of Care Program (TOC) to Transitional Care Services (TCS). • Added information on Public Policy Committee (PPC) and description of its role and actions to Stakeholder Engagement section. • Added ambulatory visits, vaccinations and immunizations to key aspects of member navigation support.		

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	• Added "Conducting initial outreach to member while they are inpatient to engage in the program and complete an inpatient discharge risk assessment" and "Coordinate care with hospital staff as needed to support safe transition to lower level of care" to list of what TCS program includes. • Removed Palliative program. • Updated Program services to include social media, multi-gap call outreach, tipsheets, Provider Best Practices guide, and Provider collaboration. • Updated Programs goals from CDC>9 to Glycemic Status >9. • Changed annual assessments to at least annually or when the member experiences a significant change in condition within LTC section. • Added disengaged/housing insecure or homeless member support information within Standardized Protocols for Unable to Reach Members section.		
#14 Standing Reports • **Finance Reports** Daniel Maychen, CFO	**Finance** <u>Financials as of March 31, 2024:</u> Total current assets recorded were approximately $767.5M; total current liabilities were approximately $621M. Current ratio is approximately 1.24. Total net equity as of the end of March 2024 was approximately $156.3M, which is approximately 877% above the minimum DMHC required TNE amount. Interest earned was approximately $6M, which is approximately $3.3M more than budgeted due to interest rates being higher than projected. Premium capitation income actual recorded was approximately $1.58B which is approximately $265.4M more than budgeted due to MCO taxes; DHCS paid MCO taxes for one quarter related to FY 2023, April through June FY 2023 quarter. This accounts for approximately $125.5M of the $265.4M in increase, the remaining is related to rates and enrollment being higher than projected. Total cost of medical care expense is approximately $1B which is approximately $132.8M more than budgeted primarily due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $43.2M, which is approximately $3.6M more than budgeted due to		***Motion**: Standing Reports Approved* *13 – 0 – 0 – 4* *(Frye / Naz)*

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	enrollment being higher than projected, and Medicaid disenrollments came in less than what was projected. MCO taxes actual recorded was approximately $517.3M, which is approximately $125.5M more than budgeted due DHCS paying the Plan MCO taxes related to the prior FY 2023, in FY 2024. Net income through March 31, 2024, was approximately $14.9M, which is approximately $8.3M more than budgeted primarily due to interest income being approximately $3.3M higher than projected, and rates and enrollment being higher than projected. <u>FY 2025 Proposed Budget</u> On March 21, 2024, the FY 2025 budget was reviewed and approved by the Finance Committee to move to the Commission for recommendation of full review and approval. FY 2025 enrollment projected to gradually decline throughout FY 2025 as DHCS works through the Medicaid disenrollment process. As of March 2024, the Plan's enrollment is approximately 435,000. It is projected by June 2025 the Plan's enrollment to be approximately 394,000. Revenues are projected to increase in comparison to prior year budget primarily due to an increase in MCO taxes which was approved by the Centers for Medicare and Medicaid Services ("CMS") noting a substantial increase in the MCO tax amount from previous years. In addition, an increase in capitation rates paid by DHCS to CalViva as a result of the additional funds generated by the new MCO tax which will be used to increase Medi-Cal rates. The State has increased the Medi-Cal fee schedule beginning 2024 to at least 87.5% of Medicare. On May 10th the State released the May revised 2024-2025 State budget. What was initially planned was an increase beginning 2025 for Provider rates, which includes Medi-Cal rates for primary care, specialty care, maternity care and non-specialty mental health related services to at least 100% of Medicare; this has been removed from the State budget. The Plan increased the capitation rate projections to account for these changes, but because the Plan knew there was a budget deficit looming, the Plan conservatively increased it only by approximately 1%. Total gross		

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	revenue impact will be approximately $12.5M. Net income impact will be approximately $188K less in net income. Taking into consideration the change to remove Medi-Cal provider rate increases beginning 2025, the Plan still believes the budget proposal is appropriate moving forward. Medical revenue is projected to be approximately $1.82B, which is approximately $84.2M more than budgeted due to MCO taxes increasing by approximately $30.9M, and an increase in rates and enrollment in comparison to FY 2024. Interest income is projected to be $4M, which is a $400K increase in comparison to FY 2024 due to the Plan allocating more funds to the money market funds and the interest rates staying higher than projected in comparison to FY 2024. Medical cost expense is projected to be approximately $1.18B, which is a $50.2M increase primarily due to rates and enrollment being higher than FY 2024. Administrative services fee expense is projected to be $53.7M which is approximately $2.3M more than budgeted primarily due to enrollment being higher than FY 2024. Salary, wages, and benefits expense is projected to be approximately $5M which is approximately $487K more than budgeted in FY 2024 due to potentially adding more staff to account for new programs moving into Medi-Cal Managed Care, including but not limited to NCQA, D-SNP, etc. Dues and subscriptions expense is projected to be approximately $298K, which is an increase of approximately $64K due to the trade associations that represent the Plan potentially hiring more staff to support the local health plans with regard to the new programs moving into Medi-Cal Managed Care. Grants expense is projected to be approximately $4.3M, which is an increase of approximately $400K to account for the new DHCS 2024 contract requirement that requires Plans to reinvest 5% of annual net income back into the community. In addition, if Plans fail to meet certain quality metrics that is published annually by DHCS, then the Plan would have to contribute an additional 7.5% of annual net		

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	income back into the community, specifically related to those quality measures that the Plan underperformed. Legal and professional fees expense is projected to be approximately $323K which is an increase of approximately $123K due to the project of adding an online member ID card option for members so that they can access their ID cards online. Recruitment expense is projected to be approximately $157K, which is $45K more than budgeted in FY 2024 due to paying placement fees to staffing agencies for their services in identifying new staff. MCO taxes are projected to be approximately $563.7M which is approximately $30.9M more than budgeted in FY 2024 due to the MCO tax having a built in escalating tax rate. Capital expenditure budget is projected to be $500K, which is an increase of $100K from FY 2024 due to vacant office space in the owned building. This is primarily due to accounting for any tenant improvements for potential new tenants. Net income is projected to be approximately $8.7M, which is approximately $192K less than budgeted for FY 2024 primarily due to an increase in admin expense net of increase of rates and enrollment. **Compliance Report**		
• **Compliance** Mary Lourdes Leone, CCO	Year to date there have been 169 Administrative & Operational regulatory filings for 2024; 12 Member Materials filed for approval; 43 Provider Materials reviewed and distributed, and 38 DMHC filings. There have been 13 potential Privacy & Security breach cases reported year to date. Since the 3/21/2024 Compliance Regulatory Report to the Commission, there were 3 new MC609 cases filed, of which 17 are under investigation. The 3 cases		

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	involved: 1) a non-participating provider, who is not enrolled as a Medi-Cal Fee-for-Service, who was identified for allegedly performing laboratory tests that their CLIA does not authorize, and for collecting payment from beneficiaries up front and not billing Medicare; 2) a non-participating laboratory was identified via data mining for billing a non-covered service; and 3) a CalViva member who allegedly has been placing fraudulent transportation requests for approximately three years The Annual Oversight Audits currently in progress since last reported include Marketing, Claims/PDR, and Health Equity. Audits completed since last reported consist of UMCM (CAP), Credentialing (CAP), and Behavioral Health. The Plan is currently awaiting response from DMHC relating to the CAP response submitted on 12/15/23 in reference to the 2022 Medical Audit. With regard to the DHCS 2023 Medical Audit, the Plan submitted its March CAP update on 2/26/24. DHCS has requested the Plan's final CAP response by 3/20/24. The Plan received the 2022 DMHC Final Audit Report on April 18, 2024, noting two findings: the Plan failed to identify PQIs in exempt grievances, and the Plan inappropriately denies post-stabilization care. The DMHC has referred the post-stabilization deficiency to the Office of Enforcement to assess the Plan's noncompliance with post-stabilization laws. DMHC will be conducting a follow-up audit within 18 months to address these findings. The Plan is in the process to issue a CAP to Health Net to begin to immediately remediate both these deficiencies. The Plan submitted the final 2023 Audit CAP response to DHCS on 3/27/2024, and DHCS closed the CAP on 4/19/2024. The Plan submitted all the Pre-Audit Documentation on 4/12/2024, and Verification Files on 5/3/2024. The Audit Entrance Conference will be held on 5/20/2024 via video teleconference and all interview sessions and file reviews will go through 5/31/2024.		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	With regard to the Annual Network Certifications, the Plan filed all the required documentation related to the 2023 Subnetwork Certification on 1/5/24. DHCS completed their initial review and asked for additional information on 2/20/2024 and 4/30/2024. The Plan submitted the additional information on 2/23/2024 and 5/3/2024 and is awaiting DHCS response. In addition, The Plan submitted the required documentation for the 2023 Annual Network Certification by 3/25/24 and is awaiting DHCS response. With regard to the Timely Access and Annual Network Reporting (TAR), the Plan submitted the annual Timely Access Report (TAR) and Annual Network Report (ANR) on 5/1/2024 and is awaiting DMHC response. In addition, DMHC issued a Network Findings Report with two findings related to Geographic Access and Data Accuracy. The Plan's response is due to the DMHC by September 9, 2024. DHCS' external auditor, Health Systems Advisory Group (HSAG), sent notification on 3/15/2024 that they will be conducting a new annual Network Adequacy Validation (NAV) audit of MCPs per CMS requirements. The Plan must submit the required documentation by 5/15/2024. The audit will take place between 6/3/2021-7/26/2024. On 5/6/24, Health Net, on behalf of CalViva, submitted CalViva's NCQA Audit documentation. CalViva anticipates filing the NCQA Health Equity Accreditation documents by 3/11/25. On 4/24/24, DMHC requested CalViva to submit, under its DMHC license, Health Net's subdelegated contracted vendor agreements for vendors that perform various Knox-Keene functions on behalf of CalViva. The Plan will need to submit all current 19 vendor contracts as separate amendments to the DMHC and any new future subdelegated contracts. Note, this was the first time since DMHC approved CalViva's license in 2010 that it is requiring these subcontract vendor agreements. Regarding Enhanced Care Management (ECM), on 2/2/24, DHCS issued to CalViva (and many other MCP plans) a "Pre-Cap" related to the Justice Involved POF with a focus on developing adequate provider networks and increasing uptake for this		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	POF. The Plan provided responses to the Pre-CAP on 3/18/24 and has not heard back. Regarding Community Supports, DHCS approval is still pending for the Community Supports MOC submitted on 1/29/24 for those services going live 7/1/24 [Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties; and Recuperative Care (Madera County). With regards to Long Term Care Carve-in, Phase II Network Readiness deliverables (i.e., additional attempts to contract and execute contracts) are due by 6/28/24. DHCS requires Plans and Third-Party Entities to submit updated MOU templates and to specify responsibilities under those MOUs. DHCS has provided base templates that the Plan must execute starting January 1, 2024, through January 1, 2025. DHCS will require quarterly status updates on the execution of those MOUs. Q1 2024 is due 4/30/2024. DHCS requires each MCP to submit quarterly updates on the status of the multi-party MOUs with third party entities (LGAs, LEAs, LHDs and other MCPs in the county). The Plan's upcoming Q2 Status Report will indicate CalViva executed a DMC-ODS MOU with Fresno County on 4/22/24. The next Public Policy Committee meeting will be June 5, 2024, 11:30 am-1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711. **Medical Management** <u>Appeals and Grievances Dashboard</u> Dr. Marabella presented the Appeals & Grievances Dashboard through March 31, 2024. • The total number of grievances for the first quarter of 2024 remains consistent compared to the previous year.		
• **Medical Management** P. Marabella, MD, CMO			

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

	• For the Quality of Service (QOS) category, the types of cases noted to contribute the most to the increase are Access (Prior Authorizations, Availability of Providers, DME delays), Administrative (member material requests, balanced billing), and Transportation.
	• The volume of Quality of Care (QOC) cases remains consistent when compared to last year.
	• The volume of Exempt Grievances remains consistent.
	• Total Appeals volume has decreased when compared to the previous year's data, while the uphold and overturn rates have remained relatively consistent. Advanced imaging and Cardiovascular imaging volume of cases has improved (declined) so far this year.
	
	<u>Key Indicator Report</u>
	
	Dr. Marabella presented the Key Indicator Report (KIR) through March 31, 2024.
	
	A summary was shared that provided the most recent data for Membership, Admissions, Bed Days, Average Length of Stay, and Readmissions through March 2024, which demonstrates that most rates have decreased.
	• Membership has had a slight increase for the Expansion population; both TANF and the SPD populations remain consistent with previous months.
	• Acute Admissions, Bed Days, and Acute Length of Stay (all adjusted PTMPY), for TANF, MCE, and SPDs remain consistent with recent months with the following exceptions:
	  ○ For Bed Days (adjusted PTMPY), SPDs show steady decline month over month in Q1 2024.
	  ○ Acute Length of Stay (adjusted PTMPY) overall decreased in March with SPDs decreasing month over month in Q1 2024.
	• Turn-around time compliance remains at 100% with the exception of Preservice urgent at 96%.
	
	Care Management (CM) results have fluctuated within the various programs; Perinatal CM slightly decreased with good engagement rates, Physical Health CM referrals are trending up with good engagement, and Transitional Care Services		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	(Transitions of Care) is declining as members are referred to appropriate services after 30 days. Behavioral Health CM capture rate remains good. First Year of Life is a new program recently added and has shown 100% engagement rates in the first 3 months of 2024. <u>QIUM Quarterly Summary Report</u> Dr. Marabella provided the QI, UMCM, and Population Health update for Q1 2024. Two meetings were held in Quarter 1, one on February 15, 2024, and one on March 21, 2024. The following guiding documents were approved at the February and March meetings: 1. QI/UM Committee Charter 2024 2. 2023 Quality Improvement End of Year Evaluation 3. 2024 Quality Improvement/Health Education Program Description 4. 2024 Quality Improvement/Health Education Work Plan 5. 2023 Utilization Management/Case Management End of Year Evaluation 6. 2024 Utilization Management Program Description 7. 2024 Case Management Program Description 8. 2024 Utilization Management/Case Management Work Plan 9. Population Health Management Segmentation Report 10. Population Health Management Assessment Report 11. Non-Behavioral Health Member Experience Report 12. Behavioral Health Member Experience Report In addition, the following general documents were approved at the meetings: 1. Pharmacy Provider Updates 2. Medical Policies 3. Pharmacy Policies The following Quality Improvement Reports were reviewed: Appeals and Grievances Dashboard, Potential Quality Issues (PQI) & Provider Preventable Conditions (PPC) Report, MHN Performance Indicator Report for Behavioral Health, Blood Lead Screening Report, and NCQA System Controls CR Oversight		

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	Report 2023. Additional Quality Improvement reports were reviewed as scheduled during Q1. The following Access Reports were reviewed: Access Work Group minutes from November 28th,2023 and the Access Workgroup Quarterly Reports for Q4 2023 & Q1 2024. Other Access-related reporting included the Standing Referrals Report, Specialty Referrals Report, and Provider Office Wait Time Report. The Utilization Management & Case Management reports reviewed were the Key Indicator Report & Concurrent Review Report, Inter-rate Reliability Results for physicians and Non-physicians, and Case Management and CCM Report. Additional UMCM reports were also reviewed as scheduled. Pharmacy quarterly reports reviewed were Pharmacy Operations Metrics, Top Medication Prior Authorization (PA) Requests, Inter-rater Reliability Review Report and Quality Assurance Results which were all reviewed for Quarter 4. HEDIS® Activity: In Q1, HEDIS® related activities focused on data capture for measurement year 2023 (MY23). Managed Care Medi-Cal health plans will have eighteen (18) quality measures that they will be evaluated on for MY2023 and the Minimum Performance Level (MPL) is the 50th percentile. Activities include: • Finalized and submitted the 2024 HEDIS® Roadmap. • MY2023 HEDIS® data gathering from clinics and providers throughout the three-county area with final submission to DHCS and HSAG. • Completed Annual HEDIS® Audit. • Initial reports in review for compliance with MCAS measures. Current improvement projects: • Clinical - Well Child Visits W-30+6 in AA/Black Population Performance Improvement Project (PIP). • Non-clinical – Improve Provider Notifications within 7-days for Members Seen in the E.D. for SUD/MH Issue Performance Improvement Project (PIP).	*Supervisor Quintero asked if the projects are mandated?* *Dr. Marabella replied that if the Plan is below the 50th percentile (minimum performance level) on the eighteen measures when compared to the overall or regional rates, then per domain (groups of measures by topic- Children, BH, Chronic*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	• Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative. • Lean Equity Improvement Projects. • Comprehensive Improvement Project. No significant compliance issues have been identified. Oversight and monitoring processes will continue.	*Disease, or Reproductive & Cancer) the Plan is required to complete an improvement project. The projects are Lean, Comprehensive or Transformational.* *For CVH we have a Lean project (Children) in Kings County, a Comprehensive project (Children & BH) in Fresno County, and a Lean project (BH) in Madera County.*	
• **Executive Report** J. Nkansah, CEO	**Executive Report** Total membership for CalViva as of March 2024 is 435,626. Anthem Blue Cross members are at 210,739, and Kaiser membership is at 5,494. Currently pending State data related to how default percentages are for March as well as the Choice percentages. Dual Eligible Membership will have a role in Medi-Cal enrollment in the foreseeable future. There are no significant issues or concerns to report at this time as it pertains to IT, Member Services, CVH Website, Provider Network, and Provider Disputes. Cybersecurity Assessment is scheduled for Calendar Year 2024. With regard to the Call Center and Website, the self-service change to allow members to request a PCP Change through the CalViva Health website has been successful. Efforts are underway to allow members a self-service option to gain access to their Member ID Card through the CalViva Health Website.	*Commissioner John Frye asked how high Kaiser numbers may go?* *Jeff Nkansah believes their membership will slowly trend up, and that there is no cap.*	

AGENDA ITEM / PRESENTER	MAJOR DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	MOTION / ACTION TAKEN
	With regard to Claims Processing, management is working with PPG 1, 3 & 8 on improving performance. PPG 1 is no longer active in the CalViva Health Service Area as of 12/31/2023. *Joyce Fields Keene left at 3:07 pm, not included in vote*		
#10 Final Comments from Commission Members and Staff	None.		
#11 Announcements	None.		
#12 Public Comment	None.		
#13 Adjourn	The meeting adjourned at 3:26 pm. The next Commission meeting is scheduled for July 18, 2024, in Fresno County.		

Submitted this Day: _____

Submitted by: _____
Cheryl Hurley
Clerk to the Commission

CalViva Health
Finance
Committee Meeting Minutes

March 21, 2024

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

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

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
#1 Call to Order D. Maychen, Chair	The meeting was called to order at 11:30 am, a quorum was present.		
#2 Finance Committee Minutes dated February 15, 2024 Attachment 2.A Action, D. Maychen, Chair	The minutes from the February 15, 2024, Finance meeting were approved as read.		Motion: *Minutes were approved* *6 – 0 – 0 – 1* *(Rogers / Neves)*
#3 Financials – as of January 31, 2024 Action D. Maychen, Chair	Total current assets recorded were approximately $711.2M; total current liabilities were approximately $570.1M. Current ratio is approximately 1.25. Current assets and liabilities are higher due to accruing for the new MCO taxes which are substantially higher than in the past. Total net equity was approximately $151M, which is approximately 847% above the minimum DMHC		Motion: *Financials as of January 31, 2024, were approved* *6 – 0 – 0 – 1* *(Frye / Rogers)*

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	required TNE amount. For the first seven months of the current fiscal year, interest income actual recorded was approximately $4.5M, which is approximately $2.4M more than budgeted due to interest rates on our money market funds being higher than projected. Premium capitation income actual recorded was approximately $1.2B which is approximately $209.6M more than budgeted due to accounting for MCO taxes that are applicable to fiscal year 2024 with $125M related to FY 2023, and enrollment and rates being higher than projected. Total cost of medical care expense actual recorded is approximately $765.4M which is approximately $80.9M more than budgeted due to rates and enrollment being higher than projected. Admin service agreement fees expense actual recorded was approximately $33.6M, which is approximately $2.4M more than budgeted due to enrollment being higher than projected. Taxes were approximately $423.4M, which is approximately $125.5M more than budgeted due to that portion of MCO taxes relating to FY 2023 (April 2023 – June 2023 quarter). Net income through January 31, 2024, was approximately $9.6M, which is approximately $4.5M more than budgeted primarily due to interest income being approximately $2.4M higher than projected, and rates and enrollment being higher than projected.		
#4 Fiscal Year 2025 – Proposed Budget	Basic assumptions have not changed from information presented at the February Finance meeting. Medical revenue is projected to be approximately $1.82B which is approximately a $84.2M more than budgeted primarily due to an increase in MCO taxes by approximately $30.9M, an increase in rates due to DHCS updating/increasing Medi-Cal rates, and an increase in enrollment in comparison to FY 2024. Interest income is projected to be approximately $4M, which is approximately $400K more than budgeted due to allocating more funds to the money market funds account. Medical Cost expense is projected to be approximately $1.18B which is approximately $50.2M more than budgeted in FY 2024 due to enrollment and		Motion: *FY 2025 Proposed Budget approved to move to Commission* 6 – 0 – 0 – 1 (Rogers / Rahn)

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	rates being higher. Admin Services fee expense is projected to be approximately $53.7M which is approximately $2.3M more than fiscal year 2024 due to higher enrollment projected in fiscal year 2025 as there has been a smaller amount of disenrollments than initially projected for fiscal year 2024. Salary and wage expense is projected to be approximately $5M which is approximately $487K more than budgeted due to potentially adding staff to meet the new 2024 contract requirements, which includes NCQA Dual-SNP Medicare/Medi-Cal program, and accounting for succession planning for key management positions nearing retirement age. Dues and subscriptions expense is projected to be approximately $298K which is approximately $64K more than projected due to trade associations that represent the Plan looking to increase their staffing as they continue to support Plans with changes occurring with the 2024 contract requirements. Grants expense is projected to be approximately $4.3M which is $400K more than budgeted due to the DHCS 2024 contract requirement which requires Plans to invest 5% of their net income to community reinvestment initiatives. In addition to the 5%, plans will have to contribute 7.5% of their net income to community reinvestment initiatives if they fail certain quality metrics to be detailed in a future guidance document. The Plan is waiting for the final guidance. Legal and professional expenses are projected to be approximately $323K which is approximately $123K more than projected in comparison to fiscal year 2024 due to CalViva Health looking to add an online option for members to access their ID cards on the CalViva Health website. Office expense is projected to be $114K, which is approximately $23K more than budgeted due to expanding current office space, specifically relating to items below our fixed asset threshold. Recruitment expense is projected to be approximately $157K, which is approximately $45K more than budgeted due to recruiting fees to add potential staff and succession planning for certain management staff near retirement age.	*John Frye asked if this was the first time for this requirement?* *Daniel Maychen confirmed, yes.* *Supervisor Neves asked if the Plan has received the guidelines yet?* *Daniel Maychen stated they haven't released the final APL yet and won't be released until Q2 2024. DHCS did release some draft materials and asked for Plan feedback.*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	MCO taxes projected to be $563.7M which is approximately $30.9M more than budgeted in FY 2024 due to the MCO tax structure that has a built-in increase. Capital Expenditure budget is projected to be $500K which is a $100K increase due to accounting for potential tenant improvements to current vacant office space, and improvements to the additional office space CVH is taking on. Net Income is projected to be approximately $8.7M which is approximately $192K less than what was budgeted in FY 2024 primarily due to an increase in admin expenses net of increase in rates and enrollment.	*Supervisor Rogers asked if there is a policy in place to distribute equally between the three counties?* *Daniel Maychen reported that DHCS has preliminarily communicated the allocation method which is mainly going to be membership driven.* *Rose Mary Rahn asked if they are going to align that with the SMART goal development as per the MOU with population health?* *Daniel Maychen stated, there are two parts to the community reinvestment plan; the base is 5% of annual net income and there are prespecified categories plans have to fund within those prespecified categories. Then there is the quality community reinvestment funding, which is an additional 7.5% of annual net*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
		income. If plans fail certain quality metrics, the State expects the plan to reinvest into the community in those failing quality metric areas. *Supervisor Neves asked if CVH is currently in line with allocations?* *Daniel Maychen stated there appears to be some alignment.* *Jeff Nkansah followed up explaining there are different categories in how DHCS is creating the buckets and the Plan's current community support program is in review to see if it's going to meet the requirements. The Plan is working to account for both scenarios.* *John Frye asked if there was anything that maybe hasn't been accounted for in the budget as of yet? And how big does Kaiser want into the Medi-Cal arena?*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
		Daniel Maychen stated the main issue would be if something happens with enrollment. Kaiser Medi-Cal is now effective in the Plan's service counties. The Plan has lost some members to Kaiser since January. *Jeff Nkansah stated that currently, Kaiser is not focusing much on Fresno, Kings, and Madera counties. They are more focused on dual membership, and foster kids. They are not taking any auto assignments in 2024.* *Rose Mary Rahn added that for Kings County, Kaiser is aligning with a lot of projects but she's not seeing the membership.*	
#5 Announcements	In follow up to the significant increase in the MCO tax discussed at previous meetings, the quarterly invoice the Plan used to pay was approximately $40M; it increased to $125.5M. In the past, DHCS would pay the Plan the money ahead of time as its embedded in the capitation rates and they paid the Plan monthly and includes the MCO tax revenues. Shortly after the end of each quarter, the plan would pay it back to DHCS. With the new MCO tax, DHCS was requiring plans to front the money, which is about $125.5M for CVH. CVH contacted DHCS on January 18, 2024, to ask for an extension, or waive the interest, until DHCS paid	*John Frye asked if this was the federal match, and based off of how quickly the government gets the money, is this why they are doing this?*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	Comments	ACTION TAKEN
	the Plan the funds. At that time, the Plan had approximately $61M in checking and $83M in a money market account, which the Plan would've been required to almost fully liquidate to front the $125.5M MCO tax. This would cause the Plan to forfeit approximately $400K in interest income. The MCO tax was due February 5, 2024, and as of March 21st, the Plan has not heard back from DHCS on the waiver decision. The Plan made the payment on March 15th after funds were received on March 14th. Before the official request was sent in, Daniel (CFO) reached out to a finance chief at DHCS to explain the situation and the response was that the waiver request appeared reasonable. Other CFO's have been encouraged by DHCS to submit a waiver as well. As such, it appears that DHCS would be agreeable to waive the interest fees.	*Daniel Maychen stated, yes, this is the MCO tax which receives a federal match. Also, when asking DHCS why they made the timeline/due date the way it was, DHCS responded that the timeline is based on applicable regulations. When asked why DHCS couldn't give Plans the money ahead of time, DHCS stated they had issues getting the MCO tax revenue funds out. Worst case scenario if the Plan has to pay the interest, it's approximately $1.3M, which the Plan will push back because of asking for the waiver three weeks in advance and having to forfeit interest income to front first MCO tax payment.*	
#6 Adjourn	Meeting was adjourned at 11:49 am		

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

Dated: May 16, 2024

Approved by Committee: Daniel Maychen
Daniel Maychen, Committee Chairperson

Dated: 5/16/24

Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
March 21st, 2024

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

Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	**Patrick Marabella, M.D.**, Emergency Medicine, CalViva Chief Medical Officer, Chair	✓	**Amy Schneider, RN,** Director of Medical Management Services
✓	**David Cardona, M.D.,** Family Medicine, Fresno County At-large Appointee, Family Care Providers	✓**	**Iris Poveda**, Medical Management Services Manager
✓	**Chrisitan Faulkenberry-Miranda, M.D.,** Pediatrics, University of California, San Francisco	✓	**Mary Lourdes Leone,** Chief Compliance Officer
	Ana-Liza Pascual, M.D., Obstetrics/Gynecology, Central Valley Obstetrics/Gynecology Medical Group	✓	**Maria Sanchez**, Compliance Manager
✓ *	**Carolina Quezada, M.D.,** Internal Medicine/Pediatrics, Family Health Care Network	✓	**Patricia Gomez,** Senior Compliance Analyst
✓	**Joel Ramirez, M.D.,** Family Medicine/Sports Medicine, Camarena Health, Madera County	✓	**Zaman Jennaty**, Medical Management Nurse Analyst
✓	**DeAnna Waugh, Psy.D.,** Psychology, Adventist Health, Fresno County	✓	**Norell Naoe,** Medical Management Administrative Coordinator
	David Hodge, M.D., Pediatric Surgery, Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
	Guests/Speakers		
	None were in attendance.		

✓ = in attendance
* = Arrived late/left early
** = Attended virtually

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D Chair	The meeting was called to order at 10:31 am. A quorum was present. Dr. Marabella introduced Dr. Christian Faulkenberry-Miranda a new QIUM Committee member whose specialty is Pediatrics with the University of California, San Francisco. She will be replacing Dr. Verma who resigned from the Committee in February.	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#2 Approve Consent Agenda Committee Minutes: - February 15th, 2024 - Specialty Referrals Report (Q4) - Standing Referrals Report (Q4) - Initial Health Appointment (IHA) Quarterly Report (Q3) - SPD HRA Outreach (Q4) - NIA/Evolent (Q4) - MedZed Integrated Care Management Report (Q4) - MHN Performance Indicator Report for Behavioral Health Services (Q4) - Pharmacy Provider Updates (Q4) (Q1) - Performance Improvement Project Updates – Non-Clinical PIP - PA Member Letter Monitoring Report (Q4) - Enhanced Care Management and Community Supports Performance Report (Q4) (Attachments A-L) **Action**	February 15th, 2024, QI/UM minutes were reviewed and highlights from today's consent agenda items were discussed and approved. Dr. Marabella reminded the committee that any item on the consent agenda may be pulled out for further discussion at the request of any committee member. A link for the Medi-Cal Rx Contract Drug List was available for reference.	Motion: *Approve* Consent Agenda (Ramirez/Cardona) 6-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Patrick Marabella, M.D Chair		
#3 QI Business - Appeals & Grievances Dashboard Report (January) - Appeals & Grievances Validation Audit Summary (Q3) (Attachment M-N) **Action** Patrick Marabella, M.D Chair	The **Appeals & Grievances Dashboard Report** through January 2024 was presented noting the following trends: o There was a total of 160 grievances received this month which has remained consistent over time. o The majority of resolved cases (153) were Quality of Service related: (21 of 25) Administrative claims were balanced billing related; (18) Transportation Access. Transportation Grievances have decreased as Dialysis and other high-risk patients have been given priority transportation. Monitoring to continue. o Providers and entities who are having the most difficulty are targeted with education and training. Members are also educated to always bring their physical membership card with them as many offices don't have a way to read the I.D. from a phone and members could be billed as a result of not having their card with them. o Quality of Care Grievances (20) also remained consistent compared to previous months. o Exempt Grievances, balanced billing (28) will continue to be monitored. o There were seven (7) Transportation Provider No Shows. o Total Appeals (24) are consistent with previous months. Eleven (11) cases related to Advanced Imaging (PET/CAT/Cardiac imaging.) o Uphold and Overturn rates were approximately half upheld (44.4%) and half overturned (50%). The **Appeals & Grievances Validation Audit Report Q3** was presented. CVH conducts weekly A&G case validations to ensure each Grievance or Appeal case contains the appropriate documentation and evidence necessary for standard and expedited Quality of Service (QOS), Quality of Care (QOC), and Appeal cases. o 74% of cases met compliance standards upon receipt. A rise in missing documents is noted this quarter. Documents were missing primarily in the Standard QOS and QOC categories. o Of the variety of document types identified as missing, most commonly: Case Review forms (81), and ack letters (25) make up 64% of the total missing documents by type. On further assessment, it was determined that files were not	Motion: *Approve* - Appeals & Grievances Dashboard Report (January) - Appeals & Grievances Validation Audit Summary (Q3) (Cardona/Ramirez) 6-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	being properly PDF'd and compiled for CVH review due to new staff, retraining occurred. o Thirty-one (31) cases were found to be missing evidence of the DMHC script being read to the members. The team has been refreshed on the internal policy requirement to read the DMHC script on all cases. All documents identified to be missing from the cases were obtained and inserted to complete the files before closing out the month.	
#3 QI Business - Blood Lead Screening Quarterly Report (Q3) (Attachment O) **Action** Patrick Marabella, M.D Chair	The **Blood Lead Screening Quarterly Report Q3** was presented and describes clinical guidelines for blood lead screening, reporting requirements related to blood lead screening and, to ensure Medi-Cal members receive anticipatory guidance related to blood lead poisoning prevention and blood lead level testing and follow-up services from providers. • The Q3 Blood Lead Level Screening (LSC) Report shows CalViva Health's performance on blood lead level screenings and anticipatory guidance monitoring from Q1 - Q3 2023. o Q3 compliance for CPT Code 83655 (lead screening only) demonstrates an upward trend of approximately 4% compared to the Q2 2022 rates and approximately a 5% increase compared to Q2 2023. o Q3 Anticipatory Guidance Codes rates demonstrate a slight downward trend of approximately 0.20% compared to the Q3 2022 rates and approximately 0.20% increase from Q2 2023. • Barriers to LSC testing include: o Incorrect coding used by the providers. o Low point of care (POC) LSC testing in provider offices. o Members do not want to go to lab locations for services due to impeded processes and lack of transportation. o Members do not show up for scheduled appointments. o Providers need to implement the workflow process and obtain regulatory approval for setting up the complete capillary screening at the provider's office. *Discussion:* *Dr. Ramirez asked if any counties in the state are doing well on this HEDIS® measure.* *Dr. Marabella indicated that integrated health plans are seeing better results, but overall, COVID affected the number of members seeking in-person care, and a secondary effect of COVID has reduced the healthcare workforce. Previously CVH had a CAP for this measure and some*	Motion: *Approve* - Blood Lead Screening Quarterly Report (Q3) (Ramirez/Cardona) 6-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	opportunities for improvement were identified, but currently, we're researching best practices amongst our practitioners and will model their efforts with other high-volume, low-performing providers for this metric.	
#3 QI Business - QI/UM Committee Charter 2024 (Attachment P) **Action** Patrick Marabella, M.D Chair	The **2024 QI/UM Committee Charter** was presented for annual review and approval. Additions or changes include: • Committee Responsibilities: o Health Education will now be combined with QI for the Program Description and Work Plan. o Updated terminology from Social *Determinants* of Health (SDoH) to Social *Drivers* of Health (SDoH.) o Separated Credentialing Sub-Committee from Peer Review Sub-Committee. • Composition: o Replaced that the CVH Health Equity Officer "is a member of" the QI/UM Committee with "will attend" the QI/UM Committee Meetings. o Updated Participating Practitioners from other specialty areas shall be "consulted" as necessary to provide specialty input. *Discussion:* *Dr. Ramirez noted that the new CVH Health Equity Officer will begin to attend the QIUM Committee meetings.* *Dr. Marabella indicated that the CVH Health Equity Officer is being onboarded and will start in early April. The new Equity Officer has a background in culture and linguistics and has career experience in equity.*	Motion: *Approve* - QI/UM Committee Charter 2024 (Cardona/Ramirez) 6-0-0-1
#4 Key Presentations - Quality Improvement/ Health Education Annual Program Description 2024 - Quality Improvement/ Health Education Annual Work Plan 2024 (Attachment Q, R) (*PowerPoint Presentation*)	The **2024 Quality Improvement/Health Education Annual Program Description** was presented to the committee for approval. Updates include: • **Updated QI Program and QI Work Plan to QI and Health Education (QIHEd) Program and Work Plan** (Throughout). • **Updated Social Determinates of Health to Social Drivers of Health (SDoH)** (Throughout). • **Information Systems and Analysis** (pg. 5) Added ECHO behavioral health survey and provider satisfaction survey to the scope of analytics. • **Health Promotion Programs** (pgs. 13-15) Added use of QR codes to promote HEd programs. Revised the CalViva Pregnancy Program, Health Promotion Incentive Program, and Member Newsletter descriptions.	Motion: *Approve* - Quality Improvement/ Health Education Annual Program Description 2024 - Quality Improvement/ Health Education Annual Work Plan 2024 (Quezada/Ramirez) 6-0-0-1

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Action Patrick Marabella, M.D Chair	• **MemberConnections® Program** (pg. 16): Added clinical pharmacy to the scope of the program. Added HEDIS Care Gap Reports as a tool used to engage members. Teams will also work in hospitals with members to connect them to Transitional Care Services. • **Health Management Programs** (pgs. 17-18): Added social needs data to data sources used for PHM assessments. Added additional details on risk stratification, segmentation, and tiering methodologies to identify changes in members' health status and connect them to health management programs. • **Health Plan Performance** (pgs. 25-26): Revised description to include additional details of performance metrics and standards that are monitored by the plan to improve health outcomes. Also, details were added on how performance data and ratings are shared with members and providers. • **Delegation** (pg. 28): Added statement regarding QI functions that are delegated. • **QI Process** (pgs. 38-39): Replaced SWBHC with CAHPS/ECHO Survey. Added REL, SOGI, and social needs status under demographics with risks. Moved information regarding communication with members and providers into its own section (pg. 56). • **Behavioral Health Medical Director** (pg. 47): Removed MHN reference. Clarified the role of the BH Medical Director (Dr. Sidrak) who functions as an advisor to the QI/UM Committee. • **Health Education** (pg. 48): Revised the population needs assessment from conducted annually to every three years. • **Corrective Actions** (pg. 57): A new section was added for corrective actions taken for problems identified. • **QIHEd Program Information Availability** (pg. 59): A new section was added regarding how the QIHEd program is communicated to members and/or providers. • Other minor edits throughout. The **2024 Quality Improvement/Health Education Annual Work Plan** was presented with a new format to standardize and better delineate processes and outcomes to meet NCQA accreditation standards. **Activities for 2024 Focus on:** • Work Plan Initiatives: Implement activities to improve performance measures. • Ongoing Work Plan Activities	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	QI Work Plan more comprehensive and inclusive of key areas for QI Work - 8 Initiative sections: (Each section has specific initiatives for a total of 13) 1. **Behavioral Health**: Improving Behavioral Health (Mental Health and Substance Use) Outcomes Objective: Meet directional improvement of 1-5% from the prior year or ≥ 50th percentile. FUA-30 (target 36.34), FUM-30 (target 54.87). MY2022: • FUA-30: (33%, 1/3) • FUM-30: (33%, 1/3) 2. **Chronic Conditions**: Objective: Meet directional improvement of 1-5% from the prior year or ≥ 50th percentile. • Diabetes: CDC >9 – HbA1c to below 9 • Heart Health: Control Blood Pressure 3. **Hospital Quality / Patient Safety**: Monitoring for hospital-acquired conditions MY2022: • CAUTI: SIR=<1.0: 50% • CLABSI: SIR=<1.0: 25% • C.Diff: SIR=<1.0: 100% • MRSA: SIR=<1.0: 50% • SSI-Colon: SIR=<1.0: 50% • NTSV C-sections: Rate =<23.6%: 20% 4. **Member Engagement and Experience**: Improve New Member completion IHA under 120 days. 5. **Pediatric and Maternal Health Programs**: • Well-Child Visits • Childhood Immunization • Prenatal and Postpartum Care • Lead Screenings Providers are supported to engage with immunization registries and the Vaccines for Children Program. 6. **Pharmacy**: Pharmacy Medical Drug Benefit 7. **Preventive Health**: • Cancer Screening (MCAS)	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ BCS – Breast Cancer Screening ○ CCS - Cervical Cancer Screening • Flu Campaign 8. **Provider Communication:** • Improving Member Experience (CAHPS) – Provider and Plan Focus • Improving Provider Survey Results **Quality Improvement Tracking System Activities Include:** **1. Behavioral Health:** Conduct live outreach to Medi-Cal members who had an ED visit for MH, SUD, or Drug Overdose. Uses ADT reports to conduct member outreach calls to close gaps. This activity is also being addressed in our Non-Clinical PIP with Community Regional Medical Center (CRMC) utilizing their Substance Use Navigators (SUNs.) **2. Chronic Conditions:** Diabetes Prevention Program (DPP) Vendor Onboarding. Multiconditions: KED Tip Sheet. **3. Hospital Quality/ Patient Safety:** Hospital outreach about patient safety, C-section overuse, and maternal health issues, Hospital Quality Scorecard program, Participation in Leapfrog Partners Advisory Committee, and Engagement with external collaboratives to promote hospital quality. **4. Member Engagement and Experience:** Annual Member Newsletter- CalViva, IHA Quarterly Reporting and focus on Low Performing Providers. **5. Pediatric/ Adolescents:** First Year of Life Program – FYOL, QI Referrals to the CalViva Health Pregnancy Program, Peds+ POD Action Plan Reviews, Pediatric/Perinatal/ Dental Provider HEDIS Tip Sheets, Provider Engagement and CPM Training on Pediatric MCAS measures for MY 2024. The Well Child Visit Disparity PIP is an adjunct to the postpartum program. The focus is to get African American/Black infants to see the pediatrician or the primary care doctor for the first baby visits, subsequent well-child visits, and receive immunizations. Partnering with Black Infant Health to focus on this target demographic. **6. Pharmacy:** Multi-Gap Family Unit (MCL) Live Call Outreach, KIC Smoking Cessation Newsletter, Community Supports Asthma Remediation Email Campaign, Provider Flyer. **7. Preventive Health:** PARS for High Volume Specialists, Ancillary, CBAS, and Behavioral Health providers. **8. Provider Engagement:** IHQC – Project Management Training and Fundamentals of QI Training. *Discussion:*	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Ramirez asked if the California Data Exchange Framework would help with obtaining information from hospitals that are reluctant to share information. *Dr. Marabella indicated that the goal is for everyone to freely exchange data, there are even state-funded incentive programs to encourage hospitals and clinics to data share.*	
#4 Key Presentations - Population Segmentation Report - PHM Assessment Report (Attachments S, T) (*PowerPoint Presentation*) **Action** Patrick Marabella, M.D Chair	The **Population Segmentation Report** was presented as a snapshot in time (December 2023) as a part of CVH's ongoing programs and activities aimed at targeting specific subpopulations. The Population Segmentation is recorded to understand the portions of the population targeted by each Population Health Management program per NCQA Accreditation: PHM 2 requirements. A four-column chart was shared listing each program along with a description of the program's eligible populations, the raw number of eligible members, and the total percentage of eligible members that would meet the program's criteria for participation as of December 2023. The **PHM Assessment Report** was presented and reviewed. The purpose of this report is to: 1. Assess the needs and characteristics of the enrolled population, including a review of the impact of Social Determinants/Drivers of Health (SDoH). o Needs & Characteristics: Social Determinants/Drivers of Health (SDoH) and Health Outcomes According to the County Health Rankings and Roadmaps (www.countyhealthrankings.org) CVH counties experience higher rates compared to other CA Counties of the following social economic contributing factors. Refer to the full comparison in Appendix B: ▪ premature death ▪ percentages of adult smoking ▪ adult obesity ▪ physical inactivity ▪ excessive drinking ▪ teen births ▪ children in poverty ▪ injury deaths ▪ air pollution ▪ ratio of population to primary care physicians and mental health providers (limited access) ▪ Fresno and Kings counties experience higher sexually transmitted infections.	Motion: *Approve* - Population Segmentation Report - PHM Assessment Report (Ramirez/Waugh) 6-0-0-1

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	○ CalViva counties compared to California overall have lower rates of: ▪ access to exercise opportunities. ▪ Kings and Madera counties experience a lower percentage of flu vaccination completion. ▪ education (High school and college completion) ▪ social associations 2. Identify key sub-populations and determine their needs. ○ Language and Limited English: Written and spoken languages of preference have similar rates. Approximately 34% have limited English with most of this category as Spanish Speakers. ○ Race & Ethnicity: (Note: Data directly from enrollment data.) ▪ Race & Ethnicity vary by region in California, with Hispanic/Latino comprising 40% of the state population. ▪ CalViva counties serve 55-60% Hispanic population. ▪ In Fresno, nearly 11% of the population is Asian with the White population representing 27% (lowest in F, K, M). ▪ Kings County has a Black/AA population of 6% (highest). ▪ Madera has the highest Hispanic (60.3%) and White (31.7%) populations. 3. Assess the needs of child and adolescent members. 4. Assess the needs of members with disabilities. 5. Assess the needs of members with serious persistent mental illness (SPMI). 6. Evaluate the extent to which current organization-wide population health management activities and resources address the needs identified in this analysis and determine if modifications are needed to better meet the needs of the enrolled population. ○ Actions taken since 2021 to address identified gaps were considered as part of this analysis. ○ Almost 40 actions were identified that address opportunities for improvement. Examples include but are not limited to: ▪ Heart Health: Cardiac + Diabetes Social media post to create awareness among members and community for heart health, diabetes, and medication adherence. ▪ Pregnancy and Birth: Outreach to newly delivered moms to address post-partum needs including encouraging follow-up visits with OB, screening for depression, and	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	referral to BH. Explore timely treatment options for pregnant mothers with substance use disorder. ▪ Pulmonary-related admissions: Enrollment of members who are active smokers to the Smoking/Vaping Cessation app via Clinical Pharmacist outreach. ▪ Healthy or At-Risk behavioral health: Calls to adult members diagnosed with major depression and demonstrating refill gaps, to improve medication adherence. ▪ Pulmonary- adults, children, and disabled: Partner with school districts to hold vaccination clinics for school-age youth focusing on low vaccination regions. 7. Evaluate the integration of community resources into population health management activities to address member needs not covered by the benefit plan and make recommendations if changes are needed. o CVH connects members with community resources and promotes community programs that actively respond to members' assessed needs. o All Care Managers have access to and utilize a central directory for local community resources (FindHelp) for this purpose and educate members on available resources. o A community resources link by county is available on the CVH website for staff and members. **Methodology and Time Period:** Data is combined from multiple sources and is stored in data warehouses. Data from the warehouse is extracted into a predictive modeling tool, (Impact Pro, a licensed proprietary model). The following data is pulled from the main data warehouse into the risk stratification tool housed in Impact Pro: (Timeframe: January through December 2023) • Medical and behavioral claims/encounters • Pharmacy claims • Laboratory results • Health appraisal results • Electronic health records • Data from health plan UM and/or CM programs • Advanced data sources such as all-payer claims databases or regional health information. **The Population Analysis reflects the following key findings (from Purposes 1-5):** • Top social determinants/drivers of health (SDoH) factors impacting CalViva Health: Smoking, Teen Birth, Air Pollution • Top needs of child and adolescent members: Pulmonary conditions	

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	• Top needs of members with disabilities: Cardiovascular and Pulmonary conditions • Top needs of members with serious and persistent mental illness (SPMI): Anxiety and Mood disorders • Top Race/Ethnicity: Hispanic, White, Black, Asian • Top language groups with Limited English Proficiency: Hispanic, Asian (SE Asian/Laotian Other) • Top Health Conditions: Pulmonary, Cardiac and Pregnancy	

#4 Key Presentations
- NCQA Non-Behavioral Health Member Experience Report
- NCQA Behavioral Health Member Experience Report
(Attachments U, V)
(*PowerPoint Presentation*)
 	
Action
Patrick Marabella, M.D Chair
	NCQA Non-Behavioral Health Member Experience Report and **NCQA Behavioral Health Member Experience Report** monitor member experience data for Behavioral Health and Non-Behavioral Health populations. Member Survey data is combined with appeal and grievance data to identify member pain points and opportunities for improvement. Behavioral Health and Non-Behavioral Health results are reported separately. (NCQA ME.7)
	
	NCQA Non-Behavioral Health Member Experience Report 2023 (MY2022)
	• The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is used to assess member satisfaction.
	• Follows scientific principles for survey design and development. Nationally recognized.
	• Going forward this will be conducted annually for CalViva membership.
	• Early in 2023, the survey was conducted to assess 2022. Appropriate sampling methodology was used.
	• All member appeals and grievances are also considered for the analysis. There is no sampling.
	• Grievances are reported as formal grievances (written), informal grievances (by phone), and appeals.
	  ○ NCQA Categories of Grievances Issues Further Classifies, MY2022 with volume:
	  ▪ Quality of Care, 194
	  ▪ Access, 290
	  ▪ Attitude of Service, 170
	  ▪ Billing and Financial Issues, 90 (denied as not medically necessary)
	  ▪ Quality of Office Practitioner Site, 1
	  ○ **Grievance Trends:** The Top grievance categories for MY2022 were Access, followed by Quality of Care and Attitude and Service. Top 5 Formal grievances MY2022 with volume:
		Motion: *Approve*
		- NCQA Non-Behavioral Health Member Experience Report
		- NCQA Behavioral Health Member Experience Report
		
		(Waugh/Faulkenberry)
		6-0-0-1

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	▪ Access to Care – Prior Authorization delay, 104 ▪ PCP – Delay in referral by PCP, 63 ▪ PCP – Inadequate Care, 42 ▪ Access to Care – Availability of appointment with PCP, 39 ▪ Access to Care – PCP Referral for Services, 39 o For My2022, the largest Informal and Formal Grievances category was Attitude and Service. Attitude and Service grievances are driven by Customer Service issues, provider office-staff communication, translation and interpreter issues, and eligibility issues. o Access grievances are a result of member barriers to Availability of Appointments with PCP, accessing care, tests, or treatments, accessing facilities, delays in referral and prior authorization, and delays in treatment. o **Appeal Trends:** Appeal types are presented below to identify any patterns and areas of opportunity. The only appeal category in MY2022 was Billing and Financial Issues. The largest issues for MY2022 were with Diagnostics - MRI, followed by CAT Scan, and Myocardial Perfusion. Top 5 Appeals, MY2022 with volume: ▪ Diagnostic – MRI, 58 ▪ Diagnostic – CAT Scan, 20 ▪ Diagnostic – Myocardial Perfusion, 13 (a decrease from prior years) ▪ Other – Self-Injectable Medication, 10 ▪ Outpatient – Procedure, 8 • **CAHPS® Survey Results MY2022:** A chart was shared listing five measures with corresponding percentages, % rank, sample size, and QC Ave %. CalViva's measures fell between 71.9% and 86.3% which aligns with other Health Plans. • **Some Opportunities Identified** o Short Term: ▪ Routine customer service training to member-facing teams within the organization. ▪ Regular monitoring of the Medi-Cal network (PCPs and specialists) to ensure members do not have a limited network to choose from. ▪ Routine training done with the Customer Contact Center on relevant member pain points particularly around how to address provider communication issues, access issues, and any referral and prior authorization delays. ▪ Regular monitoring of prior authorization and referral processes.	

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	○ Long Term: ▪ Utilize contract language to incentivize provider groups to improve on member experience measures. ▪ Create provider incentives around improving member experience. ▪ Work directly with provider groups to review and identify ways to make the prior authorization and referral process less burdensome on the member. ▪ Create a specialized Call Center Team that focuses primarily on the Medi-Cal population and addresses unique concerns/issues. ▪ Collaborate with state and other Medi-Cal health plans to address trending issues for the overall Medi-Cal population. **NCQA Behavioral Health Member Experience Report 2023 (MY2022)** The Experience of Care and Health Outcomes (ECHO®) annual survey is used to assess member satisfaction for the Behavioral Health population. • Early in 2023, the survey was conducted to assess MY2022. • All members' grievances and appeals are also evaluated. • Significance testing was conducted to test the significance between MY2022 and MY2021 ECHO survey results because of a history of ECHO survey and barrier analysis. • No significance testing for appeals and grievances. • **Data Trends for Behavioral Health:** ○ The BH grievances, appeals, and ECHO survey data point to similar opportunities. ○ The volume of data is small and while patterns may not be identified for CVH, the general trend is that the most impactful member pain points are around Access and Billing/Financial issues. ○ There is a strong focus on BH member outcomes (clinical improvement) and the ECHO results are demonstrating its effectiveness. ○ ECHO results specifically indicate that the areas of opportunity are related to Getting Treatment Quickly, Customer Service, Getting Treatment Options and Information about the Health Plan or Provider, and How Well Providers Communicate. • **Actions Taken or In Progress:** Through a barrier analysis of the ECHO results, several opportunities were identified with the following actions taken (or being implemented): ○ Grow BH Network:	

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	▪ Increase rates for newly contracted providers and providers willing to accept new patients. ▪ Focus growth in areas of need – highest numbers of OON requests. ▪ Focus on telehealth options to eliminate geo access challenges. ▪ Improve Provider Satisfaction through improved speed and accuracy of claims processing and immediate feedback on member complaints/concerns. o Greater promotion of Collaborative Care Model options and resources for PCPs treating BH. o Improve Provider Directory Accuracy. o Leverage the staggard roll-out of the BH system migration to test/learn and improve process documentation, learn/apply best practices, and minimize negative impacts (Smaller market [Marketplace] system migration to occur 6 months before large market [Medi-Cal and Commercial] system migration.) o Eliminate/reduce silos between medical and BH starting with Plan-wide BH integration: resources, systems, staff, and network. o Greater collaboration and BH data exchange with Medi-Cal counties without violating privacy rules. o Give more feedback to CVH BH providers about member experience and provide resources to make improvements. • **Barrier(s) being addressed:** o Reduction in stigma leading to greater demand and BH network options not growing at the same pace. o Delays in routine access to care/appointments rooted in member preference, compatibility, and scheduling needs and not enough options. o Network availability issues limit provider choice and provider-member compatibility. o No BH provider "assignment" and limited Value-based payment and/or incentives for BH providers. o Inaccuracies in provider directory information can lead to delays in finding a provider accepting new patients. o Temporary Health Plan staff knowledge and process gaps and delays during major migration to new systems and processes. o Administrative barriers:	

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	▪ There is no secure member BH portal. ▪ Members cannot find information about the BH care they need or BH care they obtained without calling the Plan or provider. ▪ The secure BH provider portal has limited features. ▪ Systemic silos between medical and BH do not help members obtain information and options in an easy, seamless manner. o Privacy regulation concerns limiting collaboration and BH data exchange between Medi-Cal service delivery entities. o Providers might need more frequent reminders or feedback about member perception/experience. *Dr. Cardona left the meeting at 11:25 AM and returned at 11:27 AM. A quorum was maintained. *Dr. Quezada left the meeting at 11:35 AM. A quorum was maintained.	
#5 UM/CM Business - Key Indicator Dashboard (January) - Case Management and CCM Report (Q4) - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2023 (Attachment W- Y) (Attachment Z was intentionally left blank) **Action** Patrick Marabella, M.D Chair	The **Key Indicator Dashboard** through January was presented. • Utilization for all risk types remained consistent in January 2024, but membership will decline as redeterminations continue and Kaiser Permanente has now entered the market and will edge into CVH's market share. • SPD Admits and Bed Days remain low, and Acute Admits and Bed Days remain consistent. • ER visits per thousand members per year have remained consistent. • Turnaround Times were met in all areas in January 2024. • Case Management results remained robust in the Perinatal and Integrated categories and remained consistent in all others. • All members discharged from the hospital receive Transitional Care Services (TCS) first and then are redirected to other case management services as needed. • Palliative Care is no longer a care management offering, it is now a benefit available through prior authorization. • Behavioral Health outreach has increased and has a 50% engagement rate. • The new "First Year of Life" program to engage parents to bring their children to well-child visits and get immunized is seeing success. The **Case Management and CCM Report Q4** summarizes the Case Management (CM), Transitional Care Services (TCS), MemberConnections, Palliative care, and Emergency Department (ED)	Motion: *Approve* - Key Indicator Dashboard (January) - Case Management and CCM Report (Q4) - Inter-Rater Reliability Results (IRR) for Physicians and Non-Physicians 2023 (Cardona/Ramirez) 5-0-0-2

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	diversion activities for 2023 through the fourth quarter. This includes referral volume, member engagement, and an evaluation of Program effectiveness. Findings below are as of January 20, 2024: • From Q3 to Q4, ICM referral volume dropped 33%, managed TCS cases decreased 27%, and BH CM total referral volume dropped 18%. • The engagement rate for TCS increased to 91% because members are now contacted prior to discharge. • Managed cases increased in both Integrated Care Management (ICM) and Perinatal CM in Q4. • Emergency Department Diversion completed the year with an overall 22.2% success rate of reaching members, a slight improvement over 21.8% in 2022. This program focuses on telephonic outreach to members with three or more visits in 90 days. • Overall, across all programs, members who are engaged in Care Management programs show a lower readmission rate and better outcomes than those not enrolled. • 90% of members surveyed are satisfied with their Care Management Program. **InterQual Inter-Rater Reliability (IRR) Results for Physicians and Non-Physicians 2023** was presented. UM staff use InterQual® Clinical Decision Support Criteria along with other evidence-based medical policies, clinical support guidelines, and technical assessment tools approved by the Medical Advisory Council to assist clinical reviewers in reviewing medical criteria with consistency. Following InterQual (IQ) IRR preparatory training in Q3-2022, the Optum (formerly Change Healthcare) InterQual IRR modules were administered to the physician reviewers and the non-physician clinical staff requiring a minimum score of 90% to pass. Below are the results of testing completed in Q4-2023. • The initial overall pass rate was 82%. • Following remediation and retesting, the final overall pass rate was 97%. • For all physician and non-physician reviewers who failed to pass the retesting, the Plan initiated documented coaching in Q1-2024.	
#6 Pharmacy Business - Pharmacy Executive Summary (Q4) - Pharmacy Operations	The **Pharmacy Executive Summary Q4** provides a summary of the quarterly pharmacy reports presented to the committee on operational metrics, top medication prior authorization (PA) requests, and quarterly formulary changes to assess emerging patterns in PA requests, compliance around PA turnaround time metrics, and to formulate potential process	Motion: *Approve* - Pharmacy Executive Summary (Q4) - Pharmacy Operations

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Metrics (Q4) - Pharmacy Top 25 Prior Authorizations (Q4) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q4) (Attachment AA-DD) **Action** Patrick Marabella, M.D Chair	improvements. • Pharmacy Operations Metrics o Pharmacy Prior Authorization (PA) metrics were within 5% of the standard for Q4. o Overall, TAT for Q4 was 98.6%. PA TAT was higher in Q4 than in Q3. o PA volume was slightly lower in Q4 compared to Q3. No outliers were found in Q4. The **Pharmacy Operations Metrics Q4** provides key indicators measuring the performance of the PA Department in service to CalViva Health members. The turnaround time (TAT) expectation is 100% with a threshold of 95%. • Pharmacy prior authorization (PA) metrics were within 5% of the standard for Q4 at 98.6%. • PA approval rate was lower in Q4 2023 compared to Q3 2023 and overall volume was slightly lower in Q4 2023 compared to Q3 2023. Trending in volume and TAT will be monitored to ensure consistent procedures by the PA team. The **Pharmacy Top 25 Prior Authorizations Q4** identifies the most requested medications to the PA Department for CVH members and assesses potential barriers to accessing medications through the PA process. The top ten (10) denials of the quarter by percentage and total number are consistent with recent quarters except for a few placement variations. More variance is seen in the top 15th to 25th. • IV Iron requests increased significantly in Q4 compared to Q3 due to a change in criteria that redirects to preferred agents leading to the high denial rates seen. The **Quality Assurance Reliability Results (IRR) for Pharmacy (Q4)** evaluates the medical benefit drug prior authorization requests for the health plan. A sample of 10 prior authorizations (4 approvals and 6 denials) from each month in the quarter are reviewed to ensure that they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The target goal of this review is 95% accuracy or better in all combined areas with a threshold of 90%. • 90% threshold met. 95% goal not met; overall score was 93.33%. • Two (2) cases missed TAT. • Four (4) cases the criteria used were not applied or documented appropriately after plan review.	Metrics (Q4) - Pharmacy Top 25 Prior Authorizations (Q4) - Quality Assurance Reliability Results (IRR) for Pharmacy (Q4) (Cardona/Faulkenberry) 5-0-0-2

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Zero (0) cases had letter language that could have been clearer to the member and/or MD after plan review. • Two (2) cases were determined to have a questionable denial or approval after plan review. • Criteria Application was the main issue in Q4 2023 similar to Q3 2023. Incorrect criteria were used in 2 cases resulting in likely improper decisions (1 approval and 1 denial). A more detailed review and QA on cases in Q4 2023 has been performed and results have been shared with PA management to address concerns noted. Quarterly reviews will continue to monitor for improvement.	
#7 Access Business - Access Work Group Quarterly Report (Q1) (Attachment EE) **Action** Patrick Marabella, M.D Chair	The **Access Work Group Quarterly Report (Q1)** was presented and reviewed. This report is to provide the RHA Commission with an update on the CalViva Health Access Workgroup activities in Quarter 1 of 2024. Reports and topics discussed focus on access-related issues, trends, and any applicable corrective actions. 274 Monthly Data Quality Check November and December Reports were reviewed and approved at the November 28, 2023, meeting. The following are some of the key standing reports/matters approved and discussed: • **MY 2022 Access and After-Hours CAP Evaluation:** CAPS were issued to 10 Tier 1 PPGs and 11 direct network providers. Educational Packets were issued to a total of 54 Tier 2 PPGs and 42 direct network providers. At the end of 2023, all PPG and Direct Network providers had submitted their Improvement Plans which were reviewed and validated by the Plan. Additionally, 15 Timely Access webinars were held, of which 873 participants attended (190 CVH affiliation). CAP was officially closed on 2/8/24. • **Q4 2023 Telehealth Program:** Request made for CVH to implement Teledoc in its service area. Teledoc is a telephone medical advice line staffed with physicians who provide general medical consultation. Mary Lourdes reported that CVH hadn't yet filed with DMHC and DHCS for permission to use Teledoc pending DMHC guidance on what to include in the filing. • **Practitioner Availability Report:** This is a new NCQA required report that included data from 1/1/2022 to 12/31/2022 which measured network availability of PCP including Family Practice, General Practice, Internal Medicine, and Pediatrics, and includes high volume specialties identified as OBGYN Oncology and Hematology. The report looks at two aspects for geo-access with an internally set standard of 90% within time or distance: PCP within 10 miles or 30 min, and 45 miles or 75 min for high-volume Specialists. Overall, in terms of time and distance the Plan met the standard. Additionally, physician-to-member ratios were reviewed	Motion: *Approve* - Access Work Group Quarterly Report (Q1) (Ramirez/Cardona) 5-0-0-2

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	for PCPs (Family practice, General Practice, Internal Medicine & Pediatrics), and high-volume Specialists (OB and Hematology/Oncology), 1:2,500 (PCPs), 1:3,000 (OB), and 1:8,000 (Oncology/Hematology). CVH did not meet the ratio standards for Family Practice, General Practice, Internal Medicine, and Oncology/Hematology. It was noted that these specialties and ratios are NCQA-specified. *Discussion:* *Dr. Ramirez queried if the ratio standards were acceptable since CVH did not meet them.* *Dr. Marabella indicated that NCQA standards differ from the State's standards of which CVH is in compliance. CVH does not have enough providers in certain geographic areas and anytime there is a 10% or greater change in the number of PCP specialists, mental health, or other contracted providers, CHV must inform the DMHC and submit a separate filing. We will continue to work toward improving access over time.* • **Accuracy of Prior Authorization and Referrals Information:** This is a new NCQA-required report to assess the quality and accuracy of the Prior Authorization (PA) List. The accuracy of the PA list was compared to the Member Handbook list and there were no adverse findings. For quality, an internal survey was conducted using randomly identified staff to review and verify the information on the website. Results were primarily positive except for the information that is available for referrals. Two (2) out of nine (9) people couldn't determine whether services required a referral or not for a provider outside the network. Referral information was verified as available and accurate on the web. However, there seemed to be confusion as to the difference between referrals and authorizations. • **10% Significant Network Change**: The Committee was informed that CVH submitted a Significant Network Change filing to DMHC on 1/15/24 that indicated the Plan experienced a 10% change in PCPs, Specialists, Mental Health, and Other Contracted Providers. • **APL 22-026 Implementation of TA Regulation Amendments**: The Committee was informed that on 10/27/23 DMHC approved the Plan's filing of all the deliverables evidencing compliance with the new Timely Access regulations per DMHC APL 22-026. The second part that has to do with the Accessibility requirements was filed on 1/16/24. **Access Workgroup Functions and Responsibilities**: Annual review of the Access Workgroup Functions & Responsibilities was completed. Recommendations for edits were provided and the revised document will be brought back for final approval in March. Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the	

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	ongoing monitoring of CalViva members' access to care. Except for the Access Workgroup Functions and Responsibilities, all reports were accepted by the Workgroup.	
#8 Policy & Procedure Business - Pharmacy Policy Review (Attachments FF) **Action** Patrick Marabella, M.D Chair	The **Pharmacy Policy Review (2024)** was presented to the committee. The following policies were up for annual review with no changes made: • RX-001 Medication Prior Authorization • RX-002 Program Metrics Review • RX-003 Pharmacy Program • RX-007 Injectable Medication Review • RX-008 Mental Health Parity • RX-120 Drug Utilization Review The following policies were up for annual review and were approved with the following changes: • RX-005 Pharmacy Prior Authorization and Medical Necessity Criteria: Deleted California Health and Wellness reference. • RX-006 Specialty Pharmacy Program: Updated policy reference.	Motion: *Approve* - Pharmacy Policy Review (Cardona/Waugh) 5-0-0-2

#9 Credentialing & Peer Review Subcommittee Business
- Credentialing Subcommittee Report (Q1)
- Peer Review Subcommittee Report (Q1)
(Attachments GG-HH)
 	
Action
Patrick Marabella, M.D Chair
	The **Credentialing Sub-Committee Quarterly Report (Q1)** was presented. The Credentialing Sub-Committee met on February 15, 2024. Routine credentialing and re-credentialing reports were reviewed for both delegated and non-delegated entities.
	• Reports covering Q3 were reviewed for delegated entities.
	• Q4 reports were reviewed for MHN and Health Net.
	• There were no (0) Adverse Action cases for October, November, or December for CVH.
	• The **Q4 2023 Adverse Events Report** is a new report for the Credentialing Sub-Committee in 2023 and provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period.
	  ○ There were no (0) cases identified for Q4 2023 with adverse outcomes associated with a contracted practitioner.
	  ○ There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of access to care issues.
	  ○ There were no (0) cases identified outside of the ongoing monitoring process this quarter. (NCQACR.5.A.4)
	• There were six (6) **Credentialing Policies** reviewed by the committee with edits:
	Both Policy CR-101 Delegation Evaluation and Policy CR-140 Adverse Action had:
		Motion: *Approve*
		- Credentialing Subcommittee Report (Q1)
		- Peer Review Subcommittee Report (Q1)
		(Ramirez/Waugh)
		5-0-0-2

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	○ Minor edits throughout the policy. Policy CR-109 Ongoing Monitoring of Sanctions-Complaints: ○ Added email as a mechanism for result distribution. ○ Added section regarding "Identifying, reviewing, and forwarding PQI/QOC incidents of non-compliance with Appointment Availability." Policy CR-110 Credentialing and Recredentialing: ○ Clarified the role of the Credentialing Chairperson or designee to approve clean files. ○ Removed CalAIM section, requirements are in CR-120. ○ Updated Attachments B, D, and E. ○ Full policy included in meeting materials will all attachments. Policy CR-120 Organizational Providers: ○ Added four more types of suppliers. Policy CR-160 Appeal Process: ○ Minor edits throughout the policy to strengthen and streamline language. • The **NCQA System Controls Oversight Report** was presented and reviewed. The purpose of this report is to identify any incidents of non-compliance with the credentialing policies on information management. NCQA standards require that the organization's credentialing policy describe: 1. How primary source verification information is received, dated, and stored. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify, and delete information, and circumstances when modification or deletion is appropriate. 4. Security controls that are in place to protect the information from unauthorized modification. 5. How the organization monitors its compliance with the policies and procedures in factors 1–4 at least annually and takes appropriate action when applicable. Quarterly audits were performed with no modifications to CalViva provider records during 2023, therefore no cases to audit. The Health Net audit results provided to CalViva reflect 100% compliance with audit criteria. The **Peer Review Sub-Committee Quarterly Report (Q4)** was presented. The Peer Review Sub-Committee met on February 15th, 2024.	

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	• The county-specific **Peer Review Sub-Committee Summary Reports for Q4** were reviewed for approval. No significant cases to report. • The 2023 **Adverse Events Report** is a new report for the Peer Review Sub-Committee in 2023 and provides a summary review of ongoing monitoring for potential quality issues and Credentialing Adverse Action cases during the reporting period. o There were nine (9) cases identified in Q4 that met the criteria for reporting and were submitted to the Peer Review Committee. Three (3) cases involved a practitioner and six (6) cases involved organizational providers (facilities). o Of the nine (9) cases, three (3) were tabled, one (1) was tabled with a letter of education, zero (0) were placed on a CAP, three (3) were closed with a letter of education, and two (2) were closed to track and trend. There were no (0) incidents or patterns of non-compliance resulting in substantial harm to a member or members because of access to care issues. o There was one (1) case identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4) o There were 37 cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management. • The following **Peer Review Policies** were presented to the committee for review, discussion, and approval: o PR-001 Peer Review Protected Information ▪ Definitions section updated. o PR-100 Peer Review Committee Policy ▪ Added Pending Closure definition. Updated language for clarity throughout the policy. • The **Access & Availability Substantial Harm Report Q4 2023** is another new report for the Peer Review Committee in 2023. The purpose of this report is to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability issues and are ranked by severity level. o Sixteen (16) cases were submitted to the Peer Review Committee in Q4 2023. There were	

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	zero (0) incidents found involving appointment availability issues resulting in substantial harm to a member or members. One (1) case was associated with significant harm without appointment availability issues. • The **Q4 Peer Count Report** was presented at the meeting with a total of twenty (20) cases reviewed. The outcomes for these cases are as follows: o There were ten (10) cases closed and cleared. There were five (5) cases tabled for further information. There was one (1) case with CAP outstanding and none (0) were pending closure for CAP compliance. Follow-up was initiated to obtain additional information on tabled cases and ongoing monitoring and reporting will continue. *Dr. Cardona left the meeting at 12:04 PM and returned at 12:08 PM. A quorum was maintained.	
#10 Compliance Update - Compliance Regulatory Report (Attachment II)	Mary Lourdes presented the **Compliance Regulatory Report.** **CalViva Health Oversight Activities. HealthNet.** CVH's management team continues to review monthly/quarterly reports of clinical and administrative performance indicators, participate in joint work group meetings, and discuss any issues or questions during the monthly oversight meetings with Health Net. CVH and Health Net also hold additional joint meetings to review and discuss activities related to critical projects or transitions that may affect CVH. The reports cover PPG-level data in the following areas: financial viability data, claims, provider disputes, access and availability, specialty referrals, utilization management data, grievances, appeals, etc. **Oversight Audits.** The following annual audits are in progress: Credentialing, UMCM, and Behavioral Health. The following audits have been completed since the last Commission report: Emergency Room (CAP), and Quality Improvement (CAP). **Fraud, Waste & Abuse Activity.** Since the 2/15/2024 Compliance Regulatory Report to the Committee, there were 6 new MC609 cases filed by the end of Feb 2024 that involved: 1) A participating provider specializing in case management services who allegedly billed for services not rendered according to a member complaint; 2) A participating provider who specializes in pediatrics for billing a high volume of the non-medically necessary service; 3) A participating DME provider who was referred by DHCS for upcoding services and not providing documentation to support the billing; 4) A participating behavioral health provider for possible services not rendered and conflicting "rendering provider" documentation; 5) A participating provider specializing in radiology service for knowingly rendering a non-covered service to a Medi-Cal member and billing the member; and 6) A participating pain management provider for allegedly billing services not	

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	rendered. **Department of Managed Health Care ("DMHC") 2022 Medical Audit.** Awaiting DMHC's response to the initial CAP response submitted on 12/15/23. **Department of Health Care Services ("DHCS") 2023 Medical Audit**. The Plan submitted its March CAP update on 2/26/24. DHCS has requested the Plan's final CAP response by 3/20/24. **Department of Health Care Services ("DHCS") 2024 Medical Audit**. On 2/29/2024 the Plan received DHCS audit notification and pre-audit request. The audit is to take place from 5/20/2024 through 5/31/2024 covering the review period of 4/1/2023 through 3/31/2024. All pre-audit information is due by 4/12/2024. **California Advancing and Innovating Medi-Cal (CalAIM):** • **Enhanced Care Management (ECM):** On 1/19/24 the Plan submitted an updated Justice Involved ECM network and capacity report. • **Community Supports (CS):** On 1/29/24, the Plan submitted an updated 2024 Community Supports Model of Care (MOC) for those services going live 7/1/24: Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties; and Recuperative Care (Madera County.) **Long-Term Care (LTC) Carve-In Deliverable List – Phase II (ICF/DD and Subacute Care facilities.)** Effective 1/1/2024, LTC-ICF/DD and Subacute Care services were carved into MCPs statewide. The Plan submitted deliverables associated with APL 23-004 ("Intermediate Care Facilities for Individuals with Developmental Disabilities"), and APL 23-027 ("Subacute Care Facilities") to DHCS on 11/27/23 and 1/29/24. The Plan is still working to complete Phase I of the ICF/DD network readiness requirements regarding contracting efforts. **Memorandum of Understanding (MOU).** DHCS requires Plans and Third-Party Entities to submit updated MOU templates and to specify responsibilities under those MOUs. DHCS has provided base templates that the Plan must execute starting January 1, 2024, through January 1, 2025. DHCS will require quarterly status updates on the execution of those MOUs. Q1 2024 is due 4/30/2024. **Annual Network Certifications.** • 2023 Subnetwork Certification (SNC) – The Plan filed all the required documentation on 1/5/24 and is awaiting DHCS determination. • 2023 Annual Network Certification (ANC) – The Plan is scheduled to file the required documentation by 3/25/24.	

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	• 2022 Annual Network Certification (ANC) – The Plan was informed on 3/13/24 that its Alternate Access Standard (AAS) requests were approved by DHCS and have been posted as required on the CalViva Health website. **New DHCS Regulations/Guidance.** Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2024. **Public Policy Committee.** The PPC met on March 6, 2024, at 7625 N. Palm Ave Suite 109, Fresno, CA 93711. The following programs and reports were presented: the 2024 Annual Compliance Report; the Q4 2023 Grievance & Appeals Report; and the Semi-Annual (Q3 and Q4 2023) Member Incentive Programs Report. Additionally, CVH's 2023 Annual Report was presented and posted on the Plan's website. The next Public Policy Committee meeting will be June 5, 2024, 11:30 am-1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.	
#11 Old Business	**Designation of Grievance Source: Member Vs. Family** Dr. Marabella confirmed that the source of the grievance is designated on the form (member Vs representative) and should be included in the information submitted to the attending provider.	
#12 Announcements	Dr. Marabella announced that Dr. Lee has resigned from the QIUM Committee and Dr. Ana-Liza Pascual will take her place and will be attending the May meeting. Dr. Pascual is an OB/GYN with the Central Valley Obstetrics/Gynecology Medical Group. The DHCS will be conducting an audit from 5/20/2024 through 5/31/2024 covering the review period of 4/1/2023 through 3/31/2024.	
#13 Public Comment	None.	
#14 Adjourn	The meeting was adjourned at 12:20 pm	

NEXT MEETING: May 16th, 2024

Submitted this Day: May 16, 2024

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

Acknowledgment of Committee Approval:

Patrick Marabella, MD Committee Chair

Public Policy Committee
Meeting Minutes
March 6, 2024

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

Committee Members		Community Base Organizations (Alternates)	
✓	Joe Neves, Chairman	✓*	Jeff Garner, KCAO
✓	David Phillips, Provider Representative		Roberto Garcia, Self Help
✓	Martha Miranda, Kings County Representative		**Staff Members**
✓	Sylvia Garcia, Fresno County Representative	✓	Courtney Shapiro, Director Community Relations
✓	Kristi Hernandez, Fresno County Representative	✓	Cheryl Hurley, Commission Clerk / Director, HR /Office
✓	Maria Arreola, At-Large Representative	✓	Mary Lourdes Leone, Chief Compliance Officer
✓	Norma Mendoza, Madera County Representative	✓	Steven Si, Senior Compliance & Privacy/Security Specialist
		✓	Jeff Nkansah, CEO
		✓	Maria Sanchez, Compliance Manager
		✓	Patrick Marabella, MD, CMO
		✓	Amy Schneider, RN, Director, Medical Management
		*	= late arrival
		•	= participation by teleconference

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
#1 Call to Order Joe Neves, Chair	The meeting was called to order at 11:33 am. A quorum was present.		A roll call was taken.
#2 Meeting Minutes from December 6, 2023 **Action** Joe Neves, Chair	The December 6, 2023, meeting minutes were reviewed and approved. *Jeff Garner arrived at 11:35 am; not included in vote*		**Motion:** Approve December 6, 2023, Minutes 7-0-0-2 (S. Garcia / D. Phillips)
#3 Enrollment Dashboard	Maria Sanchez presented the enrollment dashboard through December 2023. Membership as of December 31, 2023, was 430,517. CalViva Health maintains a 67.65% market share.		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
Information Maria Sanchez, Compliance Manager			
#4 Annual Report **Information** Courtney Shapiro	The Annual Report is a reflection from July 2023 through June 2024. This is a mandated report by DHCS and is for the benefit of stakeholders, community partners, and elected officials, and is posted on the CVH website for public viewing. Courtney Shapiro gave a brief summary of the report and each PPC member was provided a hard copy of the annual report.		**No Motion**
#5 Committee Member Update **Information** Joe Neves, Chair Courtney Shapiro	Public Policy Committee membership has been updated as follows: New members: Martha Miranda, Kings County, initial appointment for a term of one year. Martha gave an introduction of herself and her background. She is a volunteer of St. Bridget's and likes to learn and be informed of new things. Renewals: Maria Arreola, At-large member, was renewed for a three-year term.		**No Motion**
#6 PPC New Member Selection Committee **Information** Joe Neves, Chair Courtney Shapiro	Courtney Shapiro gave a brief overview of the newly required Selection Committee required by the Department of Health Care Services. The selection committee is now responsible for approving any new applicants when there are vacancies on the Public Policy Committee. The committee consists of Dr. David Hodge, Commission Chair, David Phillips, Provider PPC member, Norma Mendoza, Madera County PPC member, and Roberto Garcia, CBO PPC Member.		**No Motion**
#7 Appeals, Grievances and Complaints **Information** Maria Sanchez Dr. Marabella, CMO	For Q4 2023 there were no (0) Coverage Disputes (Appeals), 74 Disputes Involving Medical Necessity (Appeals), 59 Quality of Care, 154 Access to Care, and 256 Quality of Service, for a total of 546 appeals and grievances for the quarter. The majority of which are from Fresno County. Dr. Marabella gave an overview of the grievance and appeals process and how it's tracked. Once a complaint is received Health Net will process the complaint and figure how what type of complaint it is. Health Net will put together the case and categorize it. The Quality of Care (QOC) issues come to CalViva Health, then Dr. Marabella reviews for type of issue. Members can also complain and appeal a service, which also goes to Health Net to put together a case and then decide if they will overturn the appeal or overturn the ruling. Dr. Marabella then has the	*PPC member David Phillips commented that he appreciated the explanation, and it was nice to hear it again.*	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	final say based on medical necessity. The Appeals & Grievances Dashboard is a spreadsheet that tracks the appeals and grievances on a monthly basis. When grievances are received, if they are standard grievances the Plan has 30 days to correct it, or expedite it and correct it within 72 hours, based on the type of complaint. Grievances for 2023 significantly increased from 2022; however, the volume of membership has also increased. Grievances are either scored as Quality of Service which means there's no clinical care issue, or Quality of Care which is a clinical care issue. There are several categories within Quality of Service which include, Access, Administration, Continuity of Care, Interpersonal, Mental Health, Other, Pharmacy, and Transportation. There are also several categories within the Quality of Care category, such as Access, Mental Health, Other, PCP Care, PCP Delay, Pharmacy, Specialist Care, and Specialist Delay. The reasoning behind the volume of grievances has been due to COVID, Telehealth, more people on Medi-Cal, and less staff in physician offices, leading to lower service levels. Relatively, the Appeals had fewer cases. Appeals are categorized as pre-service and post-service. The majority of pre-service appeals were Advanced Imaging. As for the per thousand member per month (PTMPM) for grievances, the total increased in 2023 over 2022. The PTMPM for appeals was consistent with previous year. Maria Sanchez continued her report of Appeals Grievances and Complaints for 2023. There were 59 appeal cases for Fresno County, 4 for Kings County, 12 for Madera County, for a total of 75 for Q4 2023. There were 390 grievances cases for Fresno County, 51 for Kings County, and 30 for Madera County for a total of 471 for Q4 2023. The turn-around time compliance for resolving appeal and grievance cases was 99.94% for Standard Grievances, and 100% for Expedited Grievances. Standard Appeals and expedited appeals were both met at 100%. There was a total of 397 Exempt Grievances received in Q4 2023. Of the total grievances and appeals received in Q4, the following were associated with Seniors and Persons with Disabilities (SPD): • Grievances: 134		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Appeals: 20 • Exempt: 18 The majority of appeals and grievances were from members in Fresno County (largest CalViva Health enrollment). The majority of quality of service (QOS) grievance cases resolved were categorized as Access-Other, Administrative, and Other. The majority of quality of care (QOC) cases were categorized as PCP Delay, PCP Care, and Specialist Care. The top categories of appeal cases were related to Advanced Imaging, Other, and Pharmacy/RX. The top categories for exempt grievances were Balance Billing, PCP Assignment/Transfer Health Plan Assignment Change Request, and Health Plan Materials-ID cards not received.		
#8 Regulatory Audit Status **Information** Mary Lourdes Leone	Mary Lourdes Leone gave an update of the 2023 DHCS Audit Correction Plan (CAP), and the 2022 DMHC Audit Preliminary Report and CAP. With regard to the 2023 DHCS Audit, the State identified one deficiency relating to CalViva not identifying or processing all expressions of dissatisfaction as grievance; any expression of dissatisfaction is to be classified as a grievance. CalViva has identified the corrective action, and each month provides the DHCS with a status update. The last audit update was submitted March 1, 2024. With regard to the 2022 DMHC Audit, the preliminary audit report was not received until the Fall of 2023. DMHC identified 11 deficiencies ranging from incorrect template letters to how claims were processed from out of network hospitals. CalViva submitted a response to DMHC for all the deficiencies and the CAPs and is waiting for a response from the State.	*Dr. Marabella clarified, the DHCS is the Department of Health Care Services. This is the state agency that runs all of Medi-Cal. The DMHC, the Department of Managed Health Care, runs all managed care for all health plans.* *Mary Lourdes clarified CAP is the acronym for*	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
		Corrective Action Plan. *Courtney Shapiro added that for future meetings staff presenting will continue to elaborate what an acronym stands for when discussed during reporting.*	
#9 Health Education **Information** Steven Si	Steven Si presented the Q3 and Q4 2023 Member Incentive Programs Semi-Annual Report. The purpose of this activity is to offer CalViva Health members an opportunity to earn an incentive to increase participation in programs such as Well Care Visits, Breast Cancer Screening, Cervical Cancer Screening, and Childhood Immunization. A total of 1,634 CalViva Health members participated in the four-member incentive programs during Q3- Q4 2023. In total, $40,850.00 worth of gift cards were distributed to the members as awards. Out of the recipients, 49% were from Fresno County, 31% were from Madera, and 20% were from Kings. There was a 27% decrease in the total member incentive awards given during Q3-Q4 2023. The member incentive award program for the BCS overall strategy continues to be implemented during Quarters 3-4 of 2023. The BCS Member Incentive Program offers one to two $25 prepaid cards, to encourage non-compliant members to complete their breast cancer screening. A total of 385 gift cards were distributed among members who engaged with their provider to close the BCS care gap. The gift cards were distributed as follows: 155 to members in Fresno County, 70 to members in Kings County, and 160 to members in Madera County. In 2023, CalViva Health continues the Cervical Cancer Screening Member Incentive Program. This program offers one to two $25 prepaid cards to members who complete their cervical cancer screening, with the aim of encouraging non-compliant members to complete their	*PPC member Martha Miranda asked where members would obtain information as to what programs are available?* *Steven Si responded, it's a collaborative effort. Members can get information from the Member Call Center, Provider offices, Provider Engagement team, emails to members, CVH website, and word of mouth.*	**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	cervical cancer screening. As part of the program, providers have agreed to be responsible for reaching out to the parents and/or guardians of members to schedule CCS appointments. To further support member engagement, Walmart cards are used based on member recommendations and preferences. In Quarters 3-4 of 2023, a total of 43 gift cards were distributed to members in Kings County for engaging with their providers to close the BCS care gap. The incentive award for the CIS-10 overall strategy is still being implemented for Quarters 3-4 of the year 2023. In total, 120 gift cards were distributed to members in Fresno County as a reward for engaging with their provider to close the CIS-10 care gap. In 2023, CalViva Health continues its WCV Member Incentive Program that was launched in 2022. The program offers $25 prepaid cards to encourage parents and guardians of non-compliant members aged 3-21 to complete their well care visits (WCV). Providers have agreed to be responsible for contacting the parents and/or guardians of the members to schedule WCV appointments. To support member engagement, Walmart cards are used based on member recommendation and preference. In Quarters 3-4 of 2023, a total of 1,086 members received gift cards for engaging with their provider to close the WCV care gap. The gift cards were distributed as follows: 523 for Fresno County, 213 for Kings County, and 350 for Madera County. The total number of member incentive awards given in Q3-Q4 2023 decreased by 27% compared to Q1-Q2 2023. At the county level, Fresno had a decrease of 1,088 in incentives, Kings had an increase of 161, and Madera had an increase of 327. The previous Diabetes Prevention Program (DPP) vendor terminated business as of January 30, 2023. The health plan identified several DPP vendors and scheduled demo meetings. Not all vendors were able to meet all DHCS APL 18-018 requirements. The health plan identified a DPP vendor that met all the requirements and is working to onboard the vendor. Once everything has been reviewed the Plan will submit the DHCS application for approval. The next steps moving into Q1 and Q2 2024, CalViva will continue to distribute member incentives at point-of-care in collaboration with Childhood Immunization Status, Cervical Cancer Screening, Breast Cancer Screening, and Child and Adolescent Well Care Visits. CalViva will work to fully implement the Quality EDGE Program. A new member incentive request will be		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	submitted to the DHCS Quarter 1, 2024 requesting to cover all Medi-Cal Accountability Set (MCAS) measures held to the Minimum Performance Level (MPL). To be able to incentivize members for all applicable priority MCAS measures will enhance CalViva Health's ability to foster greater engagement between members and providers.		
#10 Annual Compliance Report **Information** Mary Lourdes Leone	In 2023, the Compliance Program was focused on the following key activities: • Standing up an Exclusively Aligned Enrollment, Dual Eligible Special Needs Plan ("EAE-DSNP") with Health Net named, "Wellcare CalViva Health Dual Align (HMO D-SNP)." • Completing all 2024 Operational Readiness Contract requirements and executing the 2024 Contract on December 20, 2023. • Responding to the annual 2023 Department of Health Care Services ("DHCS") audit and the 2022 triennial Department of Managed Care ("DMHC") audits. • Implementing the Plan's California Advancing and Innovating Medi-Cal (CalAim) Models of Care for the Children and Youth and Justice Involved populations of focus ("POF"); and • Preparing for the National Committee for Quality Assurance ("NCQA") accreditation. The Member Service Call Center received 140,329 calls, of which 139,171 were answered. Overall service level was 88%. The Member Service Call Center for Mental Health received 4,049 calls, of which 4,012 were answered. Overall service level was 92%. There were 6,860 welcome calls made to new members in 2023. The Provider Network remains stable. In 2023, contracted providers were sent approximately 266 Provider Updates with information on contractual and regulatory matters as well as health plan news and announcements. CalViva Health staff also reviewed 38 informational letter templates for contracted providers and 19 forms intended for provider use. In 2023, 33 communications were reviewed by the Plan. This included member-informing materials, health education, and information about incentive programs. It also included 12 Printed Provider Directories and 1 Member Newsletter. The 2023 Member Handbook/Evidence		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	of Coverage (EOC) was made available to members by posting to the CalViva Health website for downloading. In 2023 the Plan completed ten (10) Delegation Oversight Audits for Health Net in the areas of Appeals and Grievances, Call Center, Claims, Credentialing, Fraud Waste & Abuse, Health Education, Pharmacy, Privacy and Security, Provider Disputes, and Utilization Management. Corrective action plans (CAPs) were required for two of the functional areas, Claims and Credentialing. CAPS have been completed and approved for all categories. For calendar year 2023, the Plan had a total of 2,252 Grievances and Appeals, of which 2,190 were resolved with 99.91% turn-around-time. The number of cases resolved for Seniors & Persons with Disabilities (SPDs) was 668 with a 100% turn-around-time. The number of cases resolved for Exempt Grievances was 1,885 with a 100% turn-around-time. The Regulatory audits and Corrective Action Plans (CAPs) included: • 2023 DHCS Audit • DHCS -2021-2022 EQR Performance Evaluation • DHCS 2023 Encounter Data Validation (EDV) Study • 2023 DHCS Annual Network Certification (ANC) • RY 2022 Subnetwork Certification • 2024 Operational Readiness Work Plan • DMHC Measurement Year (MY) 2022 Timely Access Report (TAR) • DMHC Compliance with Timely Access and Network Reporting Statutes • 2022 DMHC Triennial Audit New or expanded benefits or programs consist of: • Enhanced Care Management (ECM) and Community Supports (CS) • Long Term Care (LTC) Phase II Carve-In • Adult Expansion The Plan executed the 2024 DHCS Medi-Cal Contract on December 20, 2023. Some key new requirements are briefly described below along with the Plan's compliance efforts: • Hire a Health Equity Officer		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Develop Diversity, Equity, and Inclusion (DEI) policies. • Achieve and maintain full NCQA Health Plan Accreditation and Health Equity Accreditation • Provide all Medically Necessary Covered Services for members residing in or obtaining care in an Intermediate Care Facility/Developmental Disabilities ("ICF/DD") and Subacute Care facilities. • Submit fully executed MOUs with third-party entities (i.e., Local Government Agencies, Health Departments, etc.) • Implement a EAE D-SNP product in the Service Area • Develop a Population Health Management Strategy In 2024, The Plan anticipates developing new policies and implementing/revising existing processes as a result of the initiatives described above, as well as new regulatory guidance and laws becoming effective in 2024. The Compliance Program will continue to focus on meeting the regulatory requirements associated with the 2024 DHCS Contract, working with our Plan Administrator towards achieving NCQA Accreditation, and overseeing Health Net's operation of the EAE-DSNP in our service area, and supporting Population Health Management regulatory activities. The Plan will continue its efforts to implement ECM/CS in Fresno, Kings, and Madera counties by submitting updated Models of Care (MOCs) that include updated reports of new POFs transitioning into ECM and expanding provider capacity for ECM/CS. In 2024, CalViva will once again be audited by DHCS, and will continue to submit all required documentation in fulfillment of the Operational Readiness Contract. Generally, the Plan expects increased regulatory oversight and monitoring of health plan activities, in the following areas: • Provider network adequacy and certification requirements for direct and delegated networks • Timely Access • Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) • Behavioral Health • Encounter data quality and timeliness.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	• Clinical Quality Improvement (MCAS measures) • Member Grievances/Appeals • Health Equity • Member Experience/Member Rights The Compliance Department's efforts will focus on preparing for and monitoring the successful implementation of all new and current requirements.		
#11 2024 CalViva Health member Handbook / Evidence of Coverage **Action** Mary Lourdes Leone	Mary Lourdes Leone confirmed every year, effective January 1st, CalViva is required to post the new Member Handbook / Evidence of Coverage (EOC) online on the CVH website. The 2024 Member Handbook is up and available on the CVH website. A hardcopy is also mailed out to new members.		**No Motion**
#12 CalAIM, Promotores Health Network Update **Information** Elizabeth Campos Adela Maciel de Corona	Elizabeth Campos presented updates on the CalAIM program. Focus areas of CalAIM include Enhanced Care Management (ECM), Community Supports (CS), Community Health Work (CHW), Doula, and Street Medicine. There are 26 Community Supports Providers; 15 Enhanced Care Management Providers; 7 Community Health Worker and Doula Providers, and 2 Street Medicine Providers. CalAIM Services and Populations of Focus programs include: Community Supports (CS): 1. Asthma remediation 2. Community Transition Services/Nursing Facility Transition to a Home 3. Day Habilitation Programs 4. Environmental Accessibility Adaptations (Home Modifications) 5. Housing Deposit 6. Housing Tenancy and Sustaining Services 7. Housing Transition Navigation Services 8. Meals/Medically Tailored Meals 9. Nursing Facility Transition/Diversion to Assisted Living Facilities 10. Personal Care and Homemaker Services		**No Motion**

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	11. Recuperative Care (Medical Respite) 12. Respite Services 13. Short-term Post-Hospitalization Housing 14. Sobering Centers Enhanced Care Management (ECM) Population of Focus: 1. Individuals Experiencing Homelessness; Adults, Families, Children/Youth 2. Individuals At Risk for Avoidable Hospital or ED Utilization: Adults, Childre/Your 3. Individuals with Serious Mental Health and/or SUD Needs: Adults, Children/Youth 4. Adults Livings in the Community and Ad Risk for LTC Institutionalization 5. Adult Nursing Facility Residents Transitioning to the Community 6. Children and Youth Enrollment in CCS or CCS WCM with Additional Needs Beyond the CCS Condition 7. Children and Youth Involved in Child Welfare 8. Birth Equity Population of Focus: Adults, Children/Youth 9. Individuals Transitioning from Incarceration: Adults, Children/Youth Areas of needs within the CalAIM Network include: Community Supports within Kings and Madera Counties include: • Recuperative Care (Medical Respite) • Short-term post-hospitalization • Sobering Centers Enhanced Care Management (ECM) Populations of Focus within Kings and Madera Counties include: • Adults Living in the Community and At Risk for LTC Institutionalization • Adult Nursing Facility Residents Transitioning to the Community Adela Maciel de Corona, the Promotores Health Network Coordinator, provided an update on monthly activities and redetermination projects. The Promotores Health Network Program monthly activities include: 1. PHN Education Class 2. Walking Club (2 Locations) 3. Reading Club	*PPC member Martha Miranda asked if these programs are available in all three service counties?*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	4. Art & Crafts Class 5. Viernes Social (Social Support/Networking) 6. Bailoterapia (Dance Therapy – 3 Locations) Participation for Q4 2023 included 1,448 participants, of which 1,025 of those were CalViva Health members. Key activities for the PHN Program Redetermination Project for Q2-Q4 2023 include: • Community Events • Educational Presentations • Outreach/Referrals • Social Media Messages There were 41 community events, 575 redetermination referrals, and 3,414 connections made with the public, of which 1,615 were CalViva Health Members. In the past six months, Promotores received a call requesting a presentation on WellCare. The presentation was presented in Spanish, and they ended up enrolling over 25 members.	*Adela stated these programs are currently only available in Madera County.* *Mary Lourdes added that WellCare is essentially Health Net's advantage plan and CalViva has become affiliated.* *Courtney Shapiro added that even though Promotores is essentially Madera County, they step in to assist Fresno County with events.* *PPC member Martha Miranda asked if Promotores can go into Kings County to*	

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
		promote the program? *Adela stated, yes, they can if they are invited.*	
#13 Meaningful Stakeholder Engagement Presentation **Information** Pao Houa Lee	Pao Houa Lee was present to present the Meaningful Stakeholder Engagement Presentation. Although CalViva Health is no longer pursuing the Plus accreditation, Pao Houa engaged the PPC and attendees with the presentation on Social Drivers of Health survey for informational and feedback purposes. Elizabeth Campos added the FindHelp.org link includes CalAIM Providers.		**No Motion**
#14 Announcements	Courtney Shapiro has received all PPC members' demographic report; names will not be included when submitted to the State. CalViva helped with funding a room at the new Marjaree Mason Center location; the room will be named after CalViva Health. The location will be up and operating by the end of 2024. The location is the old Heald College on Bullard and Blackstone. In the works is a CalViva soccer field at the Fresno Rescue Mission aka Fresno Mission, at the new City Center. All funds for the CalViva Health Youth Recreation Fund have been exhausted for the year. Jeff Nkansah, CEO, announced that enhancements are in the works for the CVH website. The enhancement for the ability to change a PCP has been very effective. Enhancement in the works is possibly having the ability to obtain the member ID card. Norma Mendoza shared there is a CalViva Health sponsored event Saturday March 9th celebrating International Women's Day in the cafeteria of Madera South High School at 10:00 am. For requests for CalViva Sponsored events, email Courtney Shapiro.		

AGENDA ITEM / PRESENTER	DISCUSSIONS	RECOMMENDATION(S) / QUESTION(S) / COMMENT(S)	ACTION TAKEN
	PPC Member Martha Miranda stated if there's any events that can be sponsored in Kings County, she's open to the opportunity. Maria Arreola shared information on a Parkinson's conference. There were 500 participants from around the world; 80% of participants were from the central valley, Madera and Fresno Counties. Maria asked if CalViva has any programs or support groups to help members with Parkinson's? Courtney Shapiro stated there are usually support groups through the specialist physician. At this time there are no CalViva support groups specifically through CalViva. Adela added the current Parkinsons physician available on the network is unfamiliar with any support groups. Courtney Shapiro recommended Valley Caregiver Resource Center. Courtney Shapiro also announced there is a Greater Fresno Parkinson's Support Group Jeff Garner mentioned the CalViva Health commercials have been great. He gave a shoutout to Elizabeth Campos stating she's been a great navigator for KCAO and the CalAIM program. KCAO is bringing on a new staff member to specifically assist with the CalAIM program. David Phillips announced UHC is up to 31 health centers, with three more opening this summer. UHC is also adding additional services, including GI to the Bullard site, and Mammography screening at the Minnewawa site. There is a UHC fun run/walk in July.		
#15 Public Comment	None.		
#16 Adjourn	Meeting adjourned at 1:42 pm.		

NEXT MEETING June 5, 2024, in Fresno County
11:30 am - 1:30 pm

Submitted This Day: June 5, 2024,

Submitted By: C Shapiro
Courtney Shapiro, Director Community Relations & Marketing

Approval Date: June 5, 2024

Approved By: Joe Neves
Joe Neves, Chairman

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY
FINANCE COMMITTEE CHARTER

I. Purpose

A. The purpose of the Finance Committee is to provide a committee structure to monitor and evaluate the financial status of the Fresno-Kings-Madera Regional Health Authority (RHA) from a regulatory compliance and general operating standpoint and to advise RHA on matters which are within the purview of the Finance Committee.

II. Authority

A. The Finance Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority (RHA) Commission in an advisory capacity.

III. Definitions

A. Fresno-Kings-Madera Regional Health Authority (RHA) Commission -
The Fresno-Kings-Madera Regional Health Authority (referred to as the RHA), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Responsibilities

A. The Commission's Finance Committee will discuss, advise and make recommendations to the Commission on the following areas:
   1. Compliance with all financial statutory, regulatory, and industry standard requirements
   2. Medi-Cal managed care rate and impact to the Regional Health Authority
   3. Budgets prior to submission to the Commission
   4. Unaudited financial statements prepared by staff
   5. Compensation and benefit levels for staff
   6. Selection of an independent auditing firm.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee.
   2. The Finance Committee shall consist of at least three (3) Commission members, the Chief Executive Officer, and the Chief Financial Officer.
      2.1. Chairperson: Chief Financial Officer.
      2.2. The Committee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership

1. Commissioner Committee members' terms will be established by the RHA Commission Chairperson on an annual basis at the start of each fiscal year.

C. Vacancies
1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
1. All members of the Committee shall have one vote each
2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings

A. Frequency
1. The frequency of the Finance Committee meeting will be at least quarterly
2. The Committee Chairperson or RHA Commission may call additional meetings as necessary
3. A quorum consists of at least 51% of the membership
4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Minutes
1. Minutes will be kept at every Finance Meeting by a designated staff member. Signed, dated, summary minutes are kept. Minutes are available for review by regulatory entities.
2. A report of each meeting will be forwarded to the RHA Commission for oversight review.

C. Structure

The meeting agenda will consist of:
1. Approval of minutes
2. Standing Items
3. Activity Reports
4. Data Information Reports
5. Ad-hoc Items

VII. Committee Support

A. The Chief Financial Officer/staff will provide Committee support, coordinate activities and perform the following as needed:
1. Regularly attend meetings
2. Assist Chairperson with preparation of agenda and meeting documents
3. Perform or coordinate other meeting preparation arrangements
4. Prepare minutes

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** ~~7/20/2023~~

David Hodge, MD
Commission Chairperson

Fresno-Kings-Madera Regional Health Authority
Credentialing Subcommittee Charter

I. Purpose:

A. The purpose of the Credentialing Subcommittee is to give input on the credentialing and re-credentialing policies used by CalViva Health ("CalViva" or the "Plan") and its Operating Administrator (Health Net) and monitor delegated credentialing/recredentialing activities. Delegated entities performance and compliance with credentialing standards will be monitored and evaluated on an ongoing basis by CalViva's Chief Medical Officer ("CMO"), the Chief Compliance Officer ("CCO"), and CalViva's Credentialing Subcommittee.

II. Authority:

A. The Credentialing Subcommittee serves as a Subcommittee of the Quality Improvement/Utilization Management ("QI/UM") Committee and is given its authority by the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission to act in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The Credentialing Subcommittee's responsibilities include, but are not limited to:

A. Makes recommendations regarding credentialing and recredentialing, policies, processes, and standards.
B. Has final decision-making responsibility to monitor, sanction, suspend, terminate or deny practitioners or organizational providers.
C. Provide oversight of delegated credentialing and recredentialing functions.
D. Report sanctions for quality of care issues to the appropriate licensing authority including 805 reporting requirements.
E. Provide quarterly summary reports of Credentialing activities to the QI/UM Committee and RHA Commission.
F. Ensure that the Plan's credentialing and recredentialing criteria and activities are in compliance with state, federal, NCQA and contractual requirements.

V. Committee Membership:

A. Composition
   1. The RHA Commission shall appoint the members of the Subcommittee.

2. The Subcommittee is chaired by the CalViva CMO.
3. Subcommittee size is determined by the Commission with the advice of the CMO.
4. The Subcommittee is composed of participating physicians including external participating practitioners who are also serving as members of the QI/UM Committee.
   a. Subcommittee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
   b. Membership shall consist of primary care providers and specialists to reflect our provider network.
   d. The Subcommittee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Subcommittee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   If vacancies arise during the term of Subcommittee membership, the RHA Commission will appoint a replacement member.

D. Voting
   1. All members of the Subcommittee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the Subcommittee meetings will be at least quarterly.
   2. The Subcommittee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the Subcommittee members.
   2. Subcommittee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
   1. Minutes will be kept at every Subcommittee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.

D. Confidentiality
   1. Content of the meetings is kept confidential.
   2. All members sign a confidentiality statement that shall be kept on file at CalViva Health.
   3. Meetings, proceedings, records and review/handling of related documents will comply with all applicable state and federal laws and regulations regarding confidential information, including, but not limited to, the California Confidentiality of Medical Information Act (California Civil Code, Section 56 et seq.); the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. 290dd-2); and the Privacy Act (U.S.C. 552a) and any other applicable state and federal law, rule, guideline or requirement.
   4. Meeting proceedings and records as well as related letters and correspondence to providers and/or members are also protected from discovery under California Health & Safety Code 1370 and CA Evidence Code 1157.

VII. Committee Support:

The Plan Medical Management department staff will provide Subcommittee support, coordinate activities, and perform the following as needed:

A. Regularly attend Subcommittee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and discussions,
E. Ensure a quarterly summary of Subcommittee activity and recommendations is prepared for submission to the QI/UM Committee and RHA Commission.

VIII. Authority

1. Health & Safety Code Sections 1370, 1370.1
2. California Code of Regulations, Title 28, Rule 1300.70
3. California Evidence Code Section 1157
4. California Civil Code, Section 56 et seq. (California Confidentiality of Medical Information Act)
5. 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Administration Reorganization Act)
6. U.S.C. 552a (Privacy Act)
7. DHCS Contract, Exhibit A, Attachment 4
8. MMCD Policy Letter 02-03
9. RHA Bylaws

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** ~~7/20/23~~

Fresno-Kings-Madera Regional Health Authority
Peer Review Subcommittee Charter

I. Purpose:

A. The Subcommittee processes and activities have been established to achieve an effective mechanism for the Plan's continuous review and evaluation of the quality of care delivered to its enrollees, including monitoring whether the provision and utilization of services meets professional standards of practice and care, identifying quality of care problems, addressing deficiencies by the development of corrective action plans, and initiating remedial actions and follow-up monitoring where necessary and appropriate. Through the Plan's peer review protected activities, the Plan aims to assure its enrollees receive acceptable standards of care and service.

B. To provide a peer review committee structure for the consideration of patterns of medically related grievances that the Chief Medical Officer (CMO) determines require investigation of specific participating providers and to provide peer review of practitioners or organizational providers experiencing problematic credentialing issues, performance issues or other special circumstances.

II. Authority:

A. The Peer Review Subcommittee serves as a Subcommittee of the Quality Improvement/Utilization Management ("QI/UM") Committee and is given its authority by the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission to act in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Focus:

The Peer Review Subcommittee's responsibilities include, but are not limited to:

A. Makes recommendations regarding peer review policies, processes, and standards.
B. Reviews potential quality incidents referred by the QI/UM Committee that might involve the conduct or performance of specific practitioners or organizational providers and should be further investigated.
C. Report sanctions for quality-of-care issues to the appropriate licensing authority including 805 reporting requirements.
D. Establish and maintain a process for provider appeal of provider sanctions including a process of conducting fair hearings for providers who are sanctioned for issues related to quality of care.

E. Provide quarterly summary reports of Peer Review activities to the QI/UM Committee and RHA Commission.
F. Ensure that the Plan's peer review criteria and activities are in compliance with state, federal, NCQA and contractual requirements.

V. Committee Membership:

A. Composition
   1. The RHA Commission shall appoint the members of the Subcommittee.
   2. The Subcommittee is chaired by the CalViva CMO.
   3. Subcommittee size is determined by the Commission with the advice of the CMO.
   4. The Subcommittee is composed of participating physicians including external participating providers who are also serving as members of the QI/UM Committee.
      a. Subcommittee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
      b. Membership shall consist of primary care providers and specialists to reflect our provider network.
      c. Participating Practitioners from other specialty areas shall be retained as necessary to provide peer review input.
      d. The Subcommittee shall be composed of less than a quorum of voting Commissioners.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Subcommittee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   If vacancies arise during the term of Subcommittee membership, the RHA Commission will appoint a replacement member.

D. Voting
   1. All members of the Subcommittee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency
   1. The frequency of the Subcommittee meetings will be at least quarterly.
   2. The Subcommittee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
   3. A quorum consists of at least 51% of the membership.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the Subcommittee members.
   2. Subcommittee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
   1. Minutes will be kept at every Subcommittee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities.

D. Confidentiality
   1. Content of the meetings is kept confidential.
   2. All members sign a confidentiality statement that shall be kept on file at CalViva Health.
   3. Meetings, proceedings, records and review/handling of related documents will comply with all applicable state and federal laws and regulations regarding confidential information, including, but not limited to, the California Confidentiality of Medical Information Act (California Civil Code, Section 56 et seq.); the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. 290dd-2); and the Privacy Act (U.S.C. 552a) and any other applicable state and federal law, rule, guideline or requirement.
   4. Meeting proceedings and records as well as related letters and correspondence to providers and/or members are also protected from discovery under California Health & Safety Code 1370 and CA Evidence Code 1157.

VII. Committee Support:

The Plan Medical Management department staff will provide Subcommittee support, coordinate activities and perform the following as needed:

A. Regularly attend Subcommittee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and discussions,
E. Ensure a quarterly summary of Subcommittee activity and recommendations is prepared for submission to the QI/UM Committee and RHA Commission.

VIII. Authority

1. Health & Safety Code Sections 1370, 1370.1
2. California Code of Regulations, Title 28, Rule 1300.70
3. California Evidence Code Section 1157
4. California Civil Code, Section 56 et seq. (California Confidentiality of Medical Information Act)

5. 42 U.S.C. 290dd-2 (Alcohol, Drug Abuse and Mental Health Administration Reorganization Act)
6. U.S.C. 552a (Privacy Act)
7. DHCS Contract, Exhibit A, Attachment 4
8. MMCD Policy Letter 02-03
9. RHA Bylaws

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** ~~7/20/23~~

Fresno-Kings-Madera Regional Health Authority
Quality Improvement/Utilization Management Committee Charter

I. Purpose:

A. The purpose of the Quality Improvement/Utilization Management ("QI/UM") Committee is to provide oversight and guidance for CalViva Health's ("CalViva" or the "Plan") QI, UM, Health Equity, and Credentialing Programs, monitor delegated activity, and provide professional input into CalViva's development of medical policies.
B. The QI/UM Committee monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, recommends policy decisions, evaluates the results of delegated, nondelegated, and collaborative QI and UM activities, institutes needed actions, and ensures follow up as appropriate.

II. Authority:

A. The QI/UM Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission in an advisory capacity.

III. Definitions:

A. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera.

IV. Committee Responsibilities:

The QI/UM Committee's responsibilities include but are not limited to the following activities.

A. Review and recommend approval to the RHA Commission of the program documents listed below:
   1. Annual QI and Health Education Program Description
   2. Annual QI and Health Education Work Plan
   3. Annual QI Program Evaluation
   4. Annual UM Program Description
   5. Annual CM Program Description
   6. Annual CM Program Evaluation
   7. Annual UM/CM Work Plan
   8. Annual UM/CM Program Evaluation
   ~~9. Annual Health Education Program Description~~
   ~~10. Annual Health Education Work Plan~~
   ~~11.~~9. Annual Health Education Program Evaluation
   ~~12.~~10. Annual Health Equity ("HE") Program Description

~~13.~~11. Annual Health Equity Work Plan
~~14.~~12. Annual Health Equity Program Evaluation
~~15.~~13. Population Health Management Strategy Program Description
~~16.~~14. Population Health Management Assessment Report
~~17.~~15. Population Health Management Segmentation Report
~~18.~~16. Population Health Management Effectiveness Analysis Report
~~19.~~17. Quality Improvement Health Equity Transformation Plan

B. Reviews quarterly reports of Work Plan progress for the programs listed above;
C. Monitors key clinical and service performance indicators for QI, UM, HE and Credentialing/Recredentialing activities (e.g., access & availability, over and under utilization, key UM and case management indicators, behavioral health, population health, appeals and grievances, HEDIS® and CAHPS® measure results, provider satisfaction surveys, disease management and public health programs activities, timeliness standards etc.);
D. Analyze and evaluate the results of QI and Health Equity activities;
E. Monitor effectiveness of the language assistance services offered to support members with limited English proficiency and address identified health disparities, social risk, social drivers~~determinants~~ of health (SDoH), and community needs and makes ongoing recommendations;
F. Provide oversight and review reports of delegated UM and Credentialing/ Recredentialing functions and collaborative QI functions;
G. Reviews summarized grievance reports for medically related issues and administrative quality concerns;
H. Reviews analysis of potential quality incident reports (developed from grievances/complaints, utilization management, utilization reports suggesting over or under utilization);
I. Oversees and monitors CalViva's participation in the Department of Health Care Services ("DHCS") required Performance Improvement Projects ("PIPs");
J. Approve and oversee conduct of special QI studies as warranted;
I. Brings general medically-related concerns to the attention of the Plan's Operating Administrator (Health Net);
J. Analyze and evaluate the results of the QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees such as the Public Policy Committee and Community Advisory Groups.
K. Advises on the conduct of provider and member satisfaction surveys and submits its review to the Commission;
L. Reviews the results of clinical outcome studies, identifies gaps and reports findings to the Commission;
M. Forwards to the Credentialing Sub-Committee and ~~/~~Peer Review Sub-Committee potential quality incidents that might involve the conduct of specific providers and should be further investigated;
N. Receives reports from the Credentialing Sub-Committee and ~~/~~Peer Review Sub-Committee;
O. Provide quarterly summary reports of QI, UM, HE, and Credentialing activities to the RHA Commission.

P. Ensure that the Plan follows state, federal, contractual and NCQA requirements for QI, UM, HE and Credentialing.
Q. Ensures member confidentiality is maintained during Committee discussions.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee.
   2. The Committee is chaired by the CalViva Chief Medical Officer ("CMO").
   3. The CalViva Health Equity Officer shall attend the QI/UM ~~is a member of the~~ Committee and functions in an advisory capacity.
   4. Committee size is determined by the RHA Commission with the advice of the CMO.
   5. The QI/UM Committee will be composed of:
      5.1. Participating health care providers, including external participating physicians, as well as other health care professional's representative of the CalViva direct contracting network and the Health Net provider network.
      5.2. The Committee composition may also include Commission members who are participating health care providers and shall be composed of less than a quorum of voting Commissioners.
      5.3. Committee membership shall reflect an appropriate geographic and specialty mix of participating practitioners including practitioners that serve the Seniors and Persons with Disabilities (SPD) population.
      5.4. Participating Practitioners from other specialty areas shall be ~~retained~~ consulted as necessary to provide specialty input.
      5.5. For ~~purpose~~the purpose of meeting a quorum, the RHA Commission Chair may appoint an alternate member, who is also a provider member of the RHA Commission, to serve as a voting member of the committee.

B. Term of Committee Membership
   1. Appointments shall be made for two (2) years.
   2. Commissioner Committee members' terms are coterminous with their seat on the Commission.

C. Vacancies
   1. If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member.

D. Voting
   1. All members of the Committee shall have one vote each.
   2. If a potential conflict of interest is identified, the involved member will be excused from discussion and voting.

VI. Meetings:

A. Frequency

1. The frequency of the QI/UM Committee meetings will be at least quarterly.
2. The Committee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
3. A quorum consists of at least 51% of the membership.
4. Meetings shall be open and public. Meetings will be conducted in accordance with California's Ralph M. Brown Open Meeting Law.

B. Notice
   1. The meeting date will be determined by the Chairperson with the consensus of the Committee members.
   2. Committee members will be notified in writing in advance of the next scheduled meeting.

C. Minutes
   1. Minutes will be kept at every Committee meeting by a designated staff member. Signed, dated, contemporaneous minutes are kept. Minutes are available for review by regulatory entities and will be submitted to DHCS upon request.
   2. A report of each meeting will be forwarded to the RHA Commission for oversight review and consideration of the Committee's recommendations.
   3. The minutes will be made publicly available on the CalViva Health website on at least a quarterly basis.

VII. Committee Support:

The Plan Medical Management department staff will provide Committee support, coordinate activities and perform the following as needed:

A. Regularly attend Committee meetings,
B. Assist Chairperson with preparation of agenda and meeting documents,
C. Perform or coordinate other meeting preparation arrangements,
D. Prepare minutes and capture specific "suggestions or recommendations" and improvement discussions,
E. Ensure a quarterly summary of Committee activity and Committee recommendations is prepared for submission to the RHA Commission.

VIII. Subcommittees and Work Groups reporting to QI/UM:

A. QI/UM Committee has two Subcommittees and three work groups:
   1. Credentials Sub-Committee and Peer Review Sub Committee each with their own charter
   2. QI/UM Operational Work Group consists of CalViva and Health Net staff/leadership. The QI /UM Operational Work Group has one sub group:
      - Appeals and Grievances Work Group consists of CalViva and Health Net staff to review, track, trend appeals and grievances and reports to QI/UM Operational Work Group
   3. Access Work Group reports information reviewed by CalViva and Health Net staff regarding access and availability of services to QI/UM Committee.

IX. Authority

A. Health & Safety Code Sections 1370, 1370.1
B. California Code of Regulations, Title 28, Rule 1300.70
C. DHCS Contract, Exhibit A, Attachments 4 and 5
D. RHA Bylaws

APPROVAL:

RHA Commission Chairperson David S. Hodge **Date:** ~~October 19, 2023~~

Fresno-Kings-Madera Regional Health Authority
Public Policy Committee Charter

I. Purpose:

A. The purpose of the Public Policy Committee is to provide a committee structure for the consideration and formulation of CalViva Health ("CalViva" or the "Plan") policy on issues affecting members. Subscribers and enrollees shall be afforded an opportunity to participate in establishing the public policy of the Plan.

II. Authority:

A. The Public Policy Committee is given its authority by and reports to the Fresno-Kings-Madera Regional Health Authority ("RHA") Commission. This authority is described in the RHA Bylaws.

III. Definitions:

A. **Public Policy** means acts performed by the Plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the Plan's facilities to provide health care services to them, their families, and the public. (Rule 1300.69)

B. **Fresno-Kings-Madera Regional Health Authority (RHA) Commission** – The governing board of CalViva Health.
   1. The Fresno-Kings-Madera Regional Health Authority (referred to as the "RHA"), is a public entity created pursuant to a Joint Exercise of Powers Agreement between the Counties of Fresno, Kings and Madera. On April 15, 2010, the RHA Commission adopted the name "CalViva Health" under which it will also do business.

IV. Committee Focus:

A. The Public Policy Committee's recommendations and reports will be regularly and timely reported to the Commission. The Commission shall act upon these reports and recommendations and the action taken by the Commission will be recorded in the minutes of the Commission's meetings.
B. Principal Responsibilities:
   1. Review a quarterly summary report regarding the specific nature and volume of complaints received through the grievance process and how those complaints were resolved.
   2. Make recommendations concerning the structure and operation of the Plan's grievance process including suggestions to assist the Plan in ensuring its' grievance process addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities.
   3. Review and evaluate member satisfaction survey results.
   4. Advise on health education and cultural and linguistic service needs through review of a population needs assessment, population health management, demographic, linguistic, and cultural information related to the Plan's

population to make recommendations regarding:

4.1. Linguistic needs of populations served and identify any enhancements or alternate formats that Plan materials may need.
4.2. Policies needed for increasing member access to services where there may be barriers resulting from cultural or linguistic factors.
4.3. Changes needed to the provider network to accommodate cultural, linguistic, or other ethnic preferences.
4.4. Improvement opportunities addressing member health status and behaviors, member health education, health equity, social drivers and gaps in services.

5. Advise on problems related to the availability and accessibility of services.
   5.1. Review data/other Plan information and make recommendations for policy or Plan/provider network changes needed related to Americans with Disabilities Act (ADA) requirements or to minimize barriers and increase access for members with disabilities (e.g. identifying potential outreach activities, etc.).
6. Review member literature and other plan materials sent to members and advise on the effectiveness of the presentation.
7. Make recommendations or suggestions for member outreach activities, community resources, topics, or articles/information for publication on the member website, in member education materials or newsletters, etc.
8. Recommend review/revision and/or development of policies and procedures to the RHA Commission or other Plan committees as appropriate based on the Committee's review of grievance, member satisfaction, and other Plan data.
9. Review financial information pertinent to developing the public policy of the Plan.
10. Review and provide input in annual reviews and updates to relevant policies and procedures, including PPC input pursuant to Exhibit A, Attachment III, Section5.2.11.E (Community Advisory Committee) that is relevant to policies and procedures affecting quality and Health Equity. CalViva Health must provide a feedback loop to inform PPC members how their input has been incorporated.
11. Other matters pertinent to developing the public policy of the Plan.

V. Committee Membership:

A. Composition
   1. The RHA Commission Chairperson shall appoint the members of the Committee. The Public Policy Committee Coordinator will convene a selection committee tasked with selecting the members of the Public Policy Committee. CVH must demonstrate a good faith effort to ensure that the Public Policy Committee selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the Public Policy Committee.

      The PPC selection committee must select all its PPC members promptly no later than 180 calendar days from the effective date of this contract.

Fresno-Kings-Madera Regional Health Authority
Public Policy Committee Charter

The Public Policy Committee shall consist of not less than seven (7) members, who shall be appointed as follows:

2. One member of the RHA Commission who will serve as Chairperson of the Committee.
3. One member who is a provider of health care services under contract with the Plan; and
4. All others shall be members (must make-up at least 51% of the committee members) entitled to health care services from the Plan or members can be a parent/caregiver of members less than 21 years of age.
   - 4.1. Public Policy enrollee members shall be comprised of the following:
     - 4.1.1. Two (2) enrollees from Fresno County
     - 4.1.2. One (1) enrollee from Kings County
     - 4.1.3. One (1) enrollee from Madera County
     - 4.1.4. One (1) At-Large enrollee from either Fresno, Kings, or Madera County
   - 4.2. Two (2) Community Based Organizations (CBO) representatives shall be appointed as alternate Public Policy Committee members to attend and participate in meetings of the Committee in the event of a vacancy or absence of any of the members appointed as provided in subsection 3.1 above.
     - 4.2.1. The alternates shall represent different Community Based Organizations (CBO) that serve Fresno, Kings, and/or Madera Counties and provide community service or support services to members entitled to health care services from the Plan.
     - 3.2.2 Two (2) alternates from the same CBO shall not be appointed to serve concurrent terms.
   - 4.3. The enrollee members and CBO representatives shall be persons who are not employees of the Plan, providers of health care services, subcontractors to the Plan or contract brokers, or persons financially interested in the Plan. In selecting the enrollee members and/or CBO representatives of the Committee, the RHA Commission Chairperson shall generally consider the makeup of the Plan's Medi-Cal enrollee population including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members and such factors such as ethnicity, demography, occupation, and geography. Any such selection or election of enrollee members or a CBO representative shall be conducted on a fair and reasonable basis.
   - 4.4. The Plan will leverage Member race, ethnicity, language, SOGI, and Social Determinate of Health information to identify potential candidates for PPC participation to ensure the demographic characteristics and populations served are represented. Through this process, CalViva Health will ensure at least 5% of the committee members represent a culturally diverse group of community members, consumers, and individuals.

Fresno-Kings-Madera Regional Health Authority
Public Policy Committee Charter

~~A.~~B. Term of Committee Membership

1. The Commissioner member may be appointed for a three (3) year term and his/her term will be coterminous with their seat on the Commission.
2. The provider member may be appointed for a three (3) year term.
3. Subscriber/enrollee members' and CBO representative terms shall be of reasonable length (one, two, or three years) and shall be staggered or overlapped so as to provide continuity and experience in representation.
4. At the conclusion of any term, a Committee member may be reappointed to a subsequent three-year term.

~~B.~~C. Vacancies

If vacancies arise during the term of Committee membership, the RHA Commission Chairperson will appoint a replacement member. Should a Public Policy member resign, is asked to resign, or is otherwise unable to serve on the PPC, CalViva Health must make its best effort to promptly replace the vacant seat within 60 calendar days of the vacancy.

~~C.~~D. Voting

1. All members of the Committee shall have one vote each.
2. When attending a meeting in place of a regular member, an alternate member shall be entitled to participate in the same manner and under the same standards as a regular member, to the extent that the alternate member is not otherwise disqualified from participating in discussion and voting on an item due to a conflict of interest.

~~D. Statewide Committee~~

~~1. CalViva Health must appoint one member of the Public Policy Committee, to serve as the representative to DHCS' Statewide Consumer Advisory Committee and consistent CalViva Health is responsible to compensate the Public Policy Committee member representative for their time and participation on DHCS' Statewide Consumer Advisory Committee, including transportation expenses to appear in person. Consistent with Exhibit A, Attachment 5.2.11D.~~

~~H.~~VI. Meetings:

The PPC Committee must hold its first regular meeting promptly after all initial PPC members have been selected by the PPC selection committee and quarterly thereafter. Regularly scheduled PPC meetings will be open to the public, meetings information will be posted publicly on CalViva Health's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

A. Frequency

1. The frequency of the Public Policy Committee meetings will be quarterly.
2. The Committee Chairperson or RHA Commission may call additional *ad hoc* meetings as necessary.
3. A quorum consists of at least 51% of the membership.
4. Meetings shall be open and public. Meetings will be conducted in accordance

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with California's Ralph M. Brown Open Meeting Law.

B. Place of Meetings
   1. CalViva Health will provide a location for PPC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.
   2. Sites selected for PPC should match or coincide with locations where Plan members reside or go to access services and have the ability to support virtual participation. The following should be considered when selecting a meeting site:
      • Meeting room must be able to accommodate PPC participants comfortably.
      • Safety protocols must be identified (exits, facility contact in case of emergency, etc).
      • Electrical outlets and wall space to accommodate presentation equipment (if needed).
      • Access to nearby parking and/or transportation lines.
      • Wheelchair accessible.

C. Notice
   1. At the end of each Public Policy Committee meeting, the next meeting date will be determined by consensus unless a pre-arranged schedule has been established.
   2. Committee members will be notified in writing in advance of the next scheduled meeting.

D. Minutes
   1. A written draft of minutes for each meeting and the associated discussions must be prepared. All minutes must be posted on CalViva Health's website and submitted to DHCS no later than 45 calendar days after each meeting. CalViva Health must retain the minutes for no less than 10 years and provided to DHCS, upon request.
   2. A report of each meeting will be forwarded to the RHA Commission and Quality Improvement/Utilization Management Committee for oversight review and consideration of the Committee's recommendations.

~~III.~~VII. Committee Support:

A. The Public Policy Committee Coordinator will provide Committee support, coordinate activities and perform the following as needed. A written job description detailing the PPC coordinator's responsibilities, which must include having responsibility for managing the operations of the PPC in compliance with all statutory, rule, and contract requirements, including, but not limited to:
   1. Regularly attend Public Policy meetings.
   2. Prepare agenda and meeting documents. Ensure documents are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in the meetings.

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3. CalViva Health will ensure that members are supported in their roles on the PPC, including but not limited to providing resources to educate PPC members to ensure they are able to effectively participate in meetings. Transportation and childcare reimbursement will be provided for PPC meetings. Meeting times will be scheduled to ensure the highest PPC member participation possible.
4. Perform or coordinate other meeting preparation arrangements.
5. Initiate and follow-up on action items and suggestions until completed and ensure that feedback is provided to the Committee to "close the loop".
6. Compliance staff will include a summary of Public Policy Committee activity and Committee recommendations in Compliance Reports to the RHA Commission.
7. Committee members can simply make the PPC Coordinator aware additional assistance is required by sending an email, phone call, or text. Assistance can include, but is not limited to the following:
   • Interpreter services for Committee Members upon request.
   • To arrange for interpreter services for PPC members the PPC Coordinator is responsible for partnering with Health Equity to contact and request interpreter services.

~~IV.~~VIII. Other Requirements:

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1. The Plan's Evidence of Coverage (EOC) includes a description of its system for member participation in establishing public policy.
2. The Plan will also furnish an annual EOC to its members with a description of its system for their participation in establishing public policy and will communicate material changes affecting public policy to members.
3. To ensure membership is representative of Fresno, Madera, and Kings Counties, CalViva Health must complete and submit to DHCS annually an Annual Public Policy Member Demographic Report by April 1 of each year. The Annual Member Demographic Report must include descriptions of all of the following:
   - Medi-Cal Managed Care Plans
   - The demographic composition of Public Policy Committee membership.
   - Define the demographics and diversity of its Members and Potential Members within Service Area.
   - The data sources relied upon by plan to validate that its Public Policy Committee membership aligns with Member demographics.
   - Barriers to and challenges in meeting or increasing alignment between Public Policy Committee membership with the demographics of the Members within Service Area.
   - Ongoing, updated, and new efforts and strategies undertaken in committee membership recruitment to address the barriers and challenges to achieving alignment between Public Policy Committee membership with the demographics of the Members within Service Area; and
   - A description of the committees ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how committee input impacted and

shaped Contractor initiatives and/or policies.

- CalViva Health must complete and submit to DHCS annually an Annual PPC Member Demographic Report by April 1 of each year.

~~V.~~IX. Authority

1. Health & Safety Code Section 1369
2. California Code of Regulations, Title 28, Rule 1300.69
3. RHA Bylaws

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APPROVAL:

RHA Commission Chairperson

Date:

: David Hodge, MD

Regulatory Filings:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 YTD Total
# of DHCS Filings													
Administrative/ Operational	56	46	28	35	24	19	9						217
Member Materials Filed for Approval;	1	4	1	6	5	4	0						21
Provider Materials Reviewed & Distributed	10	14	9	10	8	13	0						64
# of DMHC Filings	8	8	8	11	19	7	1						62

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

# of Potential Privacy & Security Breach Cases reported to DHCS and HHS (if applicable)													
No-Risk / Low-Risk	5	4*	3	1	3								16
High-Risk	0	0	0	0	0								0

* One of the four cases involved a cybersecurity incident at Change Healthcare that caused widespread product outages affecting many plans nationally. CalViva does not have a contractual relationship with Change Healthcare but CalViva's Plan Administrator, Health Net, does. Although Health Net submitted a Privacy Incident Report to DHCS on 2/28/24 no member PHI was impacted and DHCS closed the case as a "non-breach".

Fraud, Waste, & Abuse Activity:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2024 YTD Total
# of New MC609 Cases Submitted to DHCS	2	4	0	3	1	1	1						12
# of Cases Open for Investigation (Active Number)	17	17	15	18	21	21	22						

Summary of Potential Fraud, Waste & Abuse (FWA) cases: Since the 5/16/2024 Compliance Regulatory Report to the Commission, there were 3 new MC609 cases filed that involved: 1) A participating provider specializing in home health services was referred by DHCS for possible Kick Back Scheme; 2) A participating provider specializing in Applied Behavior Analysis (ABA) services regarding concerns of billing for services not rendered ; and 3) A non participating provider specializing in hospice services due to concerns for members receiving hospice services for greater than six months.

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

Regulatory Reviews/Audits and CAPS:	Status
Department of Managed Health Care ("DMHC") 2022 Medical Audit	In response to the 2022 DMHC Final Audit Report findings, the Plan issued CAPS to Health Net for failing to identify PQIs in exempt grievances, and inappropriately denying post-stabilization care. The CAPs were issued on 6/11/24 and 6/17/24, respectively.
Department of Health Care Services ("DHCS") 2023 Focused Audit for Behavioral Health and Transportation	On 6/18/24, the Plan received DHCS's Preliminary Final Report for the 2023 Focused Audit pertaining to Behavioral Health and Transportation. An Exit Conference to discuss the findings was held with DHCS on 6/25/24. The Preliminary Report listed nine deficiencies: 4 for Behavioral Health and 5 for Transportation. The Plan formally responded to DHCS stating that we disagreed with all 4 of the Behavioral Health findings and provided documents to support our rationale. The Plan also disagreed with 3 of the 5 Transportation findings and provided support for our rationale. The 2 Transportation findings with which the Plan agreed were related to 1) not ensuring that a copy of the Physician Certification Statement (PCS) form was on file for all members receiving NEMT services, and 2) not ensuring its transportation delegate, ModivCare, provided the appropriate level of service for members requiring ambulatory door-to-door service. The Plan will issue corrective actions to to Health Net to remediate these two findings while we await DHCS' decision on our rebuttal of the other findings.

Department of Health Care Services ("DHCS") 2024 Medical Audit	DHCS held a Closing Session for the audit on 5/31/2024 and the Plan anticipates receiving the Preliminary Report in mid-August at the time of the Exit Conference.
2024 Network Adequacy Validation (NAV) Audit	DHCS' external auditor, Health Systems Advisory Group (HSAG), conducted the first annual Network Adequacy Validation (NAV) audit on 6/18/24. Interview questions were based on information provided to HSAG on 5/15/24. The virtual audit went well and we are awaiting official response from HSAG.
New Regulations / Contractual Requirements/DHCS Initiatives:	**Status**
California Advancing and Innovating Medi-Cal (CalAIM)	• **Community Supports (CS)**: On 6/19/2024 DHCS approved the Community Supports MOC submitted on 1/29/24 for those services going live 7/1/24 [Sobering Centers and Short-term Post-Hospitalization Housing (Fresno, Kings, and Madera Counties; and Recuperative Care (Madera County]. On 7/1/24, the Plan updated its CS Final Elections to indicate that the following CS would be going live 1/1/25: Recuperative Care (Medical Respite) – Kings County Recuperative Care (Medical Respite) - Madera County Short-Term Post-Hospitalization Housing – Madera County Sobering Centers – Madera County
Long Term Care (LTC) Carve-In Deliverable List – Phase II (ICF/DD and Subacute Care facilities	Phase II Network Readiness deliverables (i.e., additional attempts to contract and execute contracts) were submitted on 6/28/24. The Plan is awaiting approval.
Memorandum of Understanding (MOU)	DHCS requires each MCP to submit quarterly updates on the status of the multi-party MOUs with third party entities (LGAs, LEAs, LHDs and other MCPs in the county). The Q2 2024 status report is due 7/31/2024.

Annual Network Certifications	• 2023 Subnetwork Certification (SNC) – On 7/3/24, DHCS requested the Plan to submit quarterly updates on the status of all CAPs the Plan previously issued to PPGs for not meeting time & distance standards in their networks. The Plan submitted its response on 7/9/2024. • 2023 Annual Network Certification (ANC) – The Plan is still awaiting DHCS' response to the Alternate Access Standards request that was submitted on 3/25/24.
Timely Access and Annual Network Reporting (TAR)	RY 2023 MY 2022- DMHC issued a Network Findings Report with two findings related to Geographic Access and Data Accuracy. The Plan's response is due to the DMHC by September 9, 2024.
NCQA Plan Accreditation	The NCQA Closing Conference was held on 6/24/24. On 7/1/24, the Plan received NCQA's Preliminary Plan Accreditation Score Report which indicated we had passed all categorical requirements (100%). We are just awaiting Final NCQA Accreditation status to be determined.
Plan Administration:	**Status**
New DHCS Regulations/Guidance	Please refer to Appendix A for a complete list of DHCS and DMHC All Plan Letters (APLs) that have been issued in CY 2024.
Committee Report:	**Status**
Public Policy Committee (PPC)	The Public Policy Committee meeting was on June 5, 2024. The items presented were Health Education Work Plan, Appeals and Grievance Report, Health Equity Work Plan and Program Description and the Public Policy Charter. Dr. Marabella gave an overview of the A&G Dashboard, noting certain types of grievances reported, and also that the number of annual 2023 grievances had increase significantly from 2022, however the membership volume had also increased in 2023. The next Public Policy Committee meeting will be held September 4, 2024, 11:30 am -1:30 pm located at 7625 N. Palm Ave Suite 109, Fresno, CA 93711.

APPENDIX A

2024 DHCS All Plan Letters:

APL 24-001 STREET MEDICINE PROVIDER DEFINITIONS AND PARTICIPATION IN MANAGED CARE

APL 24-002 MEDI-CAL MANAGED CARE PLAN RESPONSIBILITIES FOR INDIAN HEALTH CARE PROVIDERS AND AMERICAN INDIAN MEMBERS

APL 24-003 ABORTION SERVICES

APL 24-004 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION REQUIREMENTS

APL 24-005 CALIFORNIA HOUSING AND HOMELESSNESS INCENTIVE

APL 24-006 COMMUNITY HEALTH WORKER SERVICES BENEFIT

APL 24-007 TARGETED PROVIDER RATE INCREASES

APL 24-008 IMMUNIZATION REQUIREMENTS

2024 DMHC All Plan Letters:

APL 24-003 Health Equity and Quality Program Policies and Requirements

APL 24-005 - Change Healthcare Cyberattack (3.11.24)

APL 24-006 Annual Provider Directory Filing

APL 24-008 2024HealthPlanAnnualAssessments(4_15_24)

APL 24-009 Change Healthcare Cyberattack Response Filing

APL 24-011 Request for Health Plan Information and Addendum Revisions

APL 24-012 Single Point of Contact for Hospitals to Request Authorization

APL 24-013 Health Equity and Quality Program Policies and Requirements

Item #6
Attachment 6.A

BL 24-006
Review of FY End 2024 Goals

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

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

DATE: July 18, 2024
TO: Fresno-Kings-Madera Regional Health Authority Commission
FROM: Jeffrey Nkansah, CEO
RE: Review of Goals and Objectives for Fiscal Year End 2024
BL #: 24-006
Agenda Item 6
Attachment 6.A

DISCUSSION:

Category	Goal:	Review
Market Share	Maintain market share	Market Share increased from the prior Fiscal Year approximately one percentage point from approximately 67% to 68%. The "Default Formula" adopted and applied for this period, the unwinding of the freeze in Medi-Cal disenrollment(s) due to the COVID-19 Public Health Emergency, and the entrance of a third competitor (Kaiser) in the Service Area had an impact on Market Share.
Medical Management / Quality Improvement	Initiate a SWOT project to improve (1) Well Child Visits by converting sick visits to well visits and (2) Childhood Immunizations in Fresno County by working with hospitals to get newborn immunization data. Also, complete planning and initiate a Clinical PIP to improve Well Child Visits and Nonclinical PIP to improve Follow up visits for Substance Abuse and Mental Health visits to the ER.	Completed the SWOT (1) Well Child Visit (WCV) with modified intervention of special clinics to improve WCV rate and (2) completed the work with local hospitals to acquire newborn Hepatitis B vaccine data. Continued development of the PIPs: (1) Clinical – Focus on African American/Black children in Fresno County to improve WCV by partnering with Black Infant Health and (2) Nonclinical – working directly with local hospitals to assess and complete follow up within 7 days for members after ED visit for substance use disorder and/or mental health issue in Fresno and Madera Counties.
Funding of Community Support Program	Administer the Community Investment Funding Program	6 Provider recruitment grants awarded.
Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirements.	CalViva met the DMHC minimum TNE requirements during FY 2024.
Direct Contracting	Maintain current direct contracts to align with TNE requirements	Maintained current direct contracts.
Community Outreach	Continue to participate in local community initiatives	Participated in Cradle to Career, See 2 Succeed Vision Program, The Children's Movement of Fresno (TCM Fresno), Group Prenatal Care Embrace, Back 2 School Backpack event, Reading Heart Advisory Group, Help Me Grow, Coalition for Digital Health, and 150+ CBO Sponsorships.
State and Federal Advocacy	Continue to advocate Local Initiative Plan interest.	Continued as a Local Health Plan Association and Mid State MGMA Board Member.
2024 Medi-Cal Contract Readiness	Obtain the Department of Health Care Services' approval of all Contract Readiness deliverables and execute the Contract by December 31, 2023.	All Contract Readiness deliverables were approved and the Plan and DHCS executed the 2024 DHCS Contract on December 20, 2023.
Health Plan Accreditation	Maintain activities to achieve NCQA Health Plan Accreditation by 2025 and NCQA Health Equity Accreditation by 2026.	NCQA Health Plan Accreditation Submission was successfully completed on May 7, 2024. Closing Conference held with NCQA and CalViva Health on June 24, 2024. Preliminary scores are favorable to achieving accreditation. Preliminary scores are being reviewed by the NCQA Executive and Committee team(s) to finalize in accordance with NCQA guidelines. NCQA Health Equity Accreditation activities remain on schedule for Health Equity Accreditation by 2026.
Diversity, Equity, and Inclusion	Promote diversity in recruiting and hiring. Offers training to employees on cultural competency, bias or inclusion.	CalViva's first Equity Officer was hired and started 5/28/24. Employees successfully received training on cultural competency, bias or inclusion on 10/16/2023.

Item #7
Attachment 7.A

BL 24-007
Goals & Objectives FY 2025

Jeffrey Nkansah
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Fresno, CA 93711

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Fax: 559-446-1990
www.calvivahealth.org

DATE: July 18, 2024
TO: Fresno-Kings-Madera Regional Health Authority Commission
FROM: Jeffrey Nkansah, CEO
RE: Goals and Objectives for Fiscal Year 2025
BL #: BL 24-007
Agenda Item: 7
Attachment: 7.A

DISCUSSION:

Category: Goal:

Category:	**Goal:**
Market Share	Maintain market share
Medical Management / Quality Improvement	Continue the work on both PIPS: (1) Clinical-- African America/Black Well Child Visits in Fresno County and (2) Nonclinical-- Follow up after ED visit for substance use disorder (SUD)/mental health (MH) issue in Fresno and Madera Counties. Also begin work on three other QI Health Equity projects using the LEAN Methodology: (1) Madera County initiate a LEAN project to improve follow up after ED visit for SUD or MH issue, Behavioral Health Domain with an emphasis on the Hispanic population. (2) Kings County initiate a LEAN project to improve provider reconciliation /gap closures for Children's Well Care Domain measures with emphasis on the Hispanic population. (3) Fresno County initiate a Comprehensive project to improve compliance with Children's Health Domain measures (Well Child Visits, Immunizations and Lead Screening). In addition, a special Health Equity based QI project has been initiated in collaboration with the Institute for Healthcare Improvement (IHI) and sponsored by DHCS to improve Children's Well Care Visit compliance. An FQHC in Fresno County has been selected for this effort which continues through the end of March 2025.
Funding of Community Support Program	Administer the Community Investment Funding Program
Tangible Net Equity (TNE)	Meet DMHC minimum TNE requirement and meet the DHCS TNE requirement of at least 1 month's contract revenues based on CalViva's average monthly contract revenues for the previous twelve months.
Direct Contracting	Maintain current direct contracts to align with TNE requirements.
Community Outreach	Continue to participate in local community initiatives.
State and Federal Advocacy	Continue to advocate Local Initiative Plan interest.
Health Plan Accreditation	Maintain activities to have NCQA Health Plan Accreditation by 2025 and NCQA Health Equity Accreditation by 2026.
Diversity, Equity, and Inclusion	Promote diversity in recruiting and hiring. Implement activities to identify opportunities to improve around Diversity, Equity and Inclusion. Offer mandatory annual Diversity, Equity, and Inclusion training to employees which will include cultural competency, bias and/or inclusion.

Item #8

Attachment 8.A

FKM RHA Bylaws (Revised)

Bylaws of the

Fresno-Kings-Madera Regional Health Authority Commission

BYLAWS OF THE

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY COMMISSION

TABLE OF CONTENTS

B Y L A W S O F T H E

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY COMMISSION

ARTICLE I. AUTHORITY AND PURPOSE

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

ARTICLE II. COMMISSIONERS

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

pleasure of the Board appointing him or her.

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

2.3 Commission Composition

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3.6. If a Commissioner no longer qualifies for his/her prescribed position on the Commission, the position shall be vacant and the appointing authority shall appoint a replacement. The appointing authority will ensure that the candidate's background and demography are considered to ensure that the composition is reflective of the counties served.

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2.4. Selection of Commission Appointees. The Clerk of the Commission shall publicly notice the availability of appointment(s) to be made by the Commission and an application for appointment shall be required of candidates to establish his/her qualifications. The Chairperson, in consultation with the Vice Chairperson, will determine which applications meet the requirements for appointment. Candidates meeting the requirements for appointment may be interviewed by the Chairperson and other Commissioners. Candidates approved by the Chairperson will be submitted to the Commission for a vote.

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

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

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

removed from office by a majority vote of the Commission.

2.8. Alternate Members. There shall be one (1) person appointed as an alternate member for each regular member holding an elected office, for a total of three (3) alternate members, to attend and participate in meetings of the Commission in the event of the absence of any of the members appointed as provided in subsection 2.3, above. The qualifications, representation of interests or organizations, appointment, and terms of the alternate members shall be the same as the regular members for which they stand as alternates. When attending a meeting in place of a regular member, an alternate member shall be entitled to participate in the same manner and under the same standards as the regular member, to the extent that the alternate member is not otherwise disqualified from participating in discussion and voting on an item due to a conflict of interest.

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

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

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

ARTICLE III. OFFICERS

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

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

3.1.2. A Vice-Chairperson who shall be a Commissioner and who in the absence

of the Chairperson shall preside at the meetings of the Commission. If both Chairperson and Vice-Chairperson are absent, the Commissioners present will select one Commissioner to act as temporary Chairperson to conduct the meeting.

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

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

such other duties as are set forth in the Joint Exercise of Powers Agreement or specified by the Commission.

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

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

other Commissioners or may nominate themselves for offices.

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

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

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

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

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

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

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

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

Commission except money.

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

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

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

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

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

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

ARTICLE IV. MEETINGS

4.1. Regular and Special Meetings. The Commission shall establish the time and place for its regular meetings. The date, hour, and location of regular meetings

shall be fixed by resolution of the Commission. The Commission shall hold at least one regular meeting each quarter of every calendar year. Special meetings and adjourned meetings may be held as required or permitted by law.

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

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

4.4. Attendance and Participation. Commissioners must attend the regular meetings of the Commission and of committees to which they are appointed. If a Commissioner is unable to attend a meeting, he/she must notify the Clerk of the Commission of the reason and the Clerk, in turn, will notify the Chairperson.

Except in the case of an emergency, if a Commissioner fails to attend a meeting without first notifying the Clerk, the absence will be considered unexcused. Two unexcused absences during a six-month period shall be grounds for the party appointing the Commission member, either a Board of Supervisors or the Commission, to consider removing the Commissioner.

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

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

4.7. Conduct of Business.

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

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

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

the Commission.

4.8. Resolutions and Motions. All official acts of the Commission shall be taken either by resolution or a motion, duly made, seconded, and adopted by vote of the Commissioners. Motions and seconds may be made by any Commissioner, including the Chair.

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

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

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

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

in accordance with the provisions of the California Public Records Act (commencing with Section 6250 of the California Government Code).

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

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

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

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

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

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

4.17.3. The Chairperson of the Commission may establish reasonable limits on the amount of time allotted to each speaker on a particular item, and the Commission may establish reasonable limits on the total amount of time

allotted for public testimony on a particular item. When further discussion is required, the Commission may vote to allot time in the agenda of the following meeting.

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

ARTICLE V. COMMITTEES OF THE COMMISSION

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

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

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

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

5.5. Minutes. The Clerk of the Commission or designated individual shall prepare the minutes of each meeting of committees of the Commission. Official minutes shall record motions entertained and actions taken at each meeting. The minutes

shall be an accurate summary of the committee's consideration of each item on the agenda and an accurate record of each action taken by the committee. At a subsequent meeting, the Clerk or designated individual shall submit the committee meeting minutes to the Commission.

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

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

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

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

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

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

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

5.8 Committee Membership.

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

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

5.8.3. Membership for all committees shall be generally representative of the diverse skills, backgrounds, interests, and demography of persons residing in the three Counties. The appointing authority of the Committee shall ensure that a committee candidate's background and demography are considered to ensure that the composition of the Committee is reflective of the counties served.

ARTICLE VI. ADVISORY COUNCILS

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

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

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

6.4. Selection. The number of members to an advisory council shall be limited to a specific number as deemed appropriate by the Commission. The Commission shall consider all nominations to advisory councils from members of the public and from Commissioners. Members to an advisory council shall be appointed by a majority vote of the Commission. The Commission shall take into consideration a candidate's background and demography to ensure that the composition of the advisory council is reflective of the counties served.

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

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

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

ARTICLE VII. EXECUTION OF DOCUMENTS

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

7.2. Checks, Drafts, Evidence of Indebtedness. All checks, drafts or other orders

for payment of money on behalf of or payment to the Commission shall be signed or endorsed by such persons as determined by either motion or resolution of the Commission.

ARTICLE VIII. CONFLICT OF INTEREST POLICY

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

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

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

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

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

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

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

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

ARTICLE IX. MISCELLANEOUS

9.1. Purchasing, Hiring, Personnel. The Commission shall adopt either by motion or

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

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

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

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

ARTICLE X. AMENDMENT OF BYLAWS

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

CERTIFICATE OF CHAIRPERSON

I, the undersigned, do hereby certify that I am the duly elected and acting Chairperson of the Fresno-Kings-Madera Regional Health Authority Commission, a local joint powers public agency and political subdivision of the State of California, and that the foregoing Bylaws, comprising 23 pages, including this page, constitute the Bylaws of the Commission, as duly adopted by the Commission at a regular meeting, duly called and held on the ~~19th~~18th day of ~~November~~ July ~~2015~~ 2024 in Fresno County, California.

David S. Hodge

Chairperson of the Commission

Item #10
Attachment 10.A-B

Annual Delegation Oversight of Health Net

- BL 24-008
- 2023 Annual Delegation & Oversight Monitoring Report

FRESNO-KINGS-MADERA REGIONAL HEALTH AUTHORITY

Commission

Fresno County

Sal Quintero
Board of Supervisors

David Luchini, Director
Public Health Department

David Cardona, M.D.
At-large

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

Joyce Fields-Keene
At-large

Soyla Griffin - At-large

Kings County

Joe Neves
Board of Supervisors

Rose Mary Rahn
Public Health Department

Lisa Lewis, Ph.D. - At-large

Madera County

David Rogers
Board of Supervisors

Sara Bosse
Public Health Director

Aftab Naz, M.D.
At-large

Regional Hospital

Jennifer Armendariz
Valley Children's Hospital

Aldo De La Torre
Community Medical Centers

Commission At-large

John Frye
Fresno County

Kerry Hydash
Kings County

Paulo Soares
Madera County

Jeffrey Nkansah
Chief Executive Officer

7625 N. Palm Ave., Ste. 109
Fresno, CA 93711

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

DATE: July 18, 2024

TO: Fresno-Kings-Madera Regional Health Authority Commission

FROM: Jeffrey Nkansah, CEO

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

BL #: **24-008**
Agenda Item **10**
Attachment **10.A**

RHA Commissioners on February 15, 2024 were presented the 2023 Annual Delegation Oversight and Monitoring Report of Health Net.

The February 15, 2024 version of the report was approved and Health Net was approved to continue their delegated functions for another year.

Although the prior version of the report was approved and Health Net passed the Oversight and Monitoring Reviews Conducted, there was a section under Performance Standards HEDIS/MCAS which was still identified as "To Be Determined" as of February 15, 2024.

A determination is now available.

The RHA acknowledged Health Net's acceptance to pay the $72,000 DHCS penalty of which DHCS directly sanctioned CalViva Health for HEDIS/MCAS measures which were below the MPL, however, the RHA must also uphold its contractual performance standards with Health Net and assess a Performance Penalty of $53,333 due to the existence of a HEDIS Measure (i.e. W30-6 in Fresno and Kings Counties) in RHA Counties performing below the Minimum Performance Level ("MPL") as identified by RHA and confirmed by Health Net.

The measure (W30-6) was confirmed by RHA and Health Net to be below the MPL and did not meet the requirements of being exempt from the RHA performance penalty.

RECOMMENDED ACTION:

1. Approve the Revised 2023 Annual Delegation Oversight and Monitoring Plan of Health Net Community Solutions Report reflecting the update of a $53,333 monetary assessed payment.

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

REPORT SUMMARY TO COMMITTEE

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

FROM: Jeffrey Nkansah, Chief Executive Officer

COMMITTEE DATE: July 18, 2024

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

Executive Summary

PURPOSE:

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

SUMMARY OF THE DELEGATION MODEL:

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

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

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

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

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

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

SCORING:

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

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

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

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

NEXT STEPS:

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

OVERSIGHT AND MONITORING REVIEW(S):

Quality Assurance:

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

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

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

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

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

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

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

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

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

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

MEASUREMENT	DEFICIENT	DESCRIPTION OF DEFICIENCY	CAP REQUESTED	MONETARY PAYMENT ASSESSED
HEDIS / MCAS	YES	Sanction Notice – HEDIS/MCAS Measures below MPL.	NO	$53,333
Encounters	NO	N/A	N/A	N/A
Provider Network	NO	N/A	N/A	N/A
Regulatory Audits	NO	N/A	N/A	N/A
Reporting	NO	N/A	N/A	N/A

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

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

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

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

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

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

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

CALVIVA OVERSIGHT AUDIT(S) OF HEALTH NET:

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

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

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

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

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

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

CY 2023 AUDIT OVERSIGHT AUDIT RESULTS & ANALYSIS

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

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

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

Item #12
Attachment 12.A

Case Management

2023 Program Evaluation
& Executive Summary

EXECUTIVE SUMMARY REPORT TO COMMITTEE

TO: CalViva Health QI/UM Committee

FROM: Carrie-Lee Patnaude, Director Care Management

COMMITTEE DATE: July 18, 2024

SUBJECT: CalViva Care Management Program Evaluation 2023 Executive Summary

Summary:

Care Management (CM) processes have been consistent, and evaluation/monitoring of CM metrics continue to be a priority. Case Management monitors the effectiveness of programs in order to better serve our members.

Purpose of Activity:

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

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

The 2023 CM Program Evaluation encompasses a review of care management programs through the documentation of current and future strategic initiatives and goals. The evaluation tracks key performance metrics and provides for an assessment of our progress and identifies critical barriers.

Analysis/Findings/Outcomes:

I. Cases Managed

The goal to increase cases managed in 2023 over 2022 was met (3,275 in 2022 and 3,571 in 2023). Overall, 0.81% of the total population was managed in 2023 amongst physical health and behavioral health CM and the perinatal CM program. The average population of members in 2023 was 440,737. The overall percentage of population managed in Physical Health CM was 0.39%. Behavioral Health demonstrated 0.13%. The population managed in Perinatal CM was 0.29%.

II. Monitoring audits for compliance with regulatory standards

The Plan completed file reviews and audits as planned in 2023. As a result, it was identified that each program met the goal of 90% or greater audit scores in 2023. Additional training and individual coaching were completed in 2023 for staff with below goal scores.

III. Care Management Outcomes

a. Physical Health and Behavioral Health Outcomes

Measures of effectiveness for care management are evaluated using at least three measures that assess the process or outcomes of care for members in Physical and Behavioral Health CM. Measures of effectiveness include the following indicators: Readmission rates; Ed Utilization' Overall health care costs.

Claims data demonstrated a reduction in readmissions for the care managed members, 1.5% decrease (pre 36.1% vs post 34.6%) in readmission rate based on claims. There was also a 25% reduction in ED utilization for this population by 257 ED visits and a reduction of 738 ED visits per 1,000 members per year. Comparing health care costs demonstrated a reduction in inpatient claims of 481, a decrease of 4,818 for outpatient services, and a 83 increase for pharmacy.

b. Perinatal Outcomes

The Perinatal CM program was evaluated based on the member's compliance with completing their first prenatal visit within the first trimester and their post-partum visit. In addition, the rate of pre-term delivery of high-risk members managed was evaluated.

Members in the Perinatal CM program demonstrated a 5.1% percentage increase in compliance with completing the first prenatal visit in their first trimester and a 3.7% percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program. There were 4.5% fewer pre-term deliveries for high-risk members managed than high-risk members not managed.

IV. Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. The goal for member satisfaction is > than 90%. 9/10 survey questions had responses scoring over 90%. The only question below goal at 84% was "Is there anything that stopped you from taking your Care Managers advice to better your health?". There were no grievances related to care management in 2023. The goal for member complaints/grievances < 1/10,000 members was met.

V. Summary and Priorities

In 2023, the key accomplishments for the CM Program were:

- Successful coordination for CalAIM ECM member self-referrals.
- Successful CalAIM Community Support referrals.
- Successful transition of Rx carve out to the State and use of Magellan's Rx system.
- Filled open CM positions.
- Enhanced the Transitional Care Services program to meet PHM requirements:
  - Increased staffing
  - Outreach to all high-risk inpatient members
  - Created TCS hotline for recently inpatient members with care coordination needs to call for support per DHCS requirements.

The primary goals for 2024 are to complete activities related to:

- Outreach all Acute Inpatient Admissions
- Increase member enrollment in Transitional Care Services program.
  - Have non-clinical staff on site at hospitals to increase engagement.
- Increase caseload per CM to 75 to align with goals.
- Support CalAIM activities, prepare for additional Populations of Focus.
- Support CalAIM Community Supports programs and increased offerings.
- Manage more members across CM programs.

Care Management Program Evaluation 2023

Table of Contents

Care Management Program Evaluation - 2023

I. Overview

Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. Health Net is a managed care organization. Health Net attained NCQA accreditation in 2019, demonstrating the Plan's commitment to excellence. CalViva Health is also undergoing NCQA accreditation at this time.

Health Net provides Care Management to CalViva members. Care Management services were available for 428,979 assigned CalViva members in Fresno, Kings, and Madera counties in 2023.

In 2023, our focus was on strategic initiatives and Population Health Management activities, while continuing to further relationships across departments and with community partners. CalViva continued to support our members, providers, community partners, and staff. Activities included staff continuing to work from home, expansion of telehealth services, webinars for our providers, member outreach, and education.

CalViva Health is dedicated to improving access to care and providing quality health care to families in the Fresno, Kings, and Madera County area. We provide the right care at the right place and the right time.

Beliefs

- "We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enables meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities."

Purpose of Self-Assessment

The purpose of the self-assessment is to provide information about our Care Management (CM) Program and evaluate the effectiveness of the program. Performance is measured against internal and established external standards of care. This self-assessment is reflective of 2023 and findings were used to establish goals for 2024.

II. Program Infrastructure and Evaluation

Medical Management Committees

Oversight and operating authority of CM activities is delegated to CalViva's Quality Improvement Utilization Management Committee (QIUM) by CalViva's Regional Health Authority Commissioners. The annual review and revision of the CM Program Description and

the annual CM Program Evaluation are presented to the QIUM Committee for review and approval.

Care Management Program

The CM Program is a collaborative process of assessment, planning, coordinating, monitoring, and evaluation of the services required to meet an individual's needs. Care Management serves as a means for achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of CM is the provision of quality health care along a continuum, decreased fragmentation of care across settings, enhancement of the member's quality of life, and efficient utilization of patient care resources. The care manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner. In order to optimize the outcome for all concerned, CM services are best offered in a climate that allows direct communication between the Care Manager, the member (or designated representative), and appropriate service personnel. This communication focuses on maintaining the member's privacy, confidentiality, health, and safety through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory standards or guidelines. Coordination of care and services is a key function of CM across the continuum, including acute, chronic, complex, and special needs cases.

Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources. The care manager must ensure appropriate referrals are made for the member to the appropriate provider or community resource, even if these services are outside of the required core benefits of the health plan. The care manager shall ensure each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable. The Plan shall ensure each member's privacy is protected during all communications with external parties. Transfer of protected health information (PHI) will be conducted by phone, secure fax or secure email in order to ensure maintenance of member privacy at all times with only the minimal necessary information being shared.

Behavioral Health (BH) Program

When a member has behavioral health needs that fall into the mild to moderate service category (as identified by state criteria All Plan Letter 22-006) the plan manages the ongoing care and coordination of services. If a member has behavioral health care needs that require more intensive treatment, and meets specialty mental health criteria, the plan works jointly with the local county behavioral health department to facilitate a referral and works together to ensure continuity of care for the shared member.

Members who have co-morbid conditions requiring coordination of care to manage both behavioral health and physical health issues are provided integrated care services. In these

instances, a physical health and a behavioral health professional work together to jointly develop a single plan of care that addresses the full needs of the individual.

Continued participation in this process strengthened relationships and provided an opportunity to maintain current points of contact with the intent to facilitate access to appropriate levels of service. Of major importance was maintaining the standards regarding releases of information and data collection that protect the rights of the members under HIPAA guidelines and provides the information required for continuity and quality of care that was developed in prior years. Through the application of clinical and financial information the plan will be able to move forward collaboratively with other agencies to target specific interventions for the members and decrease duplication of services and enhance overall service provision to members. The shared communication among plan partners enables us to advance population health and better trend the needs of the population cross service type.

Care Management Referrals

Members for CM were identified through a variety of sources including the concurrent review process, reports such as the Notification of Pregnancy, Health Risk Screening, Sickle Cell, High Dollar, Pharmacy, Impact Pro, and Population Health Management, as well as providers and preferred provider group (PPG), county entities, and member self-referrals. Overall, the volume of referrals for 2023 was 4,670 for CM programs. The volume of referrals for physical health demonstrated an average of 242 per month for the entire year. The volume of referrals to behavioral health averaged 48 per month for the year and 99 per month for the Perinatal Care Management program. Care management cases requiring clinical expertise were managed by licensed care managers and cases only requiring assistance with psychosocial needs such as housing, finance, and other resources were managed by program specialists with social work experience.

The data for the Care Management program is divided into three categories: Physical Health, Behavioral Health, and Perinatal Care Management.

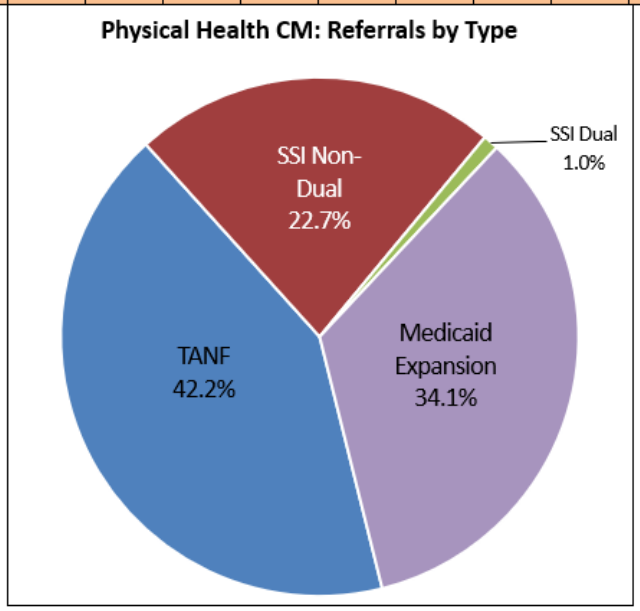
Physical Health

- Referrals by Type:
  - Total number of referrals for 2023 was 2,902.
  - 23.7 % for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 34.1 % of the members referred were Medi-Cal Expansion.
  - 42.2 % of the members referred were TANF.

Table A. Physical Health CM Referrals by Type

CalViva Physical Health Case Management Referrals By Type: 1/1/2023 - 12/31/2023

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	100	91	163	110	87	147	95	111	92	88	71	69	**1,224**
SSI Non-Dual	74	51	78	86	81	43	48	50	45	39	32	33	**660**
SSI Dual	2	0	4	1	1	1	1	2	6	5	0	5	**28**
Medicaid Expansion	93	95	135	157	112	92	60	78	60	51	33	24	**990**
TOTAL REFERRALS	**269**	**237**	**380**	**354**	**281**	**283**	**204**	**241**	**203**	**183**	**136**	**131**	**2,902**

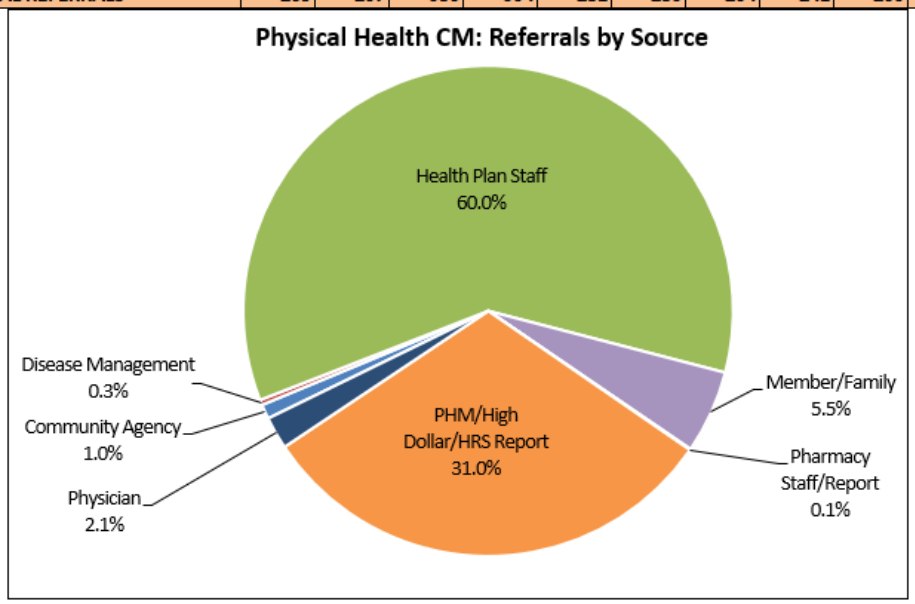


- Referral sources:
  - 60% of referrals came from within the Health Plan.
  - 31% Reports/PHM/HRS.
  - 2.1% Physician.
  - 5.5% Member and Family.
  - 0.1% Pharmacy.
  - The remainder of physical health referrals were from a variety of sources – Disease Management and Community Agencies.

Table B. Physical Health CM Referrals by Source

CalViva Physical Health Care Management Referrals By Source: 1/1/2023 - 12/31/2023

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Community Agency	1	7	0	5	1	3	1	0	2	2	3	3	**28**
Disease Management	0	1	1	1	1	1	0	1	2	1	0	1	**10**
Health Plan Staff	187	195	211	198	160	164	118	140	104	112	83	68	**1,740**
Member/Family	5	6	11	12	17	15	18	19	13	13	18	12	**159**
Pharmacy Staff/Report	0	0	1	0	0	0	0	1	0	0	0	0	**2**
PHM/High Dollar/HRS Report	64	21	152	136	97	99	65	68	76	50	30	43	**901**
Physician	12	7	4	2	5	1	2	12	6	5	2	4	**62**
TOTAL REFERRALS	**269**	**237**	**380**	**354**	**281**	**283**	**204**	**241**	**203**	**183**	**136**	**131**	**2,902**

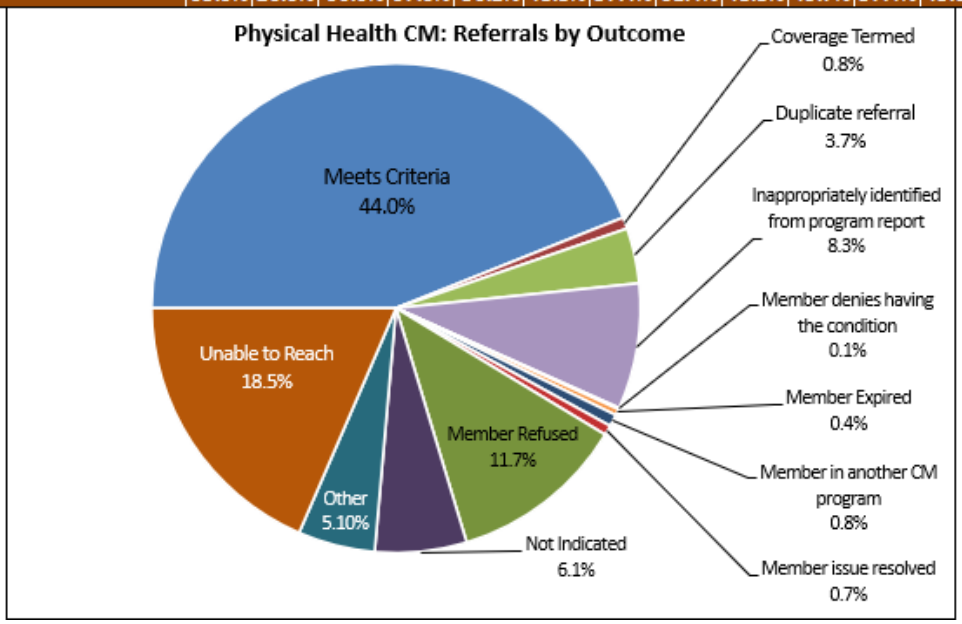


- Referral Outcome:
  - 44% meet criteria and agreed to CM.
  - 18.5% of the members were unable to be reached.
  - 11.7% of the members/representatives refused CM.
  - 25.8% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, other (including members requesting information only not a referral to CM), coverage termination, duplicate referrals, expired, member issue resolved.
  - 90% of members who met criteria and initially agreed to CM resulted in an open case.

Table C. Physical Health CM Referral Outcome

CalViva Physical Health Case Management Referrals By Outcome: 1/1/2023 - 12/31/2023

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	95	63	114	133	141	138	117	148	99	91	78	59	**1,276**
Coverage Termed	2	1	2	3	3	1	2	3	3	1	0	1	**22**
Duplicate referral	5	10	9	6	11	10	7	4	17	14	8	5	**106**
Inappropriately identified from prog	35	54	52	60	29	5	3	0	0	1	0	2	**241**
Member denies having the condition	0	0	1	0	0	2	0	0	0	0	0	0	**3**
Member Expired	1	0	3	1	2	1	3	0	0	1	0	0	**12**
Member in another CM program	1	2	2	2	1	1	4	4	3	1	2	0	**23**
Member issue resolved	0	0	1	1	1	8	1	1	2	1	1	2	**19**
Member Refused	19	16	79	52	31	34	21	22	26	14	7	18	**339**
Not Indicated	59	42	33	8	10	13	7	2	0	2	0	0	**176**
Other	10	17	12	21	10	10	9	9	15	13	13	9	**148**
Unable to Reach	42	32	72	67	42	60	30	48	38	44	27	35	**537**
TOTAL REFERRALS	**269**	**237**	**380**	**354**	**281**	**283**	**204**	**241**	**203**	**183**	**136**	**131**	**2,902**
%Meets Criteria	**35.3%**	**26.6%**	**30.0%**	**37.6%**	**50.2%**	**48.8%**	**57.4%**	**61.4%**	**48.8%**	**49.7%**	**57.4%**	**45.0%**	**44.0%**



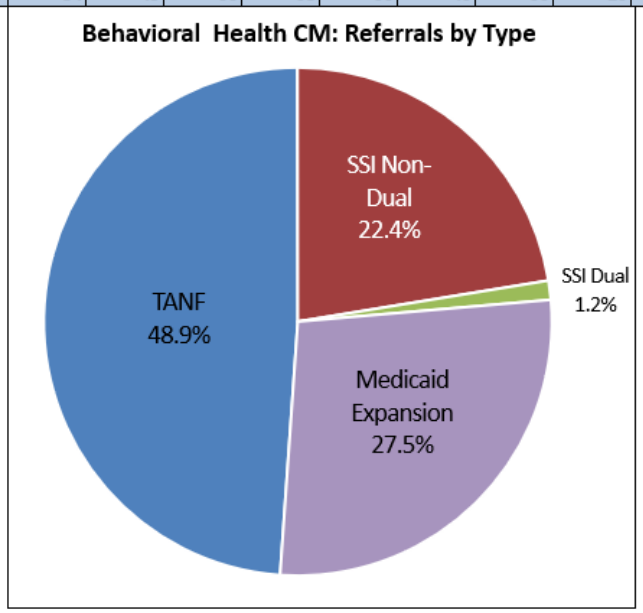
Behavioral Health

- Referrals by Type:
  - Total number of referrals 575.
  - 23.6% for Seniors and Persons with Disabilities (SPD) dual and non-dual members.
  - 27.5% of the members referred were Medi-Cal Expansion.
  - 48.9% of the members referred were TANF.

Table D. Behavioral Health CM Referrals by Type

CalViva Behavioral Health Case Management Referrals By Type: 1/1/2023 - 12/31/2023

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	29	39	37	28	32	32	20	16	21	5	15	7	**281**
SSI Non-Dual	13	13	21	11	13	15	8	15	7	6	6	1	**129**
SSI Dual	1	0	1	0	1	2	1	0	0	0	1	0	**7**
Medicaid Expansion	31	25	25	10	14	9	7	14	7	2	5	9	**158**
TOTAL REFERRALS	**74**	**77**	**84**	**49**	**60**	**58**	**36**	**45**	**35**	**13**	**27**	**17**	**575**

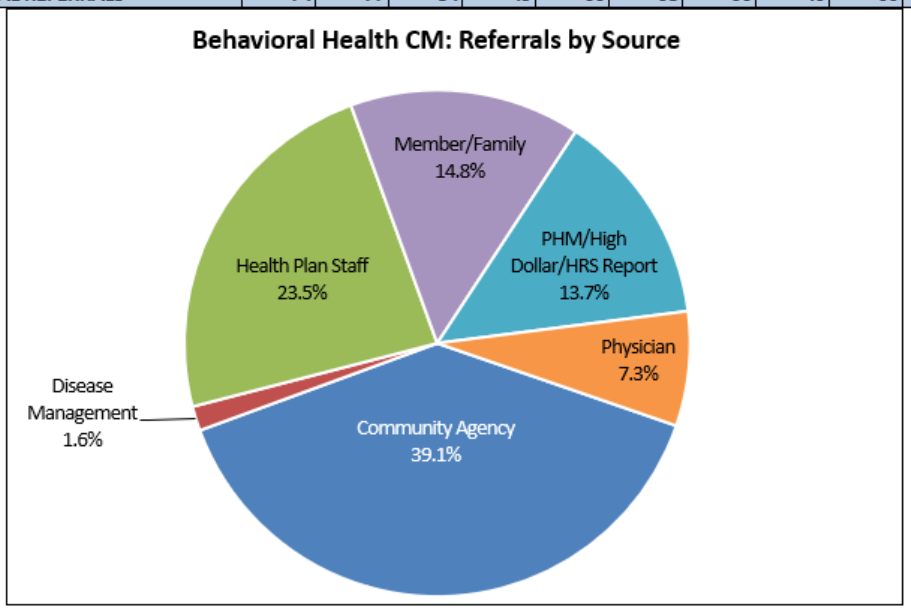


- Referral sources:
  - 23.5% of referrals came from within the Health Plan.
  - 39.1% Community agency.
  - 13.7% Reports/Impact Pro/HRS.
  - 14.8% Member and Family.
  - 7.3% Physician.
  - 1.6% Disease Management.

Table E. Behavioral Health CM Referrals by Source

CalViva Behavioral Health Care Management Referrals By Source: 1/1/2023 - 12/31/2023

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Community Agency	62	59	27	11	15	12	8	11	10	4	6	0	**225**
Disease Management	0	0	1	1	2	2	1	1	0	0	0	1	**9**
Health Plan Staff	3	8	19	22	15	14	12	16	13	3	10	0	**135**
Member/Family	6	2	9	4	6	17	11	14	9	3	1	3	**85**
PHM/High Dollar/HRS Report	0	0	21	11	21	12	1	1	1	0	4	7	**79**
Physician	3	8	7	0	1	1	3	2	2	3	6	6	**42**
TOTAL REFERRALS	**74**	**77**	**84**	**49**	**60**	**58**	**36**	**45**	**35**	**13**	**27**	**17**	**575**

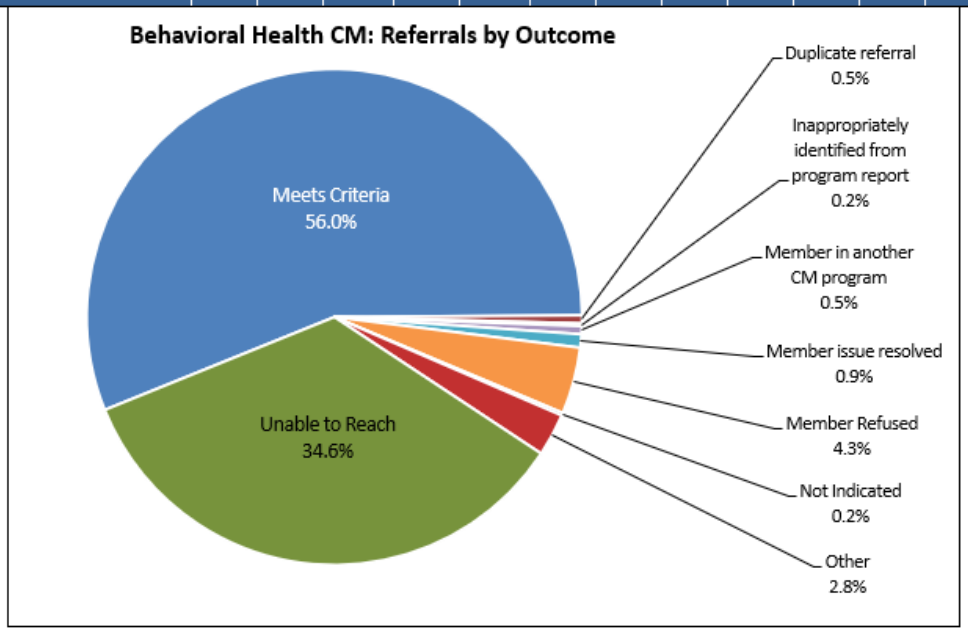


- Referral Outcome:
  - 56% meet criteria and agreed to CM.
  - 34.6% of the members were unable to be reached.
  - 4.3% of the members/representatives refused CM.
  - 5.1% Comprised of other reasons including referrals for members who were already enrolled in CM, referrals created and or closed in error, members requesting information only not a referral to CM, coverage termination, duplicate referrals, expired, member issue resolved.
  - 95% of members who met criteria and initially agreed to CM resulted in an open case.

Table F. Behavioral Health CM Referral Outcome

CalViva Behavioral Health Case Management Referrals By Outcome: 1/1/2023 - 12/31/2023

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	41	39	46	29	34	29	20	27	22	8	16	11	**322**
Duplicate referral	0	0	1	0	1	1	0	0	0	0	0	0	**3**
Inappropriately identified from program	0	1	0	0	0	0	0	0	0	0	0	0	**1**
Member in another CM program	0	1	1	0	1	0	0	0	0	0	0	0	**3**
Member issue resolved	2	0	1	0	1	1	0	0	0	0	0	0	**5**
Member Refused	1	4	6	1	2	2	2	2	1	1	2	1	**25**
Not Indicated	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Other	0	1	2	2	2	2	0	4	1	1	1	0	**16**
Unable to Reach	30	31	27	17	18	23	14	12	11	3	8	5	**199**
TOTAL REFERRALS	**74**	**77**	**84**	**49**	**60**	**58**	**36**	**45**	**35**	**13**	**27**	**17**	**575**
%Meets Criteria	**55.4%**	**50.6%**	**54.8%**	**59.2%**	**56.7%**	**50.0%**	**55.6%**	**60.0%**	**62.9%**	**61.5%**	**59.3%**	**64.7%**	**56.0%**



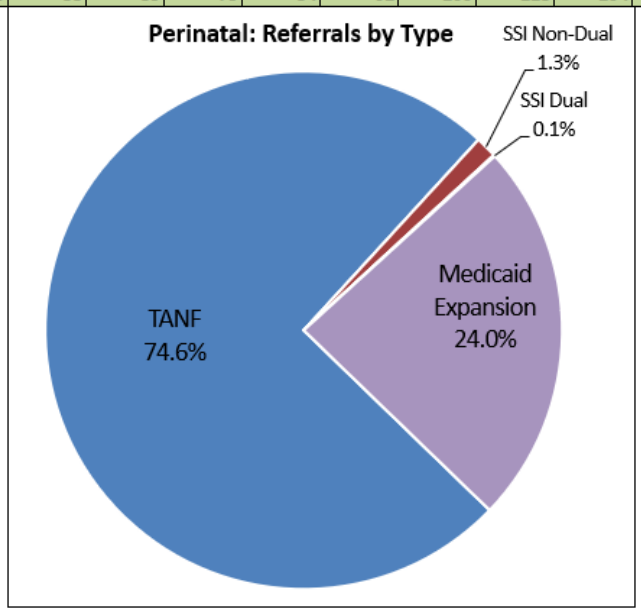
Perinatal Care Management

- Referrals by Type:
  - 1,193 referrals in 2023.
  - 1.4 % for Seniors and Persons with Disabilities (SPD) dual and non-duals members.
  - 24% of the members referred were Medi-Cal Expansion members.
  - 74.6% of the members referred were TANF members.

Table G. Perinatal CM Referrals by Type

CalViva Perinatal Case Management Referrals By Type: 1/1/2023 - 12/31/2023

PRODUCT	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TANF	68	66	65	59	59	64	43	82	87	126	96	75	**890**
SSI Non-Dual	1	3	1	1	4	1	1	1	0	0	2	1	**16**
SSI Dual	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Medicaid Expansion	25	16	22	29	16	19	17	20	31	28	40	23	**286**
TOTAL REFERRALS	**95**	**85**	**88**	**89**	**79**	**84**	**61**	**103**	**118**	**154**	**138**	**99**	**1,193**

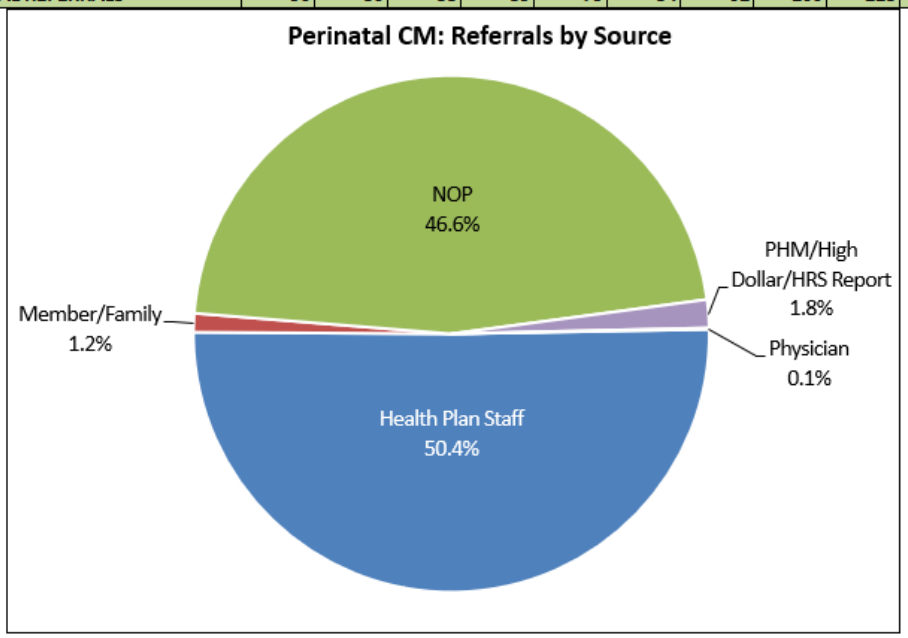


- Referral sources:
  - 46.6% of all referrals to this program were from the NOP form.
  - 50.4% of referrals came from within the Health Plan.
  - 1.8% Reports/Impact Pro/HRS.
  - 1.3% of the remaining referrals to Perinatal CM were from self-referrals by members/family, and physicians.

Table H. Perinatal CM Referrals by Source

CalViva Perinatal Care Management Referrals By Source: 1/1/2023 - 12/31/2023

REFERRAL SOURCE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTA
Health Plan Staff	12	18	15	34	31	21	27	65	70	114	109	85	**601**
Member/Family	4	2	0	2	0	2	0	0	1	1	1	1	**14**
NOP	79	60	68	53	48	57	33	36	46	35	28	13	**556**
PHM/High Dollar/HRS Report	0	4	5	0	0	4	1	2	1	4	0	0	**21**
Physician	0	1	0	0	0	0	0	0	0	0	0	0	**1**
TOTAL REFERRALS	**95**	**85**	**88**	**89**	**79**	**84**	**61**	**103**	**118**	**154**	**138**	**99**	**1,193**

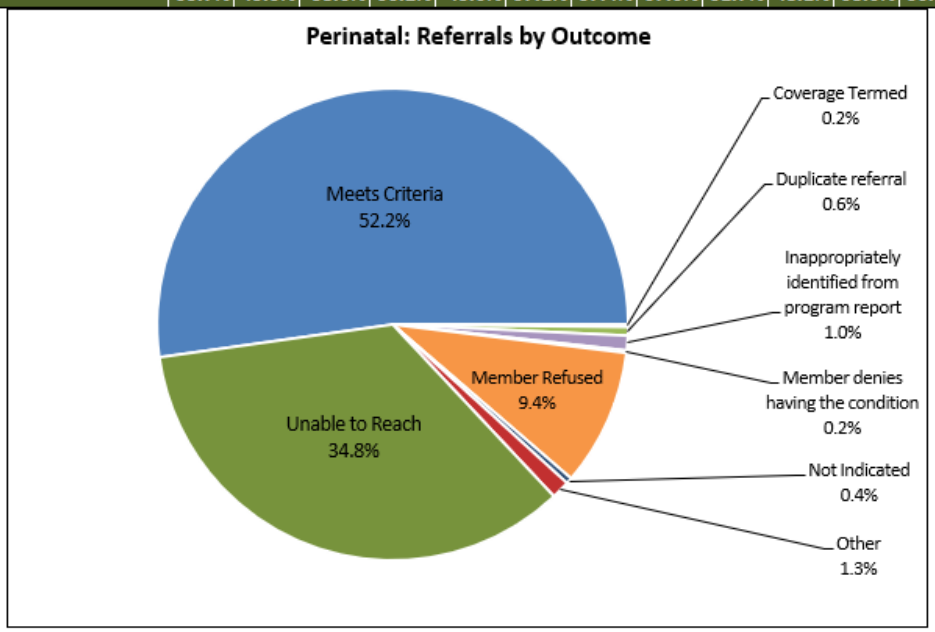


- Referral Outcome:
  - 34.8 % of the members were unable to be reached.
  - 52.2% meet criteria and agreed to CM outreach.
  - 9.4% of the members refused CM.
  - 3.6% Comprised of other, duplicate request, coverage termed, out of service area, not indicated (member reported not pregnant) and enrolled in another CM program.
  - 98% of members who met criteria and initially agreed to CM resulted in an open case.

Table I. Perinatal CM Referral Outcome

CalViva Perintal Case Management Referrals By Outcome: 1/1/2023 - 12/31/2023

OUTCOME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Meets Criteria	51	37	34	50	34	48	35	69	61	74	80	50	**623**
Coverage Termed	0	0	0	0	0	0	0	2	0	0	0	0	**2**
Duplicate referral	1	0	0	0	0	0	0	0	3	0	0	3	**7**
Inappropriately identified from program	0	1	1	3	0	0	0	0	0	0	4	3	**12**
Member denies having the condition	1	0	1	0	0	0	0	0	0	0	0	0	**2**
Member Refused	6	12	14	7	12	8	7	10	11	12	6	7	**112**
Not Indicated	1	0	0	0	0	0	0	0	0	0	4	0	**5**
Other	1	7	5	1	0	0	1	0	0	0	0	0	**15**
Unable to Reach	34	28	33	28	33	28	18	22	43	68	44	36	**415**
TOTAL REFERRALS	**95**	**85**	**88**	**89**	**79**	**84**	**61**	**103**	**118**	**154**	**138**	**99**	**1,193**
%Meets Criteria	**53.7%**	**43.5%**	**38.6%**	**56.2%**	**43.0%**	**57.1%**	**57.4%**	**67.0%**	**51.7%**	**48.1%**	**58.0%**	**50.5%**	**52.2%**



- Referral outcome comparison across programs:
  - Outcome category of other for Physical Health, Behavioral Health CM, and Perinatal CM were appropriate and represented referrals for members who were already enrolled in CM, referrals created and or closed in error, members requesting information only not a referral to CM, member delivered prior to referral, etc.
  - Number of program referrals was higher for Physical Health CM and Perinatal CM while Behavioral Health CM decreased.
    - Referral decrease to Behavioral Health CM may have been impacted by managing all high-risk inpatient within the Transitional Care Services program, including SUD and other BH related diagnosis in second half of the year.
  - Percentage of members unable to be reached was lower for Behavior Health CM followed by Perinatal CM and Physical Health CM correspondingly.

- Percentage of members who met criteria and agreed to CM outreach was higher in Behavior CM than the other programs.
- Actions taken included:
    - Continuing to address variation of success rates among CMs through individual coaching and staff development.
    - Re-educated staff on existing alternate sources of member contact information such as OMNI, pharmacy data, HIE.
    - Collaborated with UM and TCS teams on strategy to continue to increase referrals to BH CM.

Managed Population

In 2023, CM focused on processes related to the number of members managed in CM as well as the number of high-risk members managed in the CV pregnancy program. The measures were:

- At least 1% of the total managed members in CM are high-risk PHM level 1 members
- Manage 50% of members identified as high-risk on the NOP form in CM

Physical and Behavioral Health high-risk members are identified proactively through the Population Health Management (PHM) Level I report. The PHM report combines data from multiple sources to use in its population and program eligibility process including Impact Pro. Members are stratified into 1 of 10 Population Health Categories ranging from healthy to end of life. Members stratified into levels 08b High Priority Homeless/SUD, 07b High Priority PH CM, 07a high Priority BH CM, 05d Chronic Highly Complex, 05c Chronic High Risk - With Care Gap and meeting the additional criteria outlined below are evaluated for CM.
Members stratified in above levels AND have other designated parameters such as:

- CM engagement score ≥ 80 (range 0 - 100)
- Priority Flag = Yes
- ER Likelihood= Highly Likely and Most Likely

shall be referred to the care management program.

Additionally, any member, regardless of the risk stratification, who reaches a designated score based on responses to the Screening HRA shall be referred to Care Management.

Moderate and high-risk pregnancies are proactively identified through the Notification of Pregnancy. A numeric risk score is assigned to each response and the total score is used to categorize the member as high (35+), medium (15-34), or low risk (<15). Members with a score of 34 or greater are referred to High Risk OB CM; a component of the Perinatal CM Program.

High Risk Populations Managed

The volume of high-risk members managed in the CM programs *across the combined Medi-Cal membership* was 12,315, meeting the goal of >7,800 in 2023. High risk was defined as those members stratified into PHM Pyramid Level 1 (Tier 1 and 2).

Table J. High-Risk Population Managed

Case Management Metrics Key Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Definition
High Priority Unique Member Managed	700	722	1079	1275	1,329	1306	1191	1334	962	875	819	723	12,315	Member in PHM Pyrmaid Level 1 Teir 1&2

High Risk OB Population Managed

The volume of high-risk members managed in the Perinatal CM Program increased from 37.22% in 2022 to 44.08% in 2023. This report includes all high-risk members regardless of when the NOP was conducted during the reporting year.

Table K. Percentage of High-Risk Members Enrolled in Perinatal CM by Month of Referral

CY 2023 CalViva Percent of High Risk NOP in Perinatal CM

CA412 Report Date	Denominator High Risk	Numorator Case Managed	Percentage
January 31, 2023	206	102	49.51%
February 27, 2023	266	117	43.98%
March 31, 2023	269	126	46.84%
April 30, 2023	342	133	38.89%
May 31, 2023	343	140	40.82%
June 30, 2023	371	151	40.70%
July 31, 2023	342	142	41.52%
August 31, 2023	314	139	44.27%
September 30, 2023	279	137	49.10%
October 31, 2023	268	126	47.01%
November 30, 2023	244	111	45.49%
December 31, 2023	216	101	46.76%
CY 2023 Average	**288**	**127**	**44.08%**

Overall Population Managed

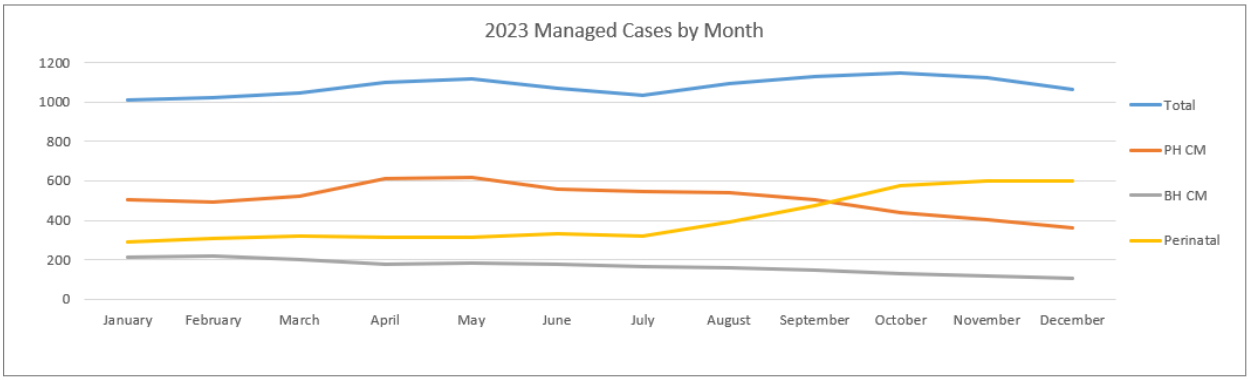
The data for cases managed is divided into three categories: Physical Health (PH CM), Behavioral Health (BH CM), and Perinatal (PCM). The table below reflects the number of cases managed each month per program. The number of cases managed each month includes cases active at any point during the month.

The average volume of cases managed by program per month in 2023 was:

- PH CM: 508
- BH CM: 167
- PCM: 404
- Total average per month: 1078, an increase over 2022 avg of 993

Table L. CM Managed Case Volume by Month and Program

Program	January	February	March	April	May	June	July	August	September	October	November	December
PH CM	505	491	522	609	616	560	547	538	503	441	403	362
BH CM	215	221	203	179	182	180	164	160	149	129	118	104
Perinatal	291	309	320	313	316	331	322	394	476	574	600	599
Total	1011	1021	1045	1101	1114	1071	1033	1092	1128	1144	1121	1065



Similarly, the total volume of CM cases managed per program are broken down by category and case type, complex versus noncomplex.

- PH CM
  - 9.4% Cases Complex
  - 90.6% Noncomplex
  - 32.2% members managed were SPD (dual and non-dual) members, followed by 47.6% Medi-Cal Expansion and 20.2% TANF

- BH CM
  - 5.59% Cases Complex
  - 94.4% Noncomplex
  - 20.5% members managed were SPD (dual and non-dual), followed by 41.6% Medi-Cal Expansion and 43.5% TANF
- PCM
  - 4.2% Cases Complex
  - 95.8% Noncomplex
  - 77.2% members managed were TANF members, followed by 26.3% Medi-Cal Expansion and 0.8% SPD (dual and non-dual)

The goal of 10% complex cases for PH and BH was not met in 2023. The goal of 3% complex for Perinatal CM was met. The decline in complex cases was attributed to staff returning from leave of absence and new staff not yet taking complex cases. A couple CMs were not following the CM process. Actions taken included:

- Reviewing both the CM process for management of complex cases and expectations with the staff. Providing additional guidance to staff around complex case criteria.
- Teaching complex case process to new staff at onboarding to not delay start of complex caseload (second half of year)
- Performance management

Table M. CM Managed Population by Program and Category

CalViva CM Managed Population by Program and Product in 2023

Program	Complex Case Management					Care Coordination					Total Managed				
	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed	CHIP	Medicaid Expansion	SPD	TANF	TOTAL Managed
PH CM	0	69	61	32	162	0	751	494	316	1,561	0	820	555	348	1,723
BH CM	0	11	7	14	32	0	216	103	221	540	0	227	110	235	572
PCM	0	13	0	41	54	0	309	10	903	1,222	0	322	10	944	1,276
Total	0	93	68	87	248	0	1,276	607	1,440	3,323	0	1,369	675	1,527	3,571

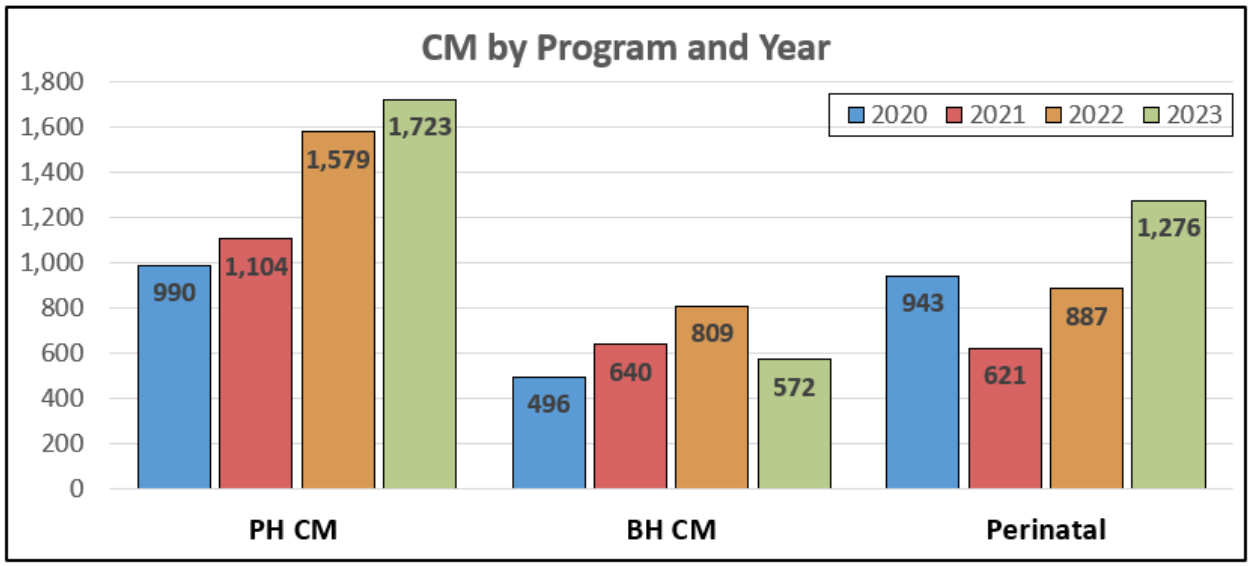
Source: CM Dossier and 412 NOP Reports

The volume of cases managed by program increased compared to prior years. Comparing 2023 specifically to 2022:

- PH CM demonstrated a 9.1% increase.
- BH CM demonstrated a 29.3% decrease.
- Perinatal CM demonstrated a 43.9% increase.

Table N. CM Cases Managed Year to Year by Program

CalViva Medi-Cal



Overall, 0.81% of the total population was managed in 2023 amongst physical health and behavioral health CM and the perinatal CM program. The average population of members in 2023 was 440,737. The overall percentage of population managed in Physical Health CM was 0.39%. Behavioral Health demonstrated 0.13%. The population managed in Perinatal CM was 0.29%.

Table O. Percentage of Total Population Managed

Percentage of Total Population Managed by Program and Product in 2023

Program	Average # Members (Population)					% of Population Managed				
	CHIP	Medicaid Expansion	SPD	TANF	TOTAL	CHIP	Medicaid Expansion	SPD	TANF	TOTAL
PH CM	0	122,424	47,977	270,336	**440,737**	0.00%	0.67%	1.16%	0.13%	**0.39%**
BH CM	0	122,424	47,977	270,336	**440,737**	0.00%	0.19%	0.23%	0.09%	**0.13%**
PCM	0	122,424	47,977	270,336	**440,737**	0.00%	0.26%	0.02%	0.35%	**0.29%**
Total	**0**	**122,424**	**47,977**	**270,336**	**440,737**	**0.00%**	**1.12%**	**1.41%**	**0.56%**	**0.81%**

Care Management (CM) Quality Audit Scores

Complex and Non-Complex Care Management

CM processes include specific instructions for documentation of CM activity specific to individual members who require complex or integrated care management with (BH) Behavioral Health. Required documentation focuses on the standards of CM practice, NCQA standards, and contractual obligations. All documentation is in the Plan's medical management system, TruCare.

Each month, audits of care management documentation are performed by the designated CM leads and or managers. In 2023, 33 audit elements were measured each quarter. Audit results for 2023 are comprised of 4 completed quarters. Typically, at least 2 unique cases that were open and actively managed for at least 60 days per care manager per month were audited. However, staff who maintained a 90% or above on each of their two monthly audits for 3 consecutive months, were audited on a quarterly basis (at the beginning of each quarter). If an employee on quarterly audits fell below the 90% threshold monthly audits were resumed.

Table P Complex and Non-Complex Care Management Audit Results show the results of the average per quarter for each program. The graph also shows individual elements shared in monthly meetings with CalViva. Trends are assessed to monitor compliance with the care management process including demonstrating member and provider collaboration. The goal for audit scores is no less than 90%. The overall average score across programs for 2023 was 98.92%, meeting overall goal of ≥90%. The overall average score per program was: Physical Health 98.25%, Behavioral Health 99.5%, and Maternity 99%.

Table P. Complex and Non-Complex Care Management Audit Results

2023 audit results	Physical Health				Behavioral Health				Perinatal			
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Overall Score	100%	95%	98%	100%	100%	100%	100%	98%	100%	99%	97%	100%
Welcome letter sent to member and PCP	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%
Calling PCP to discuss and request plan of care from PCP	100%	90%	90%	100%	100%	100%	100%	90%	100%	100%	100%	100%
Sending PCP a copy of the care plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Documentation of case closure discussed with the member & PCP/involved provider	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	90%	100%

Barriers impacting audit scores:

- Staff not following the CM process (sending welcome letter to both member and PCP and/or documentation of discussing case closure with PCP/involved provider).

Actions taken to mitigate the barriers:

- Reviewed audit findings with staff and held review sessions as needed.
- Escalated performance management for applicable staff.

Care Management Outcomes

Outcomes of the Care Management Program are evaluated at an aggregate level looking at the following key areas:

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

Utilization and Clinical Outcome Measures

Measures of effectiveness for care management are evaluated no less than annually using at least three measures that assess the process or outcomes of care for members in Physical and Behavioral Health CM. Measures of effectiveness include the following indicators:

- Readmission rates
- ED utilization
- Overall health care costs

These parameters were measured 90 days prior to the member's enrollment in physical and behavioral health care management and 90 days after enrollment.

The members included in the outcome measures met the following criteria:

- Had an active or closed case on or between 1/1/2023 and 12/31/2023 with claims paid through 4/24/2024
- Remained eligible 90 days after Case Open Date

One thousand three hundred ninety-three (1,393) members met the outcome criteria for the Physical and Behavioral Health CM programs. All cause admissions and readmissions were compared using claims data 90 days pre and post member enrollment into care management. Claims data demonstrated a reduction in readmissions for the care managed members, 1.5% decrease (pre 36.1% vs post 34.6%) in readmission rate based on claims. This was short of the 3% goal. There was also a 25% reduction in ED utilization for this population by 257 ED visits and a reduction of 738 ED visits per 1,000 members per year.

Table Q. CM Readmission Outcomes

CALVIVA CASE MANAGEMENT OUTCOMES REPORT

Members Case Managed Between 1/1/2023 and 12/31/2023, claims paid through 4/24/2024

Measure for Case Management	Members	90 days prior to CM enrollment			90 days following CM enrollment			Difference
		Admissions	Readmissions	Readmit Rate	Admissions	Readmissions	Readmit Rate	
Readmission Rate, within 30 days, all cause, based on claims data	1,393	787	284	36.1%	494	171	34.6%	-1.50%

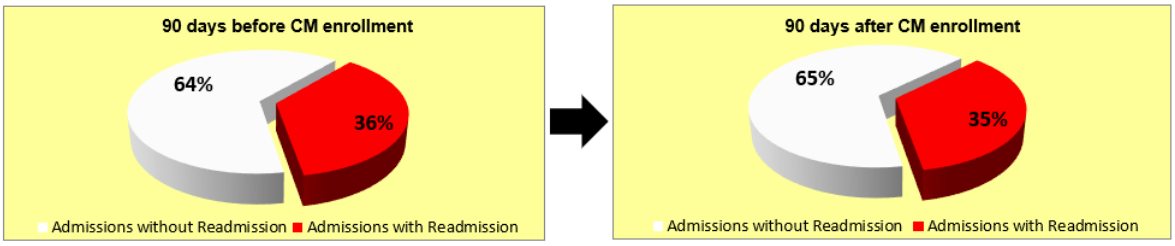
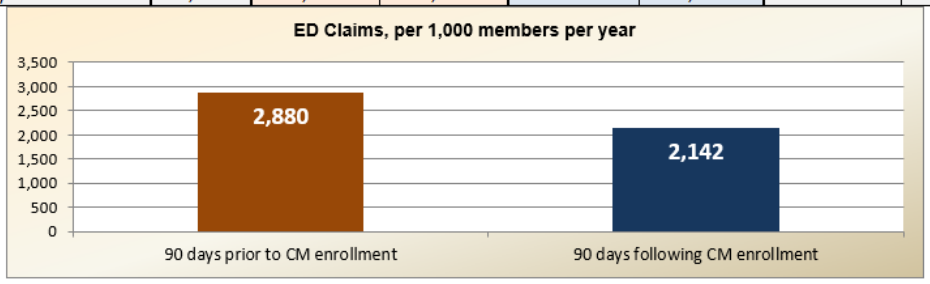


Table R. CM ED Utilization Outcomes

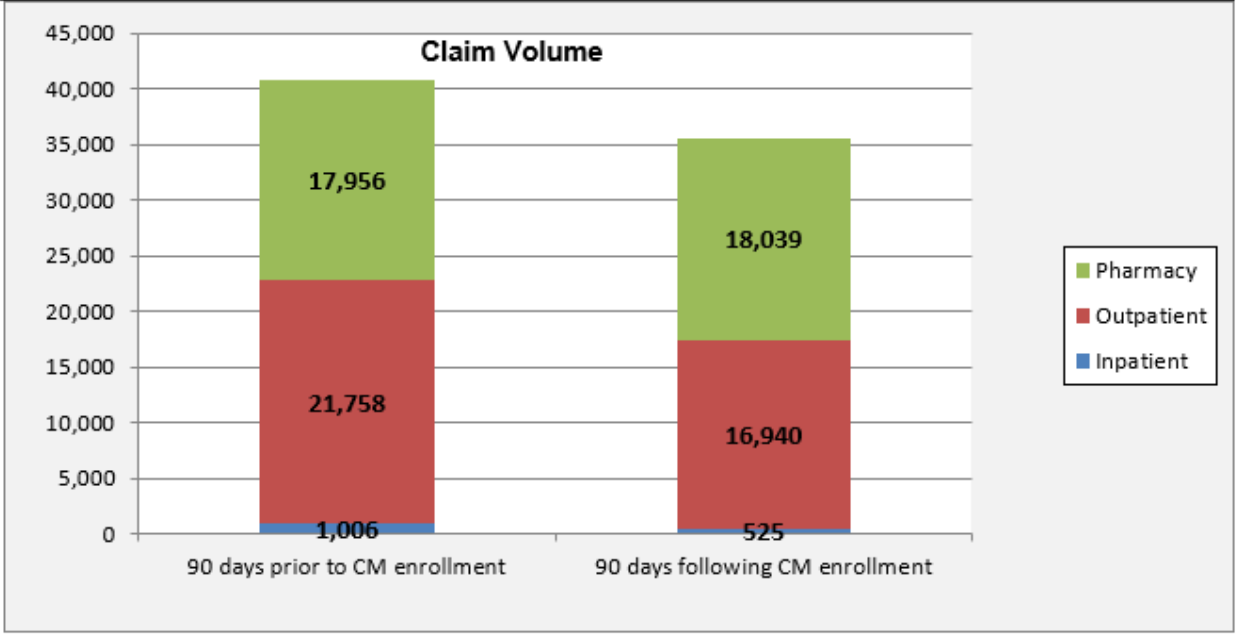
Measure for Case Management	Members	90 days prior to CM enrollment		90 days following CM enrollment		Difference	
		ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.	ED Claims	ED/1,000/Yr.
Emergency Department (ED) Claims, per 1,000 members per year	1,393	1,003	2,880	746	2,142	-257	-738



Comparing health care costs 90 days pre and post care management enrollment managed members demonstrated a reduction in inpatient claims of 481, a decrease of 4,818 for outpatient services, and an increase of 83 for pharmacy.

Table S. Physical and Behavioral Health CM Utilization Outcomes

Measure for Case Management	Members	90 days prior to CM	90 days following CM	Difference
		# Claims	# Claims	# Claims
Inpatient Paid Claims	1,393	1,006	525	-481
Outpatient/Other Paid	1,393	21,758	16,940	-4,818
Pharmacy Paid Claims	1,393	17,956	18,039	83
TOTAL PAID CLAIMS	**1,393**	**40,720**	**35,504**	**-5,216**



The effectiveness of the Perinatal CM program was evaluated based on the member's compliance with completing their first prenatal visit within the first trimester and their post-partum visit between 7 and 84 days after delivery compared to pregnant members who were not enrolled in the program. In addition, the rate of pre-term delivery of high-risk members managed to high-risk members not managed was compared. Preterm is defined as delivery prior to 36 weeks.

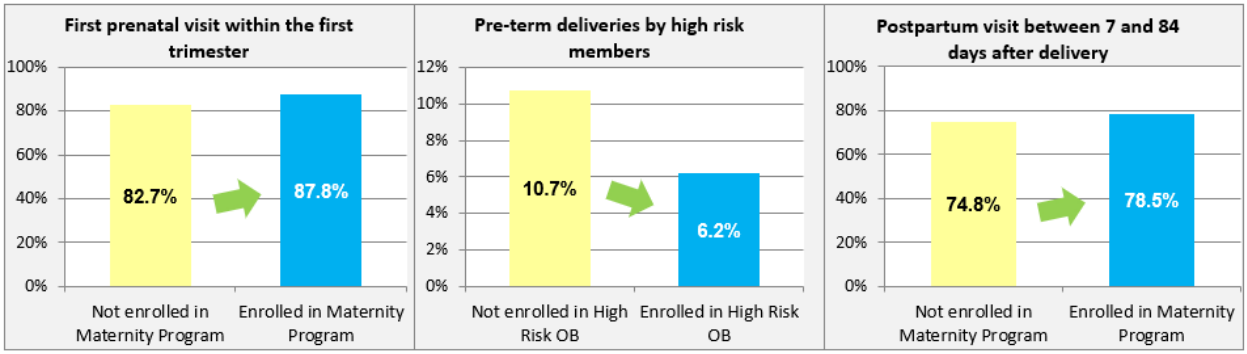
The members in the Perinatal CM program evaluated for compliance with the pre- and post-partum visits were limited to those who met the following criteria:

- Continuous enrollment
- For the prenatal metric were enrolled during their first trimester
- For the post-partum metric delivered prior to 12/31/2023.

Three hundred seventy-seven members (377) met the criteria for both the prenatal and the post-partum visit metrics and one hundred forty-five (145) members met the criteria for the pre-term delivery metric.

Table T. Clinical Outcomes for High-Risk OB Members

Measure for Perinatal Program	Members not enrolled in Perinatal Program		Members enrolled in Perinatal Program		Difference
	Members	Rate	Members	Rate	Rate
First prenatal visit within the first trimester	4,775	82.7%	377	87.8%	5.1%
Pre-term deliveries by high risk members	438	10.7%	145	6.2%	-4.5%
Postpartum visit between 7 and 84 days after delivery	4,775	74.8%	377	78.5%	3.7%



Members in the Perinatal CM program demonstrated a 5.1% percentage increase in compliance with completing the first prenatal visit in their first trimester meeting goal of ≥5%. The percentage increase in timely completion of their post-partum visit compared to pregnant members who were not enrolled in the program was 3.7% which was short of the goal of ≥5%. There were 4.5% fewer pre-term deliveries for high-risk members managed than high-risk members not managed which exceeded the 2% reduction goal.

Member Satisfaction

The effectiveness of care management based on member satisfaction is also measured. This measure is used across programs and includes complex and non-complex cases. Member satisfaction is evaluated quarterly using a member satisfaction survey and monitoring complaints/grievances related to CM. The goal for member satisfaction is > than 90% and the goal for member complaints/grievances is < 1/10,000 members.

Care Management Satisfaction Survey

A Member Satisfaction Survey is conducted near and or upon case closure. The survey is offered to members who have been in care management for a minimum of 45 days and are near case closure or subsequently closed for one of the following reasons: completion of all goals, successful closure, member requesting discontinuation of CM services or no longer eligible with the Plan. Members may be invited to complete the survey by email, text, and/or phone.

The survey consists of thirteen questions related to satisfaction with the care team. The survey results are loaded into a Qualtrics corporate dashboard system.

Care Team Satisfaction:

1. How happy are you with the Care Management Program?

2. How happy are you with the help you are getting or have gotten from your Care Manager?
3. How happy are you with the information you received from your Care Manager?
4. How happy are you with your ability to reach your Care Manager?
5. Do you feel more in control of your health now that you have started the Care Management Program?
6. Did your Care Manager care about your beliefs and values?
7. Did your Care Manager give you helpful tools to take care of your health?
8. Did your Care Manager Program help you reach your health goals?
9. Do you feel your care management team helped you organize the care between you and your doctors or other caregivers?
10. Is there anything that stopped you from taking your Care Managers Advice to better your health?
11. On a scale 1 to 5, how likely are you to recommend the Care Management Program to family and friend?
12. Is there anything else you would like to share about Care Manager Program or your Care Manager?
13. Do you have any ideas to help us give you better service?

Table U. Care Team Satisfaction

CM & TCM SATISFACTION SURVEY REPORT **CalViva** **1/1/2023 - 12/31/2023**

Question	Responses	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	% Satisfied or Better
How happy are you with the Care Management Program?	31	14	14	2	1	90%
How happy are you with the help you are getting or have gotten from your Care Manager	30	20	8	1	1	93%
How happy are you with the information you received from your Care Manager?	27	20	6	1	0	96%
How happy are you with your ability to reach your Care Manager?	25	13	11	1	0	96%
Question	Responses	Yes	No	% Yes		
Do you feel more in control of your health now that you have started the Care Management Program?	20	17	3	85%		
Did your Care Manager care about your beliefs and values?	25	23	2	92%		
Did your Care Manager give you helpful tools to take care of your health?	25	23	2	92%		
Did your Care Manager Program help you reach your health goals?	25	23	2	92%		
Do you feel your care management team helped you organize the care between you and your doctors or other caregivers?	25	24	1	96%		
Question	Responses	Yes	No	% No		
Is there anything that stopped you from taking your Care Managers Advice to better your health?	25	4	21	84%		
Question	Responses	5	4	3	2	1
On a scale 1 to 5, how likely are you to recommend the Care Management Program to family and friend?	24	14	3	3	1	3
Question	Responses	Yes	No			
Is there anything else you would like to share about Care Manager Program or your Care Manager?	0	0	0			
Do you have any ideas to help us give you better service?	0	0	0			

Care Management Program Evaluation - 2023

Results are reported for each response option per question. The response options include Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied, Yes or No. The positive responses were used to calculate the result. The CM satisfaction goal for is 90%.

Care Team Satisfaction (Table U) demonstrate 31 members were surveyed in 2023. Responses were not captured for all questions. The discrepancy in the number of members responding to the individual questions is attributed to members not answering all the questions or the response was not captured during data entry.

- 31 members responded to questions in the Care Team Satisfaction
    - 90% (28/31) of respondents were satisfied with the Care Management Program.
    - 93% (28/30) of respondents were satisfied with the help they received from CM.
    - 96% (26/27) reported they were satisfied with information given by Care Manager.
    - 96% (1/25) reported they were satisfied with their ability to reach their Care Manager.
    - 85% (17/20) reported they feel more in control of their health now that they have started the Care Management Program.
    - 92% (23/25) reported the Care Manager cared about their beliefs and values.
    - 92% (23/25) reported Care Manager gave them helpful tools to take care of their health.
    - 92% (23/25) reported the Care Manager helped them reach their health goals.
    - 96% (24/25) reported they feel their care management team helped them organize the care between them and their doctor or other caregivers.
    - 84% (21/25) reported nothing stopped them from taking their Care Managers Advice to better their health.
    - 24 members provided a rating of how likely they would recommend the Care management Program to family and friends.
    - 0 Members responded to the last two questions:
        - Is there anything else they would like to care about the Care Management Program or their Care Manager?
        - Do you have any ideas to help them receive better service?
    - Care Team Satisfaction section met goal of >90% met in 8/10 questions.

Care Management Complaints/Grievances

There were no grievances related to care management in 2023. The goal for member complaints/grievances < 1/10,000 members was met.

Table W. CM Grievances/Complaints

	Q1 2023		Q2 2023		Q3 2023		Q4 2023	
CM Complaints	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.	#	Per10K/Qtr.
	0	0	0	0	0	0	0	0

From https://cnet.centene.com/sites/CAMedi-calDataAnalytics: 2023: Q1 437,768; Q2 445,220; Q3 439, 572; Q4 428,979

Special Programs

Perinatal CM

Pregnant members are managed in the Perinatal CM program. Perinatal CM incorporates the concepts of CM, care coordination, and condition management in an effort to teach at risk pregnant members how to have healthier babies. Perinatal CM is a complete program that promotes education and communication between pregnant members, care managers, and physicians to ensure a healthy pregnancy and first year of life for babies.

Our multi-faceted approach to prenatal and postpartum care includes extensive member outreach, wellness materials, provider incentives, and intensive care management, which reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease.

The Perinatal CM program is comprised of multiple components which allow us to identify more pregnant members, interact with them earlier in pregnancy, reduce the rate of prematurity, shorten neonatal hospital stays, increase birth weights, and lessen the chance of repeat premature deliveries.

The Notification of Pregnancy (NOP) is generally the earliest notice to the Plan of a member's pregnancy. It can be completed by the physician, telephonically, via the Provider Portal, by the member on-line on the Plan's web site, or by completing and mailing a written form. Once the NOP is entered into the system, the pregnant member automatically receives a mailing from our Perinatal CM Program.

All members who completed an NOP and pregnant members who were referred by the Quality Department received outreach by the CM staff. If the NOP reflects the mother to be low to no risk, she was normally provided information about the Perinatal CM program and received regular periodic educational mailings that encouraged a healthy lifestyle for pregnancy, fetal development, and post-partum care. However, if the mother felt that she needed additional support she was offered the Perinatal CM program.

The mailings also encourage appropriate physician visits during the pregnancy and provide suggestions related to pediatrician selection. For those members identified as being medium or high risk for pregnancy complications the CM staff attempted to complete the full OB Assessment and offer the Maternity CM program. In addition to the benefits of the Perinatal CM program, members in the program were assigned to an experienced OB RN, or social worker, for one-on-one regular phone contact. It is at this point that a highly individualized plan of care was developed with the members consent and participation to achieve goals aimed at improving the overall health of both the pregnant member and fetus.

After consent for program participation and program enrollment was completed, ongoing telephonic contact was established with frequency varying depending on member need and

acuity. Ongoing reassessment of need and progress was reviewed at least monthly with updates and adjustments to plan of care occurring as needed.

Providers were notified of their patient's participation in care management programs and are encouraged to provide feedback and input to the care manager regarding the patient plan of care.

Metrics associated with the Perinatal CM program managed
Analytics provided data related to NOP Completion and Percentage of Deliveries with NOP.

NOP Completion – The number of NOPs completed. NOPs can be submitted by members and providers and may also be completed during CM telephonic outreach to members identified as pregnant on the **413 No NOP** report. In 2023 2,088 NOPs were completed.

Table X. NOP Completion per Month
2023 Perinatal CM HBR: Members with a Completed NOP Assessment
By Month of Frist NOP Assessment date
Source: 412 NOP report

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Health Net CalViva	233	176	193	273	185	244	119	128	139	167	148	83	2,088

Percentage of Deliveries with an NOP - The percentage of births with an NOP completed within eight months prior to delivery. The goal set for the Plan by Centene varied by month and was not exclusive to CalViva in 2023. There was variation in performance from a low of 36.9% in December to a high of 50.3% in January. The total at year-end average was 44.8%; a decrease from 47.2% in 2022.

Table Y. Percentage of Deliveries with NOP
2023 Perinatal CM HBR: % of Deliveries with NOP
By Month of Delivery Date
Sources: 412 NOP report and IP Validation Report

Business Line	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Health Net CalViva	50.3%	49.6%	42.9%	46.1%	46.2%	43.7%	45.4%	46.8%	46.6%	43.5%	40.0%	36.9%	44.9%
NUMERATOR	237	200	200	205	207	197	217	228	199	191	172	156	2409
DENOMINATOR	471	403	466	445	448	451	478	487	427	439	430	423	5368

The percent of timely NOP outreach to High-Risk Members - The percentage high risk members with a call/note within 7 days of NOP entry.

NOP CM Success (30-days) - Percentage of members indicated as high risk on an NOP who are put into active care management within 30 days of the NOP.

Neonatal Rate - Percentage of NICU admits per delivery.

Care Management Program Evaluation - 2023

Enrollment in this program in 2023 was 1048. We continued to make outreach to all risk categories including low risk. We found this to be of great importance and superior customer service as it allowed us to reach members that may need assistance who were not identified through the NOP. Overall, there were 13,720 pregnancy related materials mailed in 2023. Members may sign up for mailings outside of care management which explains more material being sent than members managed. Mailings are based on completion of an NOP for the Pregnancy mailing and presence of a completed Birth Event in TruCare for the Post-delivery Packet.

Table Z. Perinatal CM Outreach

Educational Packet	***Number of Packets Sent in 2023***
NOP mailings	9,313
Pregnancy mailings	1,631
Post-delivery packets	2,776
Total	13,720

Transition Care Services Program

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

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

The program includes:

- Outreach to members before discharge to assist with care coordination.
- Conducting a post-acute follow-up call within 72 hours of discharge that actively engages the member in medication reconciliation, use of a personal health record.
- Review of their disease symptoms or "red flags" that indicate a worsening condition and strategies of how to respond.
- Preparation for discussions with other health care professionals.
- Supporting the patient's self-management role.
- Educating the member to follow up with the PCP/and or specialist within 7 days of discharge.

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

In 2023 2,408 members were referred to the Transitional Care Services Program and 1,760 (73.1%) participated. The number of members participating in the program increased from 1,010 in 2022.

Palliative Care Program

A Palliative Care Program is offered to eligible members with the goal of providing an extra layer of support by providing disease education, pain management, symptom control, and additional resources and guidance to enhance the member's quality of life. Through a partnership of vendors throughout California, Palliative Care can provide nurses, medical directors, and social workers in a home setting to members at no additional cost. Palliative Care empowers the member and family through a collaborative effort of communications, coordination of care, and advance planning, while allowing the goals of both the member and family to be the guiding principle.

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

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Individualized Plan of Care including Pain and Symptom Management
- Care Coordination
- Mental Health and Medical Social Services
- Chaplain Services
- 24/7 Telephonic Palliative Care Support
- Additional medically necessary or reasonable services as provisioned within regulatory requirements

Palliative Care Services may be provided in inpatient, outpatient, home-based, community-based, and other settings based on what is medically necessary for the member's needs.

In 2023, 87 members were referred to the Palliative Care Program and 59 (67.8%) participated. The internal Palliative Care Program ended in December of 2023, as Palliative Care became a benefit effective in Q4 of 2023. Training was provided to providers on how to request authorization for Palliative Care. Care Management staff were also trained on how to help assess members for palliative care and help connect members to palliative providers.

Care Coordination Activities

In addition to providing care management to members, the CM department supports care coordination with other entities within the community.

California Children Services

The plan works with CCS counties to support members turning 21 who will be aging out of the CCS program. Outreach to members begins six months prior to the 21st birthday to educate on plan benefits and determine if the member needs assistance in transitioning to in network specialty and/or ancillary providers as well as ongoing authorizations for durable medical equipment. Additionally, in November of 2023, the CM team began to outreach members new to CCS services to offer support and facilitate care coordination between member's PCP and CCS provider.

Private Duty Nursing (PDN) Care Management for Eligible Members Under 21

In 2020 the Department of Health Care Services published All Plan Letter (APL) 20-012 date 05/15/20, mandating all Managed Care Plans care manage members under the age of 21 receiving PDN services to make sure that authorized PDN services were being monitored to ensure medically necessary services were being delivered even if those services were carved out to California Children Services. Care Management developed a process to manage these referrals to promote continuity of services for members receiving PDN. The CM team in conjunction with Public Programs and Delegation Oversight obtained monthly reports from CCS and the delegated PPGs of members approved for PDN. The CM team collaborated with the parents and/or members, CCS, and home care agencies regarding ongoing care and assisted with transition to Home and Community-Based Services one year prior to 21st birthday.

Regional Centers

Care management also worked collaboratively with the Regional Centers that are associated with the CalViva Health counties for members active in care management and have a need as described below. These needs include members:

- Under the age of 18 who are at risk or have a developmental disability that may require supportive services not otherwise provided such as early intervention for infants and families (Early Start)
- Requiring lifelong individual planning, and service coordination, placement, and monitoring for 24-hour out of home care, and advocacy for legal, civil, and service rights.

Targeted Case Management

Support continued for collaboration in counties that continue to offer targeted case management. Programs offered through targeted case management vary by county. There continued to be very limited participation on behalf of the counties in 2023. The CalViva counties offering targeted case management include Madera. The Service Coordination liaison continued efforts to re-

engage related activities with these counties with limited success. Support for collaborative activities will continue in 2024.

CalAIM

CalAIM is a multi-year 5+ framework program developed by the Department of Health Care services (DHCS) encompassing a broad-based delivery system, program, and payment reform across Medi-Cal. The focus is to address the complex challenges facing the Plan's most vulnerable members. It also provides for non-clinical interventions focused on the whole-person care (WPC) approach that targets social determinants of health (SDoH) and reduces health disparities and inequities. Enhanced Care Management (ECM) and Community Supports are the first two programs that launched on January 01, 2022. Populations of Focus (POF) in 2022 and 2023 were those members that were previously in (WPC) or (HHP); Adults and Their Families Experiencing Homelessness; Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization; Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs; Adults with Intellectual or Developmental Disabilities (I/DD); Adults who are Pregnant or Postpartum; Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; Adult Nursing Facility Residents Transitioning to the Community; Adults without Dependent Children/Youth Living with Them Experiencing Homelessness; Children & Youth Populations of Focus. Populations of Focus for 2024 will be Birth Equity; Individuals Transitioning from Incarceration; and Pre-Release Medi-Cal Services.

- **Enhanced Care Management (ECM)** is a Plan benefit that provides a community based, high-touch, person-centered/whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need members through systematic coordination of services.
- **Community Supports** are designed to be used to provide health related services as an alternative to covered Medi-Cal benefits. It will integrate care management for members at high levels of risk and intended to address SDoH. Support services may include Asthma Remediation; Community Transition Services/Nursing Facility Transition Services to a Home; Day Habilitation programs; Environmental Accessibility Adaptation (Home Modification); Housing Deposit; Housing Tenancy and Sustaining Services; Housing Transition Navigation; Medically Tailored Meals; Nursing Facility Transition/Diversion to Assisted Living Facilities; Personal Care Services and Homemaker Services; Recuperative Care; Respite Services; Short-Term Post-Hospitalization Housing; and Sobering Centers.

Members can self-refer to ECM and assigned staff will make contact to determine if they fall within the POF. If they are, CM staff will send notification to have the member assigned to an ECM provider. Care Management staff may also refer members to ECM services if they identify members in a POF and would benefit from ECM services. Care Management staff also regularly refer members to CS. Members accepted into ECM cannot be in the Plan's Complex Care Management program due to duplication of services, but can still be referred to Community Support services, Condition Specific Disease Management programs, and the Transition of Care program.

Population Health Management

We are committed to evolving to a collaborative community-wide approach to Population Health Management. We recognize that to achieve that goal requires knowledge of the community, appropriate information management tools and the application of evidence-based interventions derived from industry standards.[1] The Institute of Medicine (IOM) has defined three principal domains that effect successful health population management: [2]

1. The social, economic and environmental conditions that often act as the primary determinants of individual and population health.
2. Health care services for individuals.
3. Public health activities that target populations and address individual health behaviors, such as smoking and excessive alcohol consumption.

A population assessment is completed which provides the interdisciplinary team with a vehicle by which to analyze and prioritize health needs. Review of this information facilitates the identification of new initiatives, the ability to establish goals, evaluate and measure progress, while improving the quality, transparency and community engagement. The population health needs assessment is completed annually by the Plan's Population Health Management Team and is reported to the QIUM Committee.

Population Assessment and CM Criteria

In 2023, we continued to utilize a comprehensive Population Health Management report to support an integrated care model; care management being one component. This data is used to identify members for various programs. Impact pro data is included in the algorithm for this report.

[1] Institute of Medicine, *Primary Care and Public Health* (Washington D.C., 2012) [pre-publication copy], p. S-1

[2] IBID.

Impact Pro is a predictive modeling and care management analytic tool with a built-in proprietary risk stratification algorithm to differentiate members who are impactable and have higher risk and more complex health needs from those at lower risk. The risk stratification algorithm utilizes member specific data identified through claims, TARs, pharmacy and data provided by the State. Members are stratified into one of ten Population Health Categories: Level 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, Level 05A: Health Coaching, Level 05B: Physical Health CM, Level 05C Behavioral Health CM, Level 06: Rare High Cost Condition, Level 07A: Catastrophic: Dialysis, Level 07B: Catastrophic: Active Cancer, Level 07C: Catastrophic: Transplant Level 08A: Dementia, Level 08B: Institutional (custodial care) Level 09A: LTSS and MMP - Service Coordination, Level 09B: LTSS and MMP - High Needs Care Management or Level 10: End of Life. Members stratified into levels 05B and 5C are identified as higher risk and impactable and are referred to care management as described below.

Members identified on the PHM report who are stratified into Level 5B: Physical Health CM and Level 05C Behavioral Health CM AND have other designated parameters such as:

- CM engagement score ≥ 80
- Priority Flag = Yes
- ER Likelihood = Most Likely and Highly Likely

shall be referred to the care management program.

Additionally, any member, regardless of the risk stratification, who reaches a designated score based on responses to the Screening HRA and/or who requested an individualized care plan or individualized care team may be referred to Care Management.

III. Summary and Priorities

In 2023, the key accomplishments for the CM were:

- Successful coordination for CalAIM ECM member self-referrals.
- Successful CalAIM Community Support referrals.
- Successful transition of Rx carve out to the State and use of Magellan's Rx system.
- Filled open CM positions.
- Enhanced the Transitional Care Services program to meet PHM requirements:
    - Increased staffing
    - Outreach to all high-risk inpatient members
    - Created TCS hotline for recently inpatient members with care coordination needs to call for support per DHCS requirements.

Care Management Program Evaluation - 2023

The primary goals for 2024 are to complete activities related to:

- Outreach all Acute Inpatient Admissions
- Increase member enrollment in Transitional Care Services program.
    - Have non-clinical staff on site at hospitals to increase engagement.
- Increase caseload per CM to 75 align with goals.
- Support CalAIM activities, prepare for additional Populations of Focus.
- Support CalAIM Community Supports programs and increased offerings.
- Manage more members across CM programs.

Item #13
Attachment 13.A

Finance Report
Financials as of May 31, 2024

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Balance Sheet

As of May 31, 2024

		Total
1	ASSETS	
2	Current Assets	
3	Bank Accounts	
4	Cash & Cash Equivalents	279,202,285.17
5	Total Bank Accounts	$ 279,202,285.17
6	Accounts Receivable	
7	Accounts Receivable	174,209,183.89
8	Total Accounts Receivable	$ 174,209,183.89
9	Other Current Assets	
10	Interest Receivable	840,626.23
11	Investments - CDs	0.00
12	Prepaid Expenses	263,483.99
13	Security Deposit	39,109.96
14	Total Other Current Assets	$ 1,143,220.18
15	Total Current Assets	$ 454,554,689.24
16	Fixed Assets	
17	Buildings	5,726,765.68
18	Computers & Software	37,333.28
19	Construction in Progress	83,007.60
20	Land	3,161,419.10
21	Office Furniture & Equipment	77,528.80
22	Total Fixed Assets	$ 9,086,054.46
23	Other Assets	
24	Investment -Restricted	303,984.02
25	Lease Receivable	2,667,739.08
26	Total Other Assets	$ 2,971,723.10
27	TOTAL ASSETS	$ 466,612,466.80
28	LIABILITIES, DEFFERED INFLOW OF RESOURCES, AND EQUITY	
29	Liabilities	
30	Current Liabilities	
31	Accounts Payable	
32	Accounts Payable	92,789.17
33	Accrued Admin Service Fee	9,611,525.00
34	Capitation Payable	178,038,333.68
35	Claims Payable	0.00
36	Directed Payment Payable	5,004,972.41
37	Total Accounts Payable	$ 192,747,620.26
38	Other Current Liabilities	
39	Accrued Expenses	1,689,447.79
40	Accrued Payroll	64,007.18
41	Accrued Vacation Pay	353,471.71
42	Amt Due to DHCS	0.00
43	IBNR	65,773.55
44	Loan Payable-Current	0.00
45	Premium Tax Payable	0.00
46	Premium Tax Payable to BOE	325,611.99
47	Premium Tax Payable to DHCS	109,427,083.34
48	Total Other Current Liabilities	$ 111,925,395.56
49	Total Current Liabilities	$ 304,673,015.82
50	Long-Term Liabilities	
51	Renters' Security Deposit	25,906.79
52	Subordinated Loan Payable	0.00
53	Total Long-Term Liabilities	$ 25,906.79
54	Total Liabilities	$ 304,698,922.61
55	Deferred Inflow of Resources	2,228,914.23
56	Equity	
57	Retained Earnings	141,338,556.42
58	Net Income	18,346,073.54
59	Total Equity	$ 159,684,629.96
60	TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES AND EQUITY	$ 466,612,466.80

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Budget vs. Actuals: Income Statement

July 2023 - May 2024

		Total		
		Actual	Budget	Over/(Under) Budget
1	Income			
2	Interest Earned	7,617,872.06	3,300,000.00	4,317,872.06
3	Premium/Capitation Income	1,922,653,343.69	1,594,293,793.00	328,359,550.69
4	**Total Income**	**1,930,271,215.75**	**1,597,593,793.00**	**332,677,422.75**
5	Cost of Medical Care			
6	Capitation - Medical Costs	1,236,242,750.42	1,042,591,443.00	193,651,307.42
7	Medical Claim Costs	1,230,161.58	1,466,666.63	(236,505.05)
8	**Total Cost of Medical Care**	**1,237,472,912.00**	**1,044,058,109.63**	**193,414,802.37**
9	**Gross Margin**	**692,798,303.75**	**553,535,683.37**	**139,262,620.38**
10	Expenses			
11	Admin Service Agreement Fees	52,799,527.00	47,536,170.00	5,263,357.00
12	Bank Charges	0.00	6,600.00	(6,600.00)
13	Computer/IT Services	136,482.79	236,467.00	(99,984.21)
14	Consulting Fees	165,988.00	366,666.63	(200,678.63)
15	Depreciation Expense	300,241.70	330,000.00	(29,758.30)
16	Dues & Subscriptions	218,507.21	214,500.00	4,007.21
17	Grants	3,665,454.54	3,684,550.00	(19,095.46)
18	Insurance	321,935.31	374,160.00	(52,224.69)
19	Labor	3,407,961.32	4,128,495.00	(720,533.68)
20	Legal & Professional Fees	84,501.32	183,333.37	(98,832.05)
21	License Expense	1,159,626.44	1,281,052.63	(121,426.19)
22	Marketing	1,188,522.76	1,420,000.00	(231,477.24)
23	Meals and Entertainment	13,662.45	25,750.00	(12,087.55)
24	Office Expenses	65,827.07	83,600.00	(17,772.93)
25	Parking	127.00	1,430.00	(1,303.00)
26	Postage & Delivery	2,243.47	4,400.00	(2,156.53)
27	Printing & Reproduction	2,116.42	4,510.00	(2,393.58)
28	Recruitment Expense	83,384.17	103,125.00	(19,740.83)
29	Rent	0.00	11,000.00	(11,000.00)
30	Seminars and Training	6,909.10	26,400.00	(19,490.90)
31	Supplies	10,029.47	11,916.63	(1,887.16)
32	Taxes	611,300,820.37	485,833,337.00	125,467,483.37
33	Telephone	29,708.97	38,500.00	(8,791.03)
34	Travel	14,253.21	24,016.63	(9,763.42)
35	**Total Expenses**	**674,977,830.09**	**545,929,979.89**	**129,047,850.20**
36	**Net Operating Income/ (Loss)**	**17,820,473.66**	**7,605,703.48**	**10,214,770.18**
37	Other Income			
38	Other Income	525,599.88	550,000.00	(24,400.12)
39	**Total Other Income**	**525,599.88**	**550,000.00**	**(24,400.12)**
40	**Net Other Income**	**525,599.88**	**550,000.00**	**(24,400.12)**
41	**Net Income/ (Loss)**	**18,346,073.54**	**8,155,703.48**	**10,190,370.06**

Fresno-Kings-Madera Regional Health Authority dba CalViva Health

Income Statement: Current Year vs Prior Year

FY 2024 vs FY 2023

		Total	
		July 2023 - May 2024	July 2022 - May 2023 (PY)
1	Income		
2	Interest Earned	7,617,872.06	4,763,148.60
3	Premium/Capitation Income	1,922,653,343.69	1,199,635,364.54
4	Total Income	$ 1,930,271,215.75	$ 1,204,398,513.14
5	Cost of Medical Care		
6	Capitation - Medical Costs	1,236,242,750.42	1,039,019,730.34
7	Medical Claim Costs	1,230,161.58	1,247,695.94
8	Total Cost of Medical Care	$ 1,237,472,912.00	$ 1,040,267,426.28
9	Gross Margin	$ 692,798,303.75	$ 164,131,086.86
10	Expenses		
11	Admin Service Agreement Fees	52,799,527.00	51,273,453.00
12	Computer/IT Services	136,482.79	172,699.59
13	Consulting Fees	165,988.00	39,935.00
14	Depreciation Expense	300,241.70	271,814.45
15	Dues & Subscriptions	218,507.21	241,835.50
16	Grants	3,665,454.54	4,296,818.19
17	Insurance	321,935.31	178,424.34
18	Labor	3,407,961.32	3,032,331.84
19	Legal & Professional Fees	84,501.32	79,911.01
20	License Expense	1,159,626.44	1,077,042.43
21	Marketing	1,188,522.76	1,251,431.03
22	Meals and Entertainment	13,662.45	19,328.22
23	Office Expenses	65,827.07	73,706.06
24	Parking	127.00	184.39
25	Postage & Delivery	2,243.47	3,053.01
26	Printing & Reproduction	2,116.42	1,724.82
27	Recruitment Expense	83,384.17	38,645.73
28	Rent	0.00	0.00
29	Seminars and Training	6,909.10	8,022.99
30	Supplies	10,029.47	8,768.12
31	Taxes	611,300,820.37	91,436,708.20
32	Telephone	29,708.97	28,306.26
33	Travel	14,253.21	14,065.58
34	Total Expenses	$ 674,977,830.09	$ 153,548,209.76
35	Net Operating Income/ (Loss)	$ 17,820,473.66	$ 10,582,877.10
36	Other Income		
37	Other Income	525,599.88	498,698.65
38	Total Other Income	$ 525,599.88	$ 498,698.65
39	Net Other Income	$ 525,599.88	$ 498,698.65
40	Net Income/ (Loss)	$ 18,346,073.54	$ 11,081,575.75

Item #13
Attachment 13.B

Medical Management
Appeals & Grievances Report

Attachment M

CalViva Health

Monthly Appeals and Grievances Dashboard

CY: 2024

Current as of End of the Month: May
Revised Date: 7/8/2024

CalViva - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	15	8	2	25	7	6	0	13	0	0	0	0	0	0	0	0	38	126
Standard Grievances Received	144	132	147	423	217	196	0	413	0	0	0	0	0	0	0	0	836	1761
Total Grievances Received	**159**	**140**	**149**	**448**	**224**	**202**	**0**	**426**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**874**	**1887**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	10
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.0%**	**0.0%**	**99.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.76%**	**99.4%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	13	9	3	25	7	6	0	13	0	0	0	0	0	0	0	0	38	126
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Standard Grievances Resolved Compliant	160	125	132	417	166	213	0	379	0	0	0	0	0	0	0	0	796	1702
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.4%**	**100.0%**	**0.0%**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.87%**	**99.9%**
Total Grievances Resolved	**173**	**134**	**135**	**442**	**174**	**219**	**0**	**393**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**835**	**1829**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**153**	**118**	**119**	**390**	**154**	**183**	**0**	**337**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**727**	**1468**
Access - Other - DMHC	25	24	10	59	23	29	0	52	0	0	0	0	0	0	0	0	111	270
Access - PCP - DHCS	7	4	4	15	13	15	0	28	0	0	9	9	0	0	0	0	7	118
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	10	7	2	19	3	3	0	6	0	0	0	0	0	0	0	0	25	78
Administrative	25	30	35	90	30	34	0	64	0	0	0	0	0	0	0	0	154	186
Balance Billing	21	13	14	0	32	33	0	65										
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	12	12	16	40	16	23	0	39	0	0	0	0	0	0	0	0	79	122
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	14	10	11	83	16	13	0	29	0	0	0	0	0	0	0	0	112	339
Pharmacy/RX Medical Benefit	1	1	1	3	2	0	0	2	0	0	0	0	0	0	0	0	5	1
Transportation - Access	18	7	10	35	11	14	0	25	0	0	0	0	0	0	0	0	60	175
Transportation - Behavior	8	1	4	13	0	1	0	1	0	0	0	0	0	0	0	0	14	89
Transportation - Other	12	9	12	33	8	18	0	26	0	0	0	0	0	0	0	0	59	86
Quality Of Care Grievances	**20**	**16**	**16**	**52**	**20**	**36**	**0**	**56**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**108**	**361**
Access - Other - DMHC	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	3
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	2	3	5	10	4	3	0	7	0	0	0	0	0	0	0	0	17	60
PCP Care	8	5	5	18	7	13	0	20	0	0	0	0	0	0	0	0	38	94
PCP Delay	1	3	4	8	4	7	0	11	0	0	0	0	0	0	0	0	19	116
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	6	1	2	9	1	7	0	8	0	0	0	0	0	0	0	0	17	60
Specialist Delay	2	3	0	5	3	6	0	9	0	0	0	0	0	0	0	0	14	24
Exempt Grievances Received	146	135	176	**457**	224	185	0	**409**	0	0	0	**0**	0	0	0	**0**	**866**	1885
Access - Avail of Appt w/ PCP	4	1	2	**7**	7	3	0	**10**	0	0	0	**0**	0	0	0	**0**	**17**	15
Access - Avail of Appt w/ Specialist	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	3	**3**	0	4	0	**4**	0	0	0	**0**	0	0	0	**0**	**7**	7
Access - Wait Time - in office for appt	0	1	0	**1**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**2**	2
Access - Panel Disruption	0	0	2	**2**	4	2	0	**6**	0	0	0	**0**	0	0	0	**0**	**8**	15
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	2
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	0	1	1	**2**	5	1	0	**6**	0	0	0	**0**	0	0	0	**0**	**8**	14
Attitude/Service - Provider	6	9	16	**31**	13	9	0	**22**	0	0	0	**0**	0	0	0	**0**	**53**	43
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
Attitude/Service - Vendor	0	0	6	**6**	6	0	0	**6**	0	0	0	**0**	0	0	0	**0**	**12**	4
Attitude/Service - Health Plan	0	1	3	**4**	3	2	0	**5**	0	0	0	**0**	0	0	0	**0**	**9**	12
Authorization - Authorization Related	0	2	1	**3**	0	4	0	**4**	0	0	0	**0**	0	0	0	**0**	**7**	6

Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**3**	4
Eligibility Issue - Member not eligible per Provider	2	1	4	**7**	17	10	0	**27**	0	0	0	**0**	0	0	0	**0**	**34**	48
Health Plan Materials - ID Cards-Not Received	19	17	20	**56**	26	22	0	**48**	0	0	0	**0**	0	0	0	**0**	**104**	210
Health Plan Materials - ID Cards-Incorrect Information on Card	0	2	0	**2**	4	2	0	**6**	0	0	0	**0**	0	0	0	**0**	**8**	2
Health Plan Materials - Other	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	4
Mental Health Related	2	3	4	**9**	3	8	0	**11**	0	0	0	**0**	0	0	0	**0**	**20**	2
PCP Assignment/Transfer - Health Plan Assignment - Change Request	50	48	49	**147**	82	61	0	**143**	0	0	0	**0**	0	0	0	**0**	**290**	652
PCP Assignment/Transfer - HCO Assignment - Change Request	15	15	19	**49**	21	18	0	**39**	0	0	0	**0**	0	0	0	**0**	**88**	301
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	4	4	11	**19**	7	7	0	**14**	0	0	0	**0**	0	0	0	**0**	**33**	37
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	7
PCP Assignment/Transfer - Mileage Inconvenience	0	1	0	**1**	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	**4**	14
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider No Show	7	4	6	**17**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**18**	65
Transportation - Access - Provider Late	2	2	1	**5**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**6**	32
Transportation - Behaviour	4	0	1	**5**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**5**	76
Transportation - Other	2	4	3	**9**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**10**	53
OTHER - Other	1	4	5	**10**	4	5	0	**9**	0	0	0	**0**	0	0	0	**0**	**19**	14
Claims Complaint - Balance Billing from Provider	28	15	18	**61**	15	22	0	**37**	0	0	0	**0**	0	0	0	**0**	**98**	235

Appeals	Jan	Feb	Mar	Q1	Apr	May	June	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	2	2	6	1	1	0	2	0	0	0	0	0	0	0	0	8	34
Standard Appeals Received	22	17	32	71	40	42	0	82	0	0	0	0	0	0	0	0	153	331
Total Appeals Received	**24**	**19**	**34**	**77**	**41**	**43**	**0**	**84**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	161	**365**
Appeals Ack Letters Sent Noncompliant	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	2
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.4%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	3	**6**	1	1	0	**2**	0	0	0	**0**	0	0	0	0	8	35
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Standard Appeals Resolved Compliant	16	30	12	58	30	39	0	69	0	0	0	0	0	0	0	0	127	325
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**	**99.8%**
Total Appeals Resolved	**18**	**31**	**15**	**64**	**31**	**40**	**0**	**71**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**135**	**361**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**18**	**31**	**15**	**64**	**31**	**40**	**0**	**71**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**135**	353
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	1	4	0	5	0	0	0	0	0	0	0	0	5	9
DME	2	3	3	8	7	6	0	16	0	0	0	0	0	0	0	0	24	37
Experimental/Investigational	0	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	3	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	11	18	1	30	15	14	0	27	0	0	0	0	0	0	0	0	57	162
Other	1	4	4	9	1	7	0	7	0	0	0	0	0	0	0	0	16	35
Pharmacy/RX Medical Benefit	2	3	2	7	2	0	0	5	0	0	0	0	0	0	0	0	12	47
Surgery	2	3	2	7	5	6	0	11	0	0	0	0	0	0	0	0	18	62
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	8
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	8	8	6	**22**	11	20	0	31	0	0	0	0	0	0	0	0	53	156
Uphold Rate	**44.4%**	**25.8%**	**40.0%**	**34.4%**	**35.5%**	**50.0%**	**0.0%**	**43.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**39.3%**	**43.2%**
Overturns - Full	9	22	7	**38**	20	18	0	**38**	0	0	0	**0**	0	0	0	**0**	76	194
Overturn Rate - Full	**50.0%**	**71.0%**	**46.7%**	**59.4%**	**64.5%**	**45.0%**	**0.0%**	**53.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**56.3%**	**53.7%**
Overturns - Partials	1	1	1	**3**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	5	10
Overturn Rate - Partial	**5.6%**	**3.2%**	**6.7%**	**4.7%**	**0.0%**	**5.0%**	**0.0%**	**2.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**3.7%**	**2.8%**
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	0	**1**	1
Withdrawal Rate	**0.0%**	**0.0%**	**6.7%**	**1.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.7%**	**0.3%**
Membership	434,122	434,443	434,459		434,072	433,828	-		-	-	-		-	-	-			430,517
Appeals - PTMPM	0.04	0.07	0.03	0.05	0.07	0.09	-	0.08	-	-	-	-	-	-	-	-	0.06	0.09
Grievances - PTMPM	0.40	0.31	0.31	0.34	0.40	0.50	-	0.45	-	-	-	-	-	-	-	-	0.38	0.24

CalViva Health Appeals and Grievances Dashboard 2024 (Fresno County)

Fresno County - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	13	7	2	22	6	4	0	10	0	0	0	0	0	0	0	0	32	107
Standard Grievances Received	117	109	131	357	173	165	0	338	0	0	0	0	0	0	0	0	695	1447
Total Grievances Received	**130**	**116**	**133**	**379**	**179**	**169**	**0**	**348**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**727**	**1554**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	11	8	3	22	6	4	0	10	0	0	0	0	0	0	0	0	32	107
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Standard Grievances Resolved Compliant	130	102	109	341	153	163	0	316	0	0	0	0	0	0	0	0	657	1389
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.3%**	**100.0%**	**0.0%**	**99.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.8%**	**99.9%**
Total Grievances Resolved	**141**	**110**	**112**	**363**	**160**	**167**	**0**	**327**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**690**	**1497**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**124**	**97**	**97**	**318**	**142**	**137**	**0**	**279**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**597**	**1194**
Access - Other - DMHC	21	19	9	49	22	22	0	44	0	0	0	0	0	0	0	0	93	225
Access - PCP - DHCS	4	4	3	11	11	14	0	25	0	0	0	0	0	0	0	0	36	102
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	9	7	2	18	2	3	0	5	0	0	0	0	0	0	0	0	23	69
Administrative	24	24	29	77	28	28	0	56	0	0	0	0	0	0	0	0	133	160
Balance Billing						28	0	28										
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	10	10	13	33	16	15	0	31	0	0	0	0	0	0	0	0	64	97
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	28	22	21	71	46	9	0	55	0	0	0	0	0	0	0	0	126	283
Pharmacy/RX Medical Benefit	1	0	0	1	2	0	0	2	0	0	0	0	0	0	0	0	3	1
Transportation - Access	13	6	6	25	8	6	0	14	0	0	0	0	0	0	0	0	39	126
Transportation - Behaviour	7	1	3	11	0	0	0	0	0	0	0	0	0	0	0	0	11	70
Transportation - Other	7	4	11	22	7	12	0	19	0	0	0	0	0	0	0	0	41	61
Quality Of Care Grievances	**17**	**13**	**15**	**45**	**18**	**30**	**0**	**48**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**93**	**303**
Access - Other - DMHC	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	2	4	7	4	1	0	5	0	0	0	0	0	0	0	0	12	51
PCP Care	6	5	5	16	6	13	0	19	0	0	0	0	0	0	0	0	35	78
PCP Delay	1	2	4	7	4	6	0	10	0	0	0	0	0	0	0	0	17	97
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	6	1	2	9	0	4	0	4	0	0	0	0	0	0	0	0	13	54
Specialist Delay	2	3	0	5	3	6	0	9	0	0	0	0	0	0	0	0	14	17

CalViva Health Appeals and Grievances Dashboard 2024 (Fresno County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	2	2	2	6	1	0	0	1	0	0	0	0	0	0	0	0	7	32
Standard Appeals Received	16	10	26	52	33	32	0	65	0	0	0	0	0	0	0	0	117	278
Total Appeals Received	**18**	**12**	**28**	**58**	**34**	**32**	**0**	**66**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	124	**310**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.6%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	2	1	3	6	1	0	0	1	0	0	0	0	0	0	0	0	7	32
Expedited Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	11	19	9	39	25	32	0	**57**	0	0	0	**0**	0	0	0	**0**	96	280
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**13**	**20**	**12**	**45**	**26**	**32**	**0**	**58**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**103**	**312**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**13**	**20**	**12**	**45**	**26**	**32**	**0**	**58**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**103**	**304**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	1	4	0	5	0	0	0	0	0	0	0	0	5	8
DME	1	2	2	5	4	6	0	10	0	0	0	0	0	0	0	0	15	36
Experimental/Investigational	0	0	2	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Advanced Imaging	8	9	1	18	15	10	0	25	0	0	0	0	0	0	0	0	43	137
Other	1	4	4	9	0	4	0	4	0	0	0	0	0	0	0	0	13	32
Pharmacy/RX Medical Benefit	1	2	1	4	2	3	0	5	0	0	0	0	0	0	0	0	9	39
Surgery	2	3	2	7	4	5	0	9	0	0	0	0	0	0	0	0	16	51
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	5	5	4	**14**	10	15	0	**25**	0	0	0	**0**	0	0	0	**0**	39	139
Uphold Rate	**38.5%**	**25.0%**	**33.3%**	**31.1%**	**38.5%**	**46.9%**	**0.0%**	**43.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.9%**	**44.6%**
Overturns - Full	7	14	6	**27**	16	15	0	**31**	0	0	0	**0**	0	0	0	**0**	58	167
Overturn Rate - Full	**53.8%**	**70.0%**	**50.0%**	**60.0%**	**61.5%**	**46.9%**	**0.0%**	**53.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**56.3%**	**53.5%**
Overturns - Partials	1	1	1	**3**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	5	6
Overturn Rate - Partial	**7.7%**	**5.0%**	**8.3%**	**6.7%**	**0.0%**	**6.3%**	**0.0%**	**3.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**4.9%**	**1.9%**
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Withdrawal Rate	**0.0%**	**0.0%**	**8.3%**	**2.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.0%**	**0.0%**
Membership	347,177	347,177	347,194		346,867	346,814												**345,319**
Appeals - PTMPM	0.04	0.06	0.03	0.04	0.07	0.09	-	0.08	-	-	-	0.00	-	-	-	0.00	0.03	0.06
Grievances - PTMPM	0.41	0.32	0.32	0.35	0.46	0.48	-	0.47	-	-	-	0.00	-	-	-	0.00	0.20	0.26

CalViva Health Appeals and Grievances Dashboard 2024 (Kings County)

Kings County - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	0	1	0	1	0	2	0	2	0	0	0	0	0	0	0	0	3	9
Standard Grievances Received	11	11	6	28	18	11	0	29	0	0	0	0	0	0	0	0	57	151
Total Grievances Received	**11**	**12**	**6**	**29**	**18**	**13**	**0**	**31**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**60**	**160**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	0
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	0	1	0	1	0	2	0	2	0	0	0	0	0	0	0	0	3	9
Expedited Grievance Compliance rate	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	17	9	10	36	4	20	0	24	0	0	0	0	0	0	0	0	60	148
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	100.00%
Total Grievances Resolved	**17**	**10**	**10**	**37**	**4**	**22**	**0**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	63	157
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**14**	**9**	**10**	**33**	**4**	**19**	**0**	**23**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**56**	128
Access - Other - DMHC	0	3	1	4	1	2	0	3	0	0	0	0	0	0	0	0	7	22
Access - PCP - DHCS	2	0	0	2	0	1	0	1	0	0	0	0	0	0	0	0	3	7
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	5
Administrative	1	2	5	8	0	3	0	3	0	0	0	0	0	0	0	0	11	11
Balance Billing	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	0	1	2	0	5	0	5	0	0	0	0	0	0	0	0	7	10
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	1	0	4	1	2	0	3	0	0	0	0	0	0	0	0	7	25
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation - Access	1	0	1	2	2	2	0	4	0	0	0	0	0	0	0	0	6	22
Transportation - Behaviour	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Transportation - Other	4	3	1	8	0	3	0	3	0	0	0	0	0	0	0	0	11	20
Quality Of Care Grievances	**3**	**1**	**0**	**4**	**0**	**3**	**0**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**	29
Access - Other - DMHC	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	4
PCP Care	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2	11
PCP Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	4
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1

CalViva Health Appeals and Grievances Dashboard 2024 (Kings County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0
Standard Appeals Received	1	1	1	3	2	1	0	3	0	0	0	0	0	0	0	0	6	11
Total Appeals Received	**1**	**1**	**1**	**3**	**2**	**2**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	7	11
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	0
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	1
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Appeals Resolved Compliant	2	2	0	4	1	2	0	3	0	0	0	0	0	0	0	0	7	11
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	100.00%
Total Appeals Resolved	**2**	**2**	**0**	**4**	**1**	**3**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	0
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**2**	**2**	**0**	**4**	**1**	**3**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	12
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DME	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	1	1	0	2	0	1	0	1	0	0	0	0	0	0	0	0	3	4
Other	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	2
Pharmacy/RX Medical Benefit	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	2
Surgery	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	2
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	1	0	**2**	0	2	0	**2**	0	0	0	**0**	0	0	0	**0**	4	5
Uphold Rate	**50.0%**	**50.0%**	**0.0%**	**50.0%**	**0.0%**	**66.7%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	41.70%
Overturns - Full	1	1	0	**2**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	4	7
Overturn Rate - Full	**50.0%**	**50.0%**	**0.0%**	**50.0%**	**100.0%**	**33.3%**	**0.0%**	**50.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**50.0%**	58.30%
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	0
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	0
Membership	38,436	38,757	38,756		38,740	38,515												38436
Appeals - PTMPM	0.05	0.05	-	0.03	0.03	0.08	-	0.05	-	-	-	0.00	-	-	-	0.00	0.02	0.026019
Grievances - PTMPM	0.44	0.26	0.26	0.32	0.10	0.57	-	0.34	-	-	-	0.00	-	-	-	0.00	0.16	0.33536

Madera County - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	2	0	0	2	1	0	0	1	0	0	0	0	0	0	0	0	3	10
Standard Grievances Received	16	12	10	38	26	20	0	46	0	0	0	0	0	0	0	0	84	163
Total Grievances Received	**18**	**12**	**10**	**40**	**27**	**20**	**0**	**47**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**87**	173
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.4%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	2	0	0	2	1	0	0	1	0	0	0	0	0	0	0	0	3	10
Expedited Grievance Compliance rate	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Standard Grievances Resolved Compliant	13	14	13	40	9	30	0	39	0	0	0	0	0	0	0	0	79	0
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Grievances Resolved	**15**	**14**	**13**	**42**	**10**	**30**	**0**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**82**	**175**
Grievance Descriptions - Resolved Cases																		
Quality of Service Grievances	**15**	**12**	**12**	**39**	**8**	**27**	**0**	**35**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**74**	**146**
Access - Other - DMHC	4	2	0	6	0	5	0	5	0	0	0	0	0	0	0	0	11	27
Access - PCP - DHCS	1	0	1	2	2	0	0	2	0	0	0	0	0	0	0	0	4	9
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	4
Administrative	0	4	1	5	2	3	0	5	0	0	0	0	0	0	0	0	10	15
Balance Billing	0	0	0	0	0	4	0	4	0	0	0	0	0	0	0	0	4	
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interpersonal	1	2	2	5	0	3	0	3	0	0	0	0	0	0	0	0	8	15
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	4	0	4	8	1	2	0	3	0	0	0	0	0	0	0	0	11	31
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Transportation - Access	4	1	3	8	1	6	0	7	0	0	0	0	0	0	0	0	15	27
Transportation - Behaviour	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	13
Transportation - Other	1	2	0	3	1	3	0	4	0	0	0	0	0	0	0	0	7	5
Quality Of Care Grievances	**0**	**2**	**1**	**3**	**2**	**3**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**29**
Access - Other - DMHC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Access - PCP - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Physical/OON - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Access - Spec - DHCS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	1	1	2	0	1	0	1	0	0	0	0	0	0	0	0	3	5
PCP Care	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	5
PCP Delay	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	10
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	0	0	0	0	1	1	0	2	0	0	0	0	0	0	0	0	2	2
Specialist Delay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6

CalViva Health Appeals and Grievances Dashboard 2024 (Madera County)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Standard Appeals Received	5	6	5	16	5	9	0	14	0	0	0	0	0	0	0	0	30	38
Total Appeals Received	**5**	**6**	**5**	**16**	**5**	**9**	**0**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	30	40
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.00%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	9	3	15	4	5	0	**9**	0	0	0	**0**	0	0	0	**0**	24	31
Standard Appeals Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**3**	**9**	**3**	**15**	**4**	**5**	**0**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**24**	**37**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**9**	**3**	**15**	**4**	**5**	**0**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**24**	**37**
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	1	0	1	2	3	3	0	6	0	0	0	0	0	0	0	0	8	0
Experimental/Investigational	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	8	0	10	0	1	0	1	0	0	0	0	0	0	0	0	11	21
Other	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	1
Pharmacy/RX Medical Benefit	0	1	1	2	0	0	0	0	0	0	0	0	0	0	0	0	2	6
Surgery	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	9
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	1	2	2	**5**	1	3	0	**4**	0	0	0	**0**	0	0	0	**0**	9	12
Uphold Rate	**33.3%**	**22.2%**	**66.7%**	**33.3%**	**25.0%**	**60.0%**	**0.0%**	**44.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**37.5%**	**32.4%**
Overturns - Full	2	7	1	**10**	3	2	0	**5**	0	0	0	**0**	0	0	0	**0**	15	20
Overturn Rate - Full	**66.7%**	**77.8%**	**33.3%**	**66.7%**	**75.0%**	**40.0%**	**0.0%**	**55.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.00%**	**62.5%**	**54.1%**
Overturns - Partials	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**10.8%**
Withdrawal	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	1
Withdrawal Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**2.7%**
Membership	48,509	48,509	48,509		48,465	48,499												**46,762**
Appeals - PTMPM	0.06	0.19	0.06	0.10	0.08	0.10	-	0.09	-	-	-	0.00	-	-	-	0.00	0.05	0.06
Grievances - PTMPM	0.31	0.29	0.27	0.29	0.21	0.62	-	0.41	-	-	-	0.00	-	-	-	0.00	0.18	0.31

CalViva SPD only - 2024																		
Grievances	**Jan**	**Feb**	**Mar**	**Q1**	**Apr**	**May**	**Jun**	**Q2**	**Jul**	**Aug**	**Sep**	**Q3**	**Oct**	**Nov**	**Dec**	**Q4**	**2024 YTD**	**2023**
Expedited Grievances Received	1	3	0	4	0	1	0	1	0	0	0	0	0	0	0	0	5	42
Standard Grievances Received	22	29	29	80	47	72	0	119	0	0	0	0	0	0	0	0	199	564
Total Grievances Received	**23**	**32**	**29**	84	**47**	**73**	**0**	**120**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**204**	**606**
Grievance Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Grievance Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**99.65%**
Expedited Grievances Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Grievances Resolved Compliant	1	3	0	4	0	1	0	1	0	0	0	0	0	0	0	0	5	42
Expedited Grievance Compliance rate	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.00%**
Standard Grievances Resolved Noncompliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	0
Standard Grievances Resolved Compliant	28	18	30	76	35	67	0	102	0	0	0	0	0	0	0	0	178	550
Standard Grievance Compliance rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**97.1%**	**100.0%**	**0.0%**	**99.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**99.4%**	**100.0%**
Total Grievances Resolved	**29**	**21**	**30**	**80**	**36**	**68**	**0**	**104**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	184	592
Grievance Descriptions - Resolved Cases	**29**	**21**	**30**	**80**	**36**	**68**	**0**	**104**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	184	592
Access to primary care	0	0	1	1	2	7	0	9	0	0	0	0	0	0	0	0	10	41
Access to specialists	7	6	6	19	0	9	0	9	0	0	0	0	0	0	0	0	28	169
Continuity of Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	3	4	3	10	8	2	0	10	0	0	0	0	0	0	0	0	20	142
Out-of-network	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Physical accessibility	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
QOC Non Access	6	2	2	10	2	5	0	7	0	0	0	0	0	0	0	0	17	60
QOS Non Access	13	9	18	22	24	45	0	69	0	0	0	0	0	0	0	0	91	164
Exempt Grievances Received	9	6	5	**20**	19	9	0	**28**	0	0	0	**0**	0	0	0	**0**	**48**	**88**
Access - Avail of Appt w/ PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Avail of Appt w/ Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Wait Time - wait too long on telephone	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
Access - Wait Time - in office for appt	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Panel Disruption	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Access - Shortage of Providers	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access PCP	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Geographic/Distance Access Specialist	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Access - Interpreter Service Requested	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit needs authorization	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Benefit Issue - Specific Benefit not covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Attitude/Service - Health Plan Staff	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	0
Attitude/Service - Provider	1	2	1	**4**	3	2	0	**5**	0	0	0	**0**	0	0	0	**0**	**9**	1
Attitude/Service - Office Staff	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Attitude/Service - Vendor	0	0	0	**0**	5	0	0	**5**	0	0	0	**0**	0	0	0	**0**	**5**	1
Attitude/Service - Health Plan	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**1**	1
Authorization - Authorization Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Eligibility Issue - Member not eligible per Health Plan	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	0
Eligibility Issue - Member not eligible per Provider	0	0	0	**0**	2	1	0	**3**	0	0	0	**0**	0	0	0	**0**	**3**	2
Health Plan Materials - ID Cards-Not Received	0	0	0	**0**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**2**	20
Health Plan Materials - ID Cards-Incorrect Information on Card	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Health Plan Materials - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	3
Mental Health Related	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Health Plan Assignment - Change Request	3	2	0	**5**	4	0	0	**4**	0	0	0	**0**	0	0	0	**0**	**9**	19
PCP Assignment/Transfer - HCO Assignment - Change Request	1	0	1	**2**	1	0	0	**1**	0	0	0	**0**	0	0	0	**0**	**3**	19
PCP Assignment/Transfer - PCP effective date	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - PCP Transfer not Processed	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**1**	0
PCP Assignment/Transfer - Rollout of PPG	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
PCP Assignment/Transfer - Mileage Inconvenience	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	1
Pharmacy - Authorization Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Authorization Issue-CalViva Error	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Eligibility Issue	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Quantity Limit	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Rx Not Covered	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Pharmacy - Pharmacy-Retail	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider No Show	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Access - Provider Late	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Behaviour	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	0
Transportation - Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	5
OTHER - Other	0	0	1	**1**	1	2	0	**3**	0	0	0	**0**	0	0	0	**0**	**4**	1
Claims Complaint - Balance Billing from Provider	4	1	1	**6**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	**7**	13

CalViva Health Appeals and Grievances Dashboard 2024 (SPD)

Appeals	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD	2023
Expedited Appeals Received	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	7
Standard Appeals Received	4	5	5	14	9	11	0	20	0	0	0	0	0	0	0	0	34	68
Total Appeals Received	**4**	**5**	**5**	**14**	**10**	**11**	**0**	**21**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	35	**75**
Appeals Ack Letters Sent Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Ack Letter Compliance Rate	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**98.7%**
Expedited Appeals Resolved Noncompliant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expedited Appeals Resolved Compliant	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	10
Expedited Appeals Compliance Rate	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Standard Appeals Resolved Noncompliant	0	0	0	0	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0
Standard Appeals Resolved Compliant	3	0	4	7	7	16	0	**23**	0	0	0	**0**	0	0	0	**0**	30	66
Standard Appeals Compliance Rate	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**
Total Appeals Resolved	**3**	**0**	**4**	**7**	**8**	**16**	**0**	**24**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**	**76**
Appeals Descriptions - Resolved Cases																		
Pre-Service Appeals	**3**	**5**	**4**	**12**	**8**	**16**	**0**	**24**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**28**	**71**
Continuity of Care	0	0	0	0	0	8	0	8	0	0	0	0	0	0	0	0	8	5
Consultation	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2	3
DME	1	2	0	3	2	3	0	5	0	0	0	0	0	0	0	0	8	13
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Advanced Imaging	2	1	2	5	3	0	0	3	0	0	0	0	0	0	0	0	8	22
Other	0	1	1	2	0	1	0	1	0	0	0	0	0	0	0	0	3	6
Pharmacy/RX Medical Benefit	0	1	0	1	0	1	0	1	0	0	0	0	0	0	0	0	2	14
Surgery	0	0	1	1	3	1	0	4	0	0	0	0	0	0	0	0	5	13
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Service Appeals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Consultation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DME	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Experimental/Investigational	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacy/RX Medical Benefit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transportation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeals Decision Rates																		
Upholds	2	2	1	**5**	2	6	0	**8**	0	0	0	**0**	0	0	0	**0**	13	30
Uphold Rate	**66.7%**	**0.0%**	**25.0%**	**71.4%**	**25.0%**	**37.5%**	**0.0%**	**33.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**41.9%**	**39.5%**
Overturns - Full	1	3	2	**6**	6	9	0	**15**	0	0	0	**0**	0	0	0	**0**	21	44
Overturn Rate - Full	**33.3%**	**0.0%**	**50.0%**	**85.7%**	**75.0%**	**56.3%**	**0.0%**	**62.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**67.7%**	**57.89%**
Overturns - Partials	0	0	0	**0**	0	1	0	**1**	0	0	0	**0**	0	0	0	**0**	1	2
Overturn Rate - Partial	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.3%**	**0.0%**	**4.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.2%**	**2.6%**
Withdrawal	0	0	1	**1**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	1	0
Withdrawal Rate	**0.0%**	**0.0%**	**25.0%**	**14.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**3.2%**	**0.0%**
Membership	49,987	49,987	47,341		46,869	46,960												**49,899**
Appeals - PTMPM	0.06	-	0.08	0.00	0.17	0.34	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.06
Grievances - PTMPM	0.58	0.42	0.63	0.00	0.77	1.45	-	0.00	-	-	-	0.00	-	-	-	0.00	0.00	0.52

Cal Viva Dashboard Definitions	
Categories	**Description**
GRIEVANCE	Expression of dissatisfaction regarding any aspect of a plans or providers operations, contractual issues, activities or behaviors.
Expedited Grievances Received	Grievance received in the month with a TAT of 3 calendar days
Standard Grievances Received	Grievances received in the month with the standard 30 days TAT
Total Grievance Received	Amount of cases received within that month
Grievance Acknowledgement Sent Noncompliant	The number of Acknowledgement letters not sent within the 5 calendar day TAT
Grievance Acknowledgement Compliance Rate	Percentage of acknowledgement letters sent within 5 calendar days
Expedited Grievances Resolved Noncompliant	Expedited grievances closed after the 3 calendar day TAT
Expedited Grievances Resolved Compliant	Expedited grievances closed within the 3 calendar day TAT
Expedited Grievance Compliance Rate	Percentage of Expedited Grievances closed within the 3 calendar day TAT
Standard Grievances Resolved Noncompliant	Standard 30 day grievance cases closed after the 30 day TAT
Standard Grievances Resolved Compliant	Standard 30 day grievance cases closed within the 30 day TAT
Standard Grievance Compliance Rate	Percentage of cases closed within the 30 calendar day TAT
Total Grievances Resolved	Amount of cases closed for the month
Quality of Service Grievances	Grievances Related to non clinical concerns/administrative issues
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Administrative Grievance	
Balance Billing	Member billing for Par and Nonpar providers.
Continuity of Care - Acute	Quality of service complaint/dispute regarding the continuity of care for acute care, as perceived by the enrollee from a provider.
Continuity of Care - Newborn	Quality of service complaint/dispute regarding the continuity of care for newborn care, as perceived by the enrollee from a provider.
Continuity of Care - Other	Quality of service complaint/dispute regarding the continuity of care for any other care not already categorized, as perceived by the enrollee from a provider.
Continuity of Care - Pregnancy	Quality of service complaint/dispute regarding the continuity of care for pregnancy care, as perceived by the enrollee from a provider.
Continuity of Care - Surgery	Quality of service complaint/dispute regarding the continuity of care for surgery, as perceived by the enrollee from a provider.
Continuity of Care - Terminal Illness	Quality of service complaint/dispute regarding the continuity of care for Terminal Illness, as perceived by the enrollee from a provider.
Interpersonal Grievance	Providers interaction with member
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOS grievance types
Pharmacy/RX Medical Benefit	Long wait time for the drug to be called in or refilled
Quality of Care Grievances	Grievances Related to clinical concerns/possible impact to members health
Access to Care Grievance - Other	Long wait time for a scheduled appointment or unable to get an appointment with an ancillary provider
Access to Care Grievance - PCP	Long wait time for a scheduled appointment or unable to get an appointment with a PCP
Access to Care Grievance - Physical/OON	Access to care issues specifically due to physical distance or provider not being contracted with the plan
Access to Care Grievance - Specialist	Long wait time for a scheduled appointment or unable to get an appointment with a specialist
Mental Health	Grievances related to Mental Health providers/care
Other	All other QOC grievance types
PCP Care	Grievances related to quality of care provided by a PCP
PCP Delay	Grievances related to a delay in care provided by a PCP
Pharmacy/RX Medical Benefit	Wrong drug dispensed or adverse drug reaction.
Specialist Care	Grievances related to quality of care provided by a Specialist
Specialist Delay	Grievances related to a delay in care provided by a Specialist

APPEALS	Request for reconsideration. An oral or written request to change a decision or adverse determination.
Expedited Appeals Received	Appeals received in the month with a TAT of 3 calendar days
Standard Appeals Received	Appeals received in the month with a TAT of 30 calendar days
Total Appeals Received	Amount of cases received within that month
Appeals Acknowledgement Sent Non-compliant	Total number of acknowledgement letters not sent within the 5 calendar day TAT
Appeals Acknowledgement Compliance Rate	Percentage of Acknowledgement letters sent with the 5 calendar day TAT
Expedited Appeals Resolved Non-Compliant	Number of expedited appeals resolved after the 3 calendar day TAT
Expedited Appeals Resolved Compliant	Number of expedited appeals resolved within the 3 calendar day TAT
Expedited Appeals Compliance Rate	Percentage of expedited appeals closed with the 3 calendar day TAT
Standard Appeals Resolved Non-Compliant	Standard 30 day appeals resolved after the 30 calendar days
Standard Appeals Resolved Compliant	Standard 30 day appeals resolved within the 30 calendar days
Standard Appeals Compliance Rate	Percentage of Standard 30 calendar day TAT appeals closed within compliance
Total Appeals Resolved	Total number of appeals resolved for the month
Appeal Descriptions	
Pre Service Appeal	Any request for the reversal of a denied service prior to the services being rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.
Post Service Appeal	Any request for the reversal of a denied claim payment where the services were previously rendered.
Consultation	Denied service due to medical necessity, lack of coverage.
DME	Denied item/supply due to medical necessity, lack of coverage.
Experimental/Investigational	Denied service because it is considered experimental/investigational
Mental Health	Denied Mental Health related service due to medical necessity, lack of coverage.
Other	All other denied services due to medical necessity, lack of coverage.
Pharmacy/RX Medical Benefit	Denied medication, including those considered an RX medical benefit, due to medical necessity, lack of coverage.
Surgical	Denied service due to medical necessity, lack of coverage.

Appeals Decision Rate	Will include number of Upholds, Overturns, Partial overturns, and Withdrawals
Upholds	Number of Upheld Appeals
Uphold Rate	Percentage of Upheld appeals
Overturns - Full	Number of full overturned appeals
Overturn Rate - Full	Percentage of full overturned appeals
Overturn - Partial	Number of Partial Overturned appeals
Overturn Rate - Partial	Percentage of Partial Overturned appeals
Withdrawls	Number of withdrawn appeals
Withdrawl Rate	Percentage of withdrawn appeals

EXEMPT GRIEVANCE	Grievances received over the telephone that are not coverage dipsutes, disputed health care services involving medical necessity or experimental/investigational treatment that are resolved the the close of the next business day (1300.68 (d)(8).

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

Membership	Excludes Kaiser membership and is addressed separately in a quarterly report by Kaiser Plan.
PTMPM	Per thousand members per month. PTMPM rates are calculated using the total number of appeals or grievances, divided by total membership and multiplied by 1,000

Item #13
Attachment 13.C

Medical Management
Key Indicator Report

Attachment T

Healthcare Solutions Reporting

Key Indicator Report

Auth Based Utilization Metrics for CALVIVA California SHP

Report from 5/01/2024 to 5/31/2024

Report created 6/26/2024

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

Exhibits:

Contact Information

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

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 5/01/2024 to 5/31/2024
Report created 6/26/2024

ER utilization based on Claims data	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-04	2024-05	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
MEMBERSHIP																	Quarterly Averages						Annual Averages		
Expansion Mbr Months	119,132	120,031	121,145	120,818	120,165	119,044	118,421	117,508	116,609		115,570	119,572	119,992	120,073	120,279		116,736	120,103	120,009	117,513	118,378		118,590	119,097	
Adult/Family/O TLIC Mbr Mos	270,443	271,856	272,240	271,242	270,065	268,231	266,908	265,208	263,113		262,709	267,059	267,730	267,209	266,454		267,795	271,513	269,846	265,076	265,833		268,558	266,232	
Aged/Disabled Mbr Mos	49,486	49,683	49,844	50,020	49,804	49,597	49,395	49,074	48,807		46,270	47,506	47,234	46,940	46,026		45,552	49,671	49,807	49,092	47,003		48,531	46,795	
COUNTS																									
Admits - Count	2,074	2,206	2,062	2,164	2,144	1,984	1,998	2,026	2,180		2,211	2,046	2,072	1,940	2,121		2,071	2,114	2,097	2,068	2,110		2,088	2,078	
Expansion	642	696	653	702	705	632	609	674	681		736	670	647	637	691		600	664	680	655	684		649	676	
Adult/Family/O TLIC	880	955	887	927	909	876	913	861	936		913	840	923	860	959		897	907	904	903	892		903	899	
Aged/Disabled	552	555	522	535	530	476	476	491	563		562	536	502	443	471		574	543	514	510	533		535	503	
Admits Acute - Count	1,382	1,510	1,359	1,440	1,421	1,287	1,326	1,349	1,463		1,379	1,379	1,364	1,316	1,400		1,343	1,354	1,428	1,417	1,436		1,381	1,368	
Expansion	527	564	532	582	563	474	489	519	519		532	525	496	501	555		488	541	540	509	518		520	522	
Adult/Family/O TLIC	419	493	402	419	422	418	438	434	496		445	442	473	443	465		438	438	420	456	453		438	454	
Aged/Disabled	436	453	425	439	436	395	399	396	448		402	412	395	372	380		417	438	423	414	403		423	392	
Readmit 30 Day - Count	235	225	225	257	252	213	230	221	245		230	240	224	202	155		242	228	241	232	231		236	210	
Expansion	90	83	90	119	97	79	86	89	100		89	89	90	79	61		94	88	98	92	89		93	82	
Adult/Family/O TLIC	43	50	38	33	44	32	37	40	38		35	46	34	48	33		51	44	36	38	38		42	39	
Aged/Disabled	102	92	97	105	111	102	107	92	107		106	105	100	75	61		97	97	106	102	104		101	89	
**ER Visits - Count	14,473	15,819	13,938	13,968	14,138	13,647	13,632	14,003	14,712		13,560	13,425	13,977	13,443	6,752		13,289	14,743	13,918	14,116	13,654		14,016	12,231	
Expansion	3,784	4,120	3,782	4,019	4,096	3,635	3,763	3,529	3,780		3,716	3,432	3,595	3,524	1,720		3,549	3,895	3,917	3,691	3,581		3,763	3,197	
Adult/Family/O TLIC	8,829	9,639	8,219	7,986	7,989	8,232	8,138	8,621	9,064		8,055	8,163	8,574	8,242	4,383		8,155	8,896	8,069	8,608	8,264		8,432	7,483	
Aged/Disabled	1,860	2,060	1,937	1,963	2,053	1,780	1,731	1,853	1,868		1,789	1,830	1,808	1,677	649		1,585	1,952	1,932	1,817	1,809		1,822	1,551	
PER/K																									
Admits Acute - PTMPY	37.8	41.0	36.8	39.1	38.8	35.4	36.6	37.5	41.0		39.0	38.1	37.6	36.4	38.8		37.5	36.8	39.0	39.4	40.0		38.0	38.0	
Expansion	53.1	56.4	52.7	57.8	56.2	47.8	49.6	53.0	53.4		55.2	52.7	49.6	50.1	55.4		50.2	54.1	54.0	52.0	52.5		52.6	52.6	
Adult/Family/O TLIC	18.6	21.8	17.7	18.5	18.8	18.7	19.7	19.6	22.6		20.3	19.9	21.2	19.9	20.9		19.6	19.4	18.7	20.6	20.5		19.6	20.4	
Aged/Disabled	105.7	109.4	102.3	105.3	105.1	95.6	96.9	96.8	110.1		104.3	104.1	100.4	95.1	99.1		109.9	105.8	102.0	101.3	102.9		104.6	100.6	
Bed Days Acute - PTMPY	218.3	214.0	191.8	205.9	203.7	191.3	201.0	214.1	222.0		215.0	202.6	197.0	185.8	189.1		202.7	208.0	200.4	212.4	204.8		205.8	197.8	
Expansion	323.6	315.4	283.9	297.4	333.1	301.7	307.0	318.6	302.4		318.8	305.1	286.8	277.3	271.3		297.4	307.5	310.7	309.4	303.4		306.3	291.6	
Adult/Family/O TLIC	77.2	86.5	65.8	73.5	65.8	65.8	71.4	67.6	93.4		77.8	72.9	79.8	72.5	81.5		74.2	76.5	68.4	77.4	76.8		74.1	76.9	
Aged/Disabled	736.5	666.4	656.0	703.2	639.5	605.1	647.7	756.1	723.3		734.5	673.7	632.6	596.4	597.1		715.5	686.2	649.4	708.9	679.9		689.4	646.8	
ALOS Acute	5.8	5.2	5.2	5.3	5.3	5.4	5.5	5.7	5.4		5.5	5.3	5.2	5.1	4.9		5.4	5.6	5.1	5.4	5.1		5.4	5.2	
Expansion	6.1	5.6	5.4	5.1	5.9	6.3	6.2	6.0	5.7		5.8	5.8	5.8	5.5	4.9		5.9	5.7	5.8	6.0	5.8		5.8	5.5	
Adult/Family/O TLIC	4.2	4.0	3.7	4.0	3.5	3.5	3.6	3.4	4.1		3.8	3.7	3.8	3.6	3.9		3.8	4.0	3.7	3.7	3.8		3.8	3.8	
Aged/Disabled	7.0	6.1	6.4	6.7	6.1	6.3	6.7	7.8	6.6		7.0	6.5	6.3	6.3	6.0		6.5	6.5	6.4	7.0	6.6		6.6	6.4	
Readmit % 30 Day	11.3%	10.2%	10.9%	11.9%	11.8%	10.7%	11.5%	10.9%	11.2%		10.4%	11.7%	10.8%	10.4%	7.3%		11.7%	10.8%	11.5%	11.2%	11.0%		11.3%	10.1%	
Expansion	14.0%	11.9%	13.8%	17.0%	13.8%	12.5%	14.1%	13.2%	14.7%		12.1%	13.3%	13.9%	12.4%	8.8%		15.6%	13.2%	14.5%	14.0%	13.1%		14.3%	12.1%	
Adult/Family/O TLIC	4.9%	5.2%	4.3%	3.6%	4.8%	3.7%	4.1%	4.6%	4.1%		3.8%	5.5%	3.7%	5.6%	3.4%		5.6%	4.8%	4.0%	4.2%	4.3%		4.7%	4.4%	
Aged/Disabled	18.5%	16.6%	18.6%	19.6%	20.9%	21.4%	22.5%	18.7%	19.0%		18.9%	19.6%	19.9%	16.9%	13.0%		16.9%	17.9%	20.6%	20.0%	19.4%		18.8%	17.8%	
**ER Visits - PTMPY	395.6	429.9	377.4	379.2	385.6	374.9	376.3	389.2	412.0		383.3	371.1	385.6	371.5	187.2		370.8	400.9	379.9	392.4	380.0		386.1	339.7	
Expansion	381.2	411.9	374.6	399.2	409.0	366.4	381.3	360.4	389.0		385.8	344.4	359.5	352.2	171.6		364.8	389.2	391.6	376.9	363.0		380.8	322.2	
Adult/Family/O TLIC	391.8	425.5	362.3	353.3	355.0	368.3	365.9	390.1	413.4		367.9	366.8	384.3	370.1	197.4		365.4	393.2	358.8	389.7	373.0		376.8	337.3	
Aged/Disabled	451.0	497.6	466.3	470.9	494.7	430.7	420.5	453.1	459.3		464.0	462.3	459.3	428.7	169.2		417.5	471.7	465.5	444.2	461.8		450.4	397.6	
Services	TAT Compliance Goal: 100%										TAT Compliance Goal: 100%						TAT Compliance Goal: 100%						TAT Compliance Goal: 100%		
Preservice Routine	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	99.1%	100.0%				
Preservice Urgent	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%		100.0%	100.0%	96.0%	94.0%	98.0%		100.0%	99.1%	100.0%	99.1%	98.2%				
Postservice	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Concurrent (inpatient only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Routine	100.0%	100.0%	100.0%	96.6%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	98.0%		96.9%	100.0%	98.9%	100.0%	100.0%				
Deferrals - Urgent	100.0%	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%				
Deferrals - Post Service	NA	NA	NA	NA	NA	NA	NA	NA	NA		null	null	null	null	null		null	null	null	null	null				

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
Report from 5/01/2024 to 5/31/2024
Report created 6/26/2024

ER utilization based on Claims data	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-04	2024-05	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
	CCS ID RATE										CCS ID RATE						CCS ID RATE						CCS ID RATE		
CCS %	7.94%	7.90%	7.90%	7.90%	7.88%	7.83%	7.72%	7.77%	7.70%		7.56%	7.59%	7.63%	8.57%	8.53%		8.17%	7.91%	7.87%	7.73%	7.59%		7.92%	7.98%	
	Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand										Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand						Inpatient Maternity Utilizatin ALL CV Mbrshp Rate Per Thousand								
Births	13.2	13.3	13.6	14.4	14.7	13.7	14.0	13.3	14.1		14.6	12.8	13.7	12.6	13.9		13.7	13.4	14.3	13.8	13.7		13.8		
OB % Days	2.7%	3.8%	4.3%	4.1%	6.1%	5.0%	5.8%	5.0%	4.9%		2.3%	4.0%	6.0%	7.4%	9.3%		2.0%	3.6%	5.1%	5.3%	4.1%		17.0%		
OB % Admits	22.7%	22.0%	24.0%	24.3%	25.0%	24.9%	25.3%	23.3%	23.0%		22.3%	21.8%	23.7%	23.0%	23.4%		22.2%	22.9%	24.7%	23.8%	22.6%		30.0%		
	Perinatal Case Management										Perinatal Case Management						Perinatal Case Management						Perinatal Case Management		
Total Number Of Referrals	150	149	149	84	132	167	170	147	133		319	201	163	278	256		472	598	476	386	683		318	1,217	
Pending	0	0	0	0	0	0	0	0	0		0	0	0	0	0		0	2	1	21	0		3	0	
Ineligible	11	5	5	3	3	10	9	8	7		10	21	9	10	9		18	32	10	19	40		5	59	
Total Outreached	139	144	144	81	129	157	161	139	126		309	180	154	268	247		454	564	465	346	643		310	1,158	
Engaged	51	50	62	64	128	130	146	130	115		225	136	103	143	159		157	224	183	137	464		228	766	
Engagement Rate	37%	35%	43%	79%	99%	83%	91%	94%	91%		73%	76%	67%	53%	64%		35%	40%	39%	40%	72%		74%	66%	
Total Cases Managed	313	316	331	322	394	476	574	600	599		699	687	603	610	618		344	432	496	410	937		702	1239	
Total Cases Closed	47	47	70	57	48	58	90	116	127		150	184	136	151	150		136	154	182	180	470		150	771	
Cases Remained Open	258	267	251	261	341	419	478	495	469		547	509	442	439	467		199	263	263	224	442		547	467	
	Physical Health Case Management										Physical Health Case Management						Physical Health Case Management						Physical Health Case Management		
Total Number Of Referrals	343	239	258	198	220	194	161	114	132		187	276	314	260	345		799	840	612	407	777		2,658	1,382	
Pending	0	0	1	1	2	0	2	4	19		0	1	0	1	45		0	1	3	25	1		29	47	
Ineligible	56	56	52	32	37	32	35	16	22		25	23	33	28	36		194	164	101	73	81		532	145	
Total Outreached	287	183	205	165	181	162	124	94	91		162	252	281	231	264		605	675	508	309	695		2,097	1,190	
Engaged	173	115	134	116	124	98	81	72	62		80	124	138	118	125		343	422	338	215	342		1,318	585	
Engagement Rate	60%	63%	65%	70%	69%	60%	65%	77%	68%		49%	49%	49%	51%	47%		57%	63%	67%	70%	49%		63%	49%	
Total Screened and Refused/Decline	55	42	35	26	21	29	12	7	13		36	33	39	31	41		172	132	76	32	108		412	180	
Unable to Reach	59	26	36	23	36	35	31	15	16		46	95	104	82	98		90	121	94	62	245		367	425	
Total Cases Closed	105	188	122	128	132	137	107	102	94		114	101	88	75	97		325	415	397	303	303		1,440	475	
Cases Remained Open	464	406	415	399	384	354	336	302	262		226	252	296	350	376		399	415	354	262	296		262	376	
Total Cases Managed	609	616	560	547	538	503	441	403	362		360	372	405	435	484		746	848	769	591	622		1723	863	
Complex Case	68	82	85	85	79	69	61	60	62		65	59	64	62	65		61	94	95	84	99		161	120	
Non-Complex Case	541	534	475	462	459	434	380	343	300		295	313	341	373	419		685	754	674	507	523		1562	743	
	Transitional Care Services										Transitional Care Services						Transitional Care Services								
Total Number Of Referrals	166	301	283	261	338	228	278	277	130		265	290	147	127	186		296	750	827	685	702		2,558	1,015	
Pending	0	0	0	0	0	0	0	4	13		0	0	0	1	7		0	0	0	17	0		17	8	
Ineligible	9	11	6	10	11	7	13	19	18		43	40	14	7	6		33	26	28	50	97		137	110	
Total Outreached	157	290	277	251	327	221	265	254	99		222	250	133	119	173		263	724	799	618	605		2,404	897	
Engaged	128	275	270	241	322	220	256	217	52		100	163	108	86	121		216	673	783	525	371		2,197	578	
Engagement Rate	82%	95%	97%	96%	98%	100%	97%	85%	53%		45%	65%	81%	72%	70%		82%	93%	98%	85%	61%		91%	64%	
Total Screened and Refused/Decline	4	1	2	6	0	0	6	10	14		31	24	4	9	4		7	7	6	30	59		50	72	
Unable to Reach	25	14	5	4	5	1	3	27	33		91	63	21	24	48		40	44	10	63	175		157	247	
Total Cases Closed						212	230	191	79		61	47	128	108	85		195	476	645	500	236		1,816	429	
Cases Remained Open	59	96	73	80	96	69	61	50	12		29	132	107	92	109		19	73	69	12	107		12	109	
Total Cases Managed	147	339	443	357	452	380	382	310	125		126	204	258	210	220		265	695	901	654	397		2,248	604	
	Behavioral Health Care Management										Behavioral Health Care Management						Behavioral Health Care Management						Behavioral Health Care Management		
Total Number Of Referrals	46	59	61	37	51	40	26	40	38		78	92	72	67	138		235	166	128	104	242		633	447	
Pending	0	0	0	0	0	0	0	0	0		0	0	0	0	7		0	0	0	0	0		0	7	
Ineligible	6	4	6	3	4	3	1	5	10		8	5	2	2	2		21	16	10	16	15		63	19	
Total Outreached	40	55	55	34	47	37	25	35	28		70	87	70	65	129		214	150	118	88	227		570	421	
Engaged	28	34	46	27	37	36	25	21	12		36	72	52	34	64		139	108	100	58	160		405	258	
Engagement Rate	70%	62%	84%	79%	79%	97%	100%	60%	43%		51.0%	83.0%	74.0%	52.0%	50.0%		65%	72%	85%	66%	70%		71%	61%	
Total Screened and Refused/Decline	4	6	2	1	2	1	0	1	4		2	2	1	7	10		6	12	4	5	5		27	22	
Unable to Reach	8	15	7	6	8	0	0	13	12		32	13	17	24	55		69	30	14	25	62		138	141	
Total Cases Closed	31	48	43	41	46	41	34	26	27		33	25	30	54	60		154	122	128	87	88		491	202	
Cases Remained Open	146	131	138	126	109	106	95	89	75		64	119	142	121	127		149	138	106	75	142		75	127	
Total Cases Managed	179	182	180	164	160	149	129	118	104		113	150	176	179	189		307	264	237	170	237		572	333	
Complex Case	16	16	15	16	16	15	12	15	15		14	11	10	10	15		13	17	20	18	19		32	27	
Non-Complex Case	163	166	165	148	144	134	117	103	89		99	139	166	169	174		294	247	217	152	218		540	306	

Key Indicator Report
Auth Based Utilization Metrics for CALVIVA California SHP
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Report created 6/26/2024

ER utilization based on Claims data	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2023-Trend	2024-01	2024-02	2024-03	2024-04	2024-05	2024-Trend	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Qtr Trend	CY- 2023	YTD-2024	YTD-Trend
	First Year of Life Care Management										First Year of Life Care Management						First Year of Life Care Management						First Year of Life Care Management		
Total Number Of Referrals	0	1	7	15	19	26	28	18	27		32	29	47	35	29		0	8	60	73	108		141	172	
Pending	0	0	0	0	0	0	0	0	0		0	0	0	0	1		0	0	0	0	0		0	1	
Ineligible	0	0	0	0	0	0	0	2	1		1	1	0	0	1		0	1	0	3	2		4	3	
Total Outreached	0	0	0	0	0	0	28	16	26		31	28	47	35	27		0	7	60	70	106		137	168	
Engaged	0	0	0	0	0	0	28	16	21		31	28	47	35	27		0	3	60	65	106		128	168	
Engagement Rate	0%	0%	0%	0%	0%	0%	1	1	0.81		100.0%	100.0%	100.0%	100.0%	100.0%		0.0%	43.0%	100.0%	93.0%	100.0%		93.0%	100.0%	
Total Screened and Refused/Decline	0	0	0	0	0	0	0	0	2		0	0	0	0	0		0	2	0	2	0		4	0	
Unable to Reach	0	0	0	0	0	0	0	0	3		0	0	0	0	0		0	2	0	3	0		5	0	
Total Cases Closed	0	0	0	0	0	0	8	4	4		2	8	10	9	8		0	0	3	16	20		19	37	
Cases Remained Open	0	0	0	0	0	0	74	91	108		140	160	196	218	243		0	3	56	108	196		108	243	
Total Cases Managed	0	0	0	0	0	0	88	95	113		143	169	207	232	250		0	3	62	125	217		128	279	

Item #13
Attachment 13.D

Medical Management
Quarterly Summary Report

REPORT SUMMARY TO COMMITTEE

TO: Fresno-Kings-Madera Regional Health Authority Commissioners

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

COMMITTEE DATE: July 18th, 2024

SUBJECT: CalViva Health QI, UMCM & Population Health Update of Activities Quarter 2 2024 (July 2024)

Purpose of Activity:
This report is to provide the RHA Commission with an update on the CalViva Health Quality Improvement, Utilization Management, Case Management, and Population Health Management performance, programs and regulatory activities in Quarter 2 of 2024.
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I. Meetings

One QI/UM meeting was held in Quarter 2, on May 16th, 2024. One new provider joined the CalViva Health QI/UM Committee to fill a vacant position during this reporting period and attended her first meeting in May. **Ana-Liza Pascual, M.D.,** Obstetrics/Gynecology, Central Valley Obstetrics/Gynecology Medical Group. The following **guiding documents** were approved at the May meeting:

1. 2023 Health Equity End of Year Evaluation
2. 2024 Health Equity Program Description
3. 2024 Health Equity Work Plan
4. 2023 Health Equity Language Assistance Program Report
5. 2023 Health Education End of Year Evaluation
6. 2023 PHM Effectiveness Analysis Report
7. 2024 PHM Strategy Program Description
8. 2023 Continuity & Coordination of Medical & Behavioral Healthcare Report
9. 2024 Continuity & Coordination of Medical & Behavioral Healthcare Report

In addition, the following **general documents** were adopted/approved at the meeting:

1. Medical Policies
2. Pharmacy Provider Updates
3. Appeals & Grievances Policies & Procedures Annual Review

The following **Oversight Audit Results** were presented and accepted at the May meeting:

1. Utilization Management/Case Management 2023
2. Quality Management 2024
3. Behavioral Health 2024

II. QI Reports - The following is a summary of some of the reports and topics reviewed:

1. The **Appeal and Grievance Dashboard & Quarterly A & G Reports** through March 2024 were presented with a general overview. An explanation was provided of how Members and providers submit grievances via phone, fax, email, or online, and each of these is categorized and

reported on the dashboard and in other narrative reports. Standardized criteria as outlined in our policies and procedures are used to classify each case in order to include them in the appropriate area on the monthly dashboard.

Each monthly Excel file includes lists or logs identifying each member who submitted a grievance that month and details about their issue and its resolution. These data logs are included on tabs such as Formal Resolved, CCC Exempt Grievances, and MHN Exempt. The Outlier tab provides an analysis of the data trends.

There was a total of 149 grievances received this month, 448 total for Q1, consistent with 2023.

Current trends reviewed included:

a. For Q1, most grievances (390) were **Quality of Service** related.
b. Most common issues were:
    - Access- Prior Authorization delays
    - Transportation Access
    - Balanced billing.
c. Exempt Grievances are resolved over the phone within one business day. They remained consistent with the exception of balanced billing which increased.
d. Total Standard Appeals for Q1 was 77 with thirty (30) cases related to Advanced Imaging (MRI, PET scans, and Cardiac imaging): both trending downwards.

2. The **Potential Quality Issues (PQI) Report** provides a summary of issues (PQIs) identified during the reporting period that may result in substantial harm to a CVH member.

PQI reviews may be initiated by a member, non-member or peer review-activities. Peer review activities include cases with a severity code level of III or IV or any case the CVH CMO requests to be forwarded to Peer Review. Data for Q1 was reviewed for all case types including the follow up actions taken when indicated. The number of cases reviewed in Quarter 1 2024 was consistent with or slightly lower than recent months. Follow-up occurs when indicated.

3. Additional Quality Improvement Reports presented were A & G Interrater Reliability, Member Letter Monitoring, Expedited Grievance Report, and the A & G Validation Audit Report for the Q2 QI/UM Committee.

III. UMCM Reports -

The following is a summary of the reports and topics reviewed:

1. The Key Indicator Report (KIR) & UM Concurrent Review Report provide data through March 31st, 2024. Membership has increased slightly. Quarterly comparisons were reviewed with the following results:

a. Utilization for most risk types increased slightly in March 2024, and SPDs remained consistent.
b. Acute Admits PTMPY for TANF populations increased in March, while Expansion and SPD populations declined.
c. Bed Days for SPDs have remained low and ER visits remained consistent.
d. Case Management results are positive overall. TCS numbers are down as the new process stabilizes and members are referred to other programs. Behavioral Health referrals have shown some variation.
e. The new *First Year of Life* program focuses on transitioning members from the Perinatal program into the first year after delivery with an emphasis on Well-Child visits, immunizations and other preventive health with a current engagement rate of 100%.
f. Turnaround Times were not met for Pre-Service Urgent cases in March 2024, follow up occurred with staff. All other metrics met turnaround times in Q1.

2. NCQA System Controls Appeals & Denials Oversight Report 2023 demonstrates CalViva's oversight of information management and security standard compliance by HealthNet. Per NCQA standards, the report describes how UM Appeals & Denials information is received, stored, reviewed, tracked, and dated.

The UM System Controls Policy includes the following:

a. Defines the date of receipt consistent with NCQA requirements.
b. Defines the date of written notification consistent with NCQA requirements.
c. Describes the process for recording dates in systems.
d. Specifies titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
e. Specifies how the system tracks modified dates.
f. Describes system security controls in place to protect data from unauthorized modification.
g. Describes how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable.

All cases audited met compliance standards for both Appeals and Denials.

3. **Additional UMCM Reports** include Concurrent Review IRR Report, CCS Report, Turning Point, PA Member Letter Monitoring Report and others scheduled for presentation at the QI/UM Committee during Q2.

IV. Access Related Reporting for Q2 included the Access Work Group minutes from January 30th, 2024.

The following are some of the key standing reports/matters approved and discussed:

1. **Access & After-Hours CAP & Evaluation** - MY 2022:
    a. CAP Improvement Plans are being submitted by providers; delayed responses were escalated to Provider Network Management for follow up.
    b. Non-compliant PPGs and providers are required to attend the Timely Access provider training webinars and submit a webinar completion certificate.
2. **Practitioner Availability Report**: This report measures the network availability of PCPs reviewing two aspects for geo access which has an internally set standard of 90% within time or distance.
3. **Accuracy of Prior Authorization (PA) and Referrals Information**: This new report for NCQA accreditation verifies that PA and referral information are clear and accurate, and that this information is available for members on the CalViva website.
4. **Other Access-related** reporting included the Provider Office Wait Time Report for Q1 2024.

V. Pharmacy Quarterly Reports include Pharmacy Executive Summary, Operations Metrics, Top 25 Medication Prior Authorization (PA) Requests, and the Quality Assurance (IRR) Results which were all reviewed for Quarter 1. All metrics are expected to be within 5% of the standard or goal.

- **All metrics were within 5% of the goal** this quarter with an average turnaround time rate of 98.5%. Prior authorization volumes were slightly lower in Q1 compared to Q4 2023 with no outliers identified.

Quality Assurance (Interrater Reliability) reports are based upon a sample of cases that are audited each month to ensure they are completed timely, accurately, and consistently according to regulatory requirements and established health plan guidelines. The goal is ninety-five percent (95%) with a threshold for action of ninety percent (90%.)

- Overall, the ninety percent (90%) threshold was met, but not the goal of 95%.
- Opportunities for improvement were identified for turnaround time, criteria used, and clear and concise letter language.
- Three (3) cases were determined to have a questionable denial or approval after plan review. Results have been shared with PA Managers in order to provide review and feedback with individual staff involved in the decisions. Feedback includes Criteria Application review expectations as well as proper documentation of clinically relevant information.

VI. HEDIS® Activity

In Q2, HEDIS® related activities were focused on finalizing and preparing **Measurement Year** (**MY)2023 full HEDIS® Data for submission** to HSAG & DHCS for the Managed Care Accountability Set (MCAS) measures. Final Attestations and IDSS submission were completed on June 14th. Medi-Cal Managed Care (MCMC) health plans currently have 18 quality measures (MCAS) on which we will be evaluated this year. The Minimum Performance Level (MPL) remains at the 50th percentile.

Our current improvement projects are:

- ***Clinical - Well Child Visits W-30+6 in AA/Black Population Performance Improvement Project*** *(PIP)2023-2026.* In progress. Working with Black Infant Health to implement interventions for improvement. Next report due to HSAG/DHCS September 2024.

- ***Non-clinical – Improve Provider Notifications within 7-days for Members Seen in the E.D. for SUD/MH Issue Performance Improvement Project*** *(PIP) 2023-2026.* In progress. Working with Community Medical Centers to implement interventions for Improvement. Next report due to HSAG/DHCS September 2024.

- ***Institute for Healthcare Improvement (IHI) Equity Focused Well-Child Sprint Collaborative*** *April 2024 through March 2025.* In progress. Working with Clinica Sierra Vista (CSV) and IHI to improve WCV for *Hispanic Children 0-15 months* in Fresno County through testing of interventions related to Provider/Caregiver Experience, Equitable Scheduling and Community Resources.
    - Intervention #1 on Disparity Data complete.
    - Intervention #2 in progress. The team will conduct interviews of CSV providers/staff and CSV parents/caregivers of Hispanic children under 15 months to better understand the Provider/Caregiver Experience as it relates to Well Child Visits. Interview findings will be applied to a patient *WCV Journey Map* for equity analysis.
    - Intervention #2 completion set for August 29, 2024.

- ***Lean (Green) Equity Improvement Projects*** *in Kings (Child Domain) and Madera (Behavioral Health Domain) assigned in April 2024*. A-3 Project Summaries submitted to DHCS 05/30/24. Feedback received from DHCS. We will continue with intervention implementation. Next submission due to DHCS Sept 2024.

- ***Comprehensive (Orange) Improvement Project*** *in Fresno County (Child & Behavioral Health Domains) assigned in April 2024.* Fishbone Diagram submitted to DHCS 05/31/24. Feedback received and Initial Strategies and Action Items submitted to DHCS 06/28/24. Awaiting feedback from DHCS.

VI. Findings/Outcomes

Reports covering all pertinent areas have been reviewed and evaluated according to the established schedule to facilitate the ongoing monitoring of the quality and safety of care provided to CalViva members. No significant compliance issues have been identified. Oversight and monitoring processes will continue.

Item #13
Attachment 13.E

Medical Management
Credentialing Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

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

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

COMMITTEE DATE: July 18th, 2024

SUBJECT: CalViva Health Credentialing Sub-Committee Report of Activities in Quarter 2 2024

Purpose of Activity:
This report is to provide the QI/UM Committee and RHA Commission with a summary of the 2nd Quarter 2024 CalViva Health Credentialing Sub-Committee activities.

I. The Credentialing Sub-Committee met on May 16th, 2024. At the May meeting, routine credentialing and recredentialing reports were reviewed for both delegated and non-delegated services.

II. Reports covering the fourth quarter for 2023 were reviewed for delegated entities and first quarter 2024 for Health Net and MHN (BH). A summary of the fourth quarter 2023 data is included in the table below.

Of note, corrected versions of the Q1 to Q4 2023 Health Net Credentialing reports were reviewed and approved at this meeting. A reporting error was discovered and corrected related to computer parameter settings that were incorrectly identifying practitioners for initial and recredentialing activities for these reports.

III. Table 1. Quarter 4 2023 Credentialing/Recredentialing

	Sante	ChildNet	MHN	HN	LaSalle	ASH	Envolve	IMG	CVMP	Adventist	UPN	Totals
Initial credentialing	53	16	25	9	31	0	1	8	49	48	60	**300**
Recredentialing	64	15	26	3	26	0	2	12	23	9	0	**180**
Suspensions	0	0	0	0	0	0	0	0	0	0	0	**0**
Resignations (for quality of care only)	0	0	0	0	0	0	0	0	0	0	0	**0**
Totals	**117**	**31**	**51**	**12**	**57**	**0**	**3**	**20**	**72**	**57**	60	**480**

IV. **Credentialing Adverse Actions** report for Q1 for CalViva from Health Net Credentialing Committee was presented. There were two (2) cases presented for discussion. Both cases remain open and are subject to semiannual monitoring to continue through the completion of probation.

V. The **Adverse Events Q1 2024** report was reviewed. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period.

- Credentialing submitted zero (0) cases to the Credentialing Committee in the first quarter of 2024.
- There were no (0) reconsiderations or fair hearings during the first quarter of 2024.

- There were no (0) incidents involving appointment availability issues resulting in substantial harm to a member or members in the first quarter of 2024.
- There were zero cases identified outside of the ongoing monitoring process, in which an adverse injury occurred during a procedure by a contracted practitioner in the first quarter of 2024.

VI. The **Access & Availability Substantial Harm Report Q1 2024** was presented and reviewed. The purpose of this report is to identify incidents of appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved Quality of Care (QOC) and Potential Quality Issues (PQIs) related to identified appointment availability and are ranked on severity level.

After a thorough review of all first quarter 2024 PQI/QOC cases, the Credentialing Department identified zero new cases of appointment availability resulting in substantial harm as defined in Civil Code section 3428(b)(1).

VII. The **2024 Credentialing Oversight Audit Results** of Health Net Community Solutions (HNCS) Credentialing/Re-Credentialing function were presented and reviewed. The audit review period was Jan. 1, 2023, through Dec. 31, 2023. The audit was conducted from Dec. 2023 through April 2024.

- Based upon a review of documents and communication with appropriate HNCS staff, overall, CalViva Health observed a 98.8% compliance rate with the 82 standards assessed.
- A total of one-hundred-and-seventy-four (174) practitioner & organizational provider files were reviewed for this audit.
- Overall compliance with the inclusion of required documentation for both initial credentialing and re-credentialing of practitioners was excellent at 100% and 99.5% respectively. The Organizational Providers file review also demonstrated 100% compliance.
- Issues with timeliness were noted for attestations in the Recredentialing files for one PPG which will require corrective action. Additionally, the timeliness of Re-Credentialing within thirty-six months for HealthNet will also require corrective action. These two items must pass at 100% or corrective action is required.

VIII. **The Credentialing Sub-Committee Charter for 2024** was reviewed and approved by the committee. There were no changes to the Charter this year.

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Item #13
Attachment 13.F

Medical Management
Peer Review Sub-Committee
Quarterly Report

REPORT SUMMARY TO COMMITTEE

TO:	Fresno-Kings-Madera Regional Health Authority Commissioners CalViva QI/UM Committee
FROM:	Patrick C. Marabella, MD Amy R. Schneider, RN
COMMITTEE DATE:	July 18th, 2024
SUBJECT:	CalViva Health Peer Review Sub-Committee Report of Activities in Quarter 2 2024

Purpose of Activity:

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

I. The Peer Review Sub-Committee met on May 16th, 2024. The county-specific Peer Review Sub-Committee Summary Reports for Quarter 1 2024 were reviewed for approval. There were no significant cases to report.

II. The Q1 2024 **Adverse Events Report** was presented. This report provides a summary of potential quality issues (PQIs) as well as Credentialing Adverse Action (AA) cases identified during the reporting period.

- There were seven (7) cases identified in Q1 that met the criteria and were reported to the Peer Review Committee.
  - Three (3) cases involved a practitioner and four (4) cases involved organizational providers (facilities).
  - Of the seven (7) cases, three (3) were tabled, one (1) was closed with a letter of education, and three (3) were closed to track and trend.
  - Six cases were quality of care grievances, one was a potential quality issue, zero were lower-level cases, and zero were track and trend.
  - Two cases involved seniors and persons with disabilities (SPDs).
- There were no incidents involving appointment availability issues resulting in substantial harm to a member or members in Q1 2024.
- There were two (2) cases identified outside of the ongoing monitoring process this quarter, in which an adverse injury occurred during a procedure by a contracted practitioner. (NCQA CR.5.A.4)

- There were seventeen (17) cases identified that required further outreach. Outreach can include but is not limited to an advisement letter (site, grievance, contract, or allegation), case management referral, or notification to Provider Network Management.

III. **The Access & Availability Substantial Harm Report for Q1 2024** was also presented. This is a new report for the Peer Review Committee. The purpose of this report is to identify incidents related to appointment availability resulting in substantial harm to a member or members as defined in Civil Code section 3428(b)(1). Assessments include all received and resolved grievances **Quality of Care (QOC)** and **Potential Quality Issues (PQIs)** related to identified appointment availability issues and they are ranked by severity level.

- Thirteen (13) cases were submitted to the Peer Review Committee in Q1 2024. There were zero (0) incidents found involving appointment availability issues resulting in substantial harm to a member or members. Two (2) cases were determined to be related to significant harm without appointment availability issues.

IV. The **Q1 2024 Peer Count Report** was presented and discussed with the committee. There was a total of thirteen (13) cases reviewed. There were six (6) cases closed and cleared. No (0) cases were closed/terminated. There were four (4) cases tabled for further information. There were two (2) cases with CAP outstanding and one (1) was pending closure for CAP compliance.

V. The **Peer Review Sub-Committee Charter for 2024** was reviewed and approved by the Committee. There were no changes to the Charter this year.

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

Item #13
Attachment 13.G

Executive Dashboard

	2023	2023	2023	2023	2023	2023	2023	2023	2024	2024	2024	2024	2024
Month	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**
CVH Members													
Fresno	355,821	357,098	355,405	353,005	350,061	348,373	346,709	345,319	343,493	347,888	348,065	348,349	347,954
Kings	39,372	39,665	39,611	39,697	39,366	38,824	38,583	38,436	38,232	38,901	38,877	38,831	38,563
Madera	48,217	48,323	48,426	48,375	48,124	47,588	47,150	46,762	46,717	48,656	48,684	48,579	48,666
Total	443,410	445,086	443,442	441,077	437,551	434,785	432,442	430,517	428,442	435,445	435,626	435,759	435,183
SPD	50,455	50,626	50,793	50,616	50,476	50,222	49,987	49,899	47,393	47,212	47,029	46,869	46,763
CVH Mrkt Share	67.26%	67.28%	67.36%	67.44%	67.46%	67.51%	67.59%	67.65%	67.15%	66.84%	66.83%	66.81%	66.83%
ABC Members													
Fresno	158,902	159,464	158,068	156,328	155,030	154,141	152,908	151,942	151,485	155,843	155,594	155,721	155,374
Kings	25,987	26,085	25,976	25,952	25,737	25,319	25,075	24,901	25,311	25,600	25,550	25,522	25,234
Madera	30,902	30,915	30,793	30,642	30,333	29,752	29,339	29,018	28,693	29,862	29,595	29,230	28,949
Total	215,791	216,464	214,837	212,922	211,100	209,212	207,322	205,861	205,489	211,305	210,739	210,473	209,557
Kasier													
Fresno									3,562	3,998	4,627	5,075	5,467
Kings									2	54	67	87	98
Madera									574	673	800	884	918
Total									4,138	4,725	5,494	6,046	6,483
Default													
Fresno	53.92%	53.61%	55.37%	55.25%	64.51%	55.31%	52.18%	54.90%	48.76%	57.21%			
Kings	61.94%	61.04%	63.36%	61.54%	56.71%	63.12%	65.00%	58.18%	62.64%	53.82%			
Madera	59.75%	57.35%	56.39%	55.58%	64.21%	55.26%	58.30%	56.41%	55.86%	54.76%			
County Share of Choice as %													
Fresno	68.52%	70.20%	69.06%	65.32%	48.06%	66.31%	65.72%	51.27%	66.82%	59.92%			
Kings	65.50%	56.54%	60.82%	50.51%	65.47%	66.67%	61.84%	69.21%	65.78%	62.47%			
Madera	61.02%	65.93%	64.78%	63.87%	57.35%	63.79%	66.57%	57.79%	69.02%	58.71%			

IT Communications and Systems	**Active Presence of an External Vulnerability within Systems**	**NO**	Description: A good status indicator is all potential external vulnerabilities scanned and a very low identification of confirmed and/or potential vulnerabilities.
	Active Presence of Viruses within Systems	**NO**	Description: A specific type of malware (designed to replicate and spread) intended to run and disable computers and/or computer systems without the users knowledge.
	Active Presence of Failed Required Patches within Systems	**NO**	Description: A good status indicator is all identified and required patches are successfully being installed.
	Active Presence of Malware within Systems	**NO**	Description: Software that is intended to damage or disable computers and computer systems.
	Active Presence of Failed Backups within Systems	**NO**	Description: A good status indicator is all identified and required backups are successfully completed.
	Average Security Risk	**2**	Description: Average security risk for all hosts. 5 = High Severity. 1 = Low Severity
	Business Risk Score	**24**	Description: Business risk is expressed as a value (0 to 100). Generally, the higher the value the higher the potential for business loss since the service returns a higher value when critical assets are vulnerable.
	Average Age of Workstations	**3.7 Years**	Description: Identifies the average Computer Age of company owned workstations.
Message From The CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's IT Communication and Systems. The Average Age of Workstations is decreasing as older workstations are being updated. Business Risk and Average Security Risk were added to the Dashboard.		

Member Call Center CalViva Health Website		**Year**	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**
		Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	(Main) Member Call Center	**# of Calls Received**	**24,875**	**35,660**	**34,897**	**34,897**	**34,875**	**41,520**
		# of Calls Answered	**24,707**	**35,418**	**34,625**	**34,595**	**34,533**	**41,114**
		Abandonment Level (Goal < 5%)	**0.70%**	**0.70%**	**0.80%**	**0.90%**	**1.00%**	**1.00%**
		Service Level (Goal 80%)	**96%**	**94%**	**87%**	**88%**	**83%**	**85%**
	Behavioral Health Member Call Center	**# of Calls Received**	**602**	**813**	**940**	**860**	**1,436**	**940**
		# of Calls Answered	**596**	**808**	**930**	**848**	**1,426**	**936**
		Abandonment Level (Goal < 5%)	**1.00%**	**0.60%**	**1.10%**	**1.40%**	**0.70%**	**0.40%**
		Service Level (Goal 80%)	**92%**	**91%**	**89%**	**89%**	**95%**	**97%**
	Transportation Call Center	**# of Calls Received**	**9,278**	**12,407**	**12,107**	**12,554**	**8,239**	**9,469**
		# of Calls Answered	**9,241**	**12,394**	**12,083**	**12,466**	**8,181**	**9,384**
		Abandonment Level (Goal < 5%)	**0.20%**	**0.10%**	**0.00%**	**0.50%**	**0.50%**	**0.60%**
		Service Level (Goal 80%)	**88%**	**94%**	**93%**	**87%**	**86%**	**79%**
	CalViva Health Website	**# of Users**	**27,000**	**54,000**	**42,000**	**40,000**	**45,000**	**54,000**
		Top Page	**Do You Qualify?**	**Main Page**	**Main Page**	**Main Page**	**Main Page**	**Main Page**
		Top Device	**Mobile (57%)**	**Mobile (60%)**	**Mobile (60%)**	**Mobile (61%)**	**Mobile (61%)**	**Mobile (61%)**
		Session Duration	**~ 1 minute**	**~ 2 minutes**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**	**~ 1 minute**
Message from the CEO	Q2 2024 numbers are not yet available.							

Provider Network & Engagement Activities	**Year**	**2023**	**2023**	**2024**	**2024**	**2024**	**2024**	**2024**
	Month	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
	Hospitals	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	Clinics	**157**	**156**	**156**	**156**	**156**	**156**	**157**
	PCP	**392**	**383**	**395**	**396**	**396**	**397**	**401**
	PCP Extender	**332**	**357**	**380**	**391**	**392**	**421**	**433**
	Specialist	**1470**	**1493**	**1461**	**1468**	**1468**	**1471**	**1477**
	Ancillary	**243**	**244**	**258**	**266**	**278**	**279**	**283**
	Year	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**
	Quarter	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
	Behavioral Health	**472**	**507**	**593**	**598**	**592**	**353**	**652**
	Vision	**30**	**37**	**104**	**110**	**104**	**108**	**116**
	Urgent Care	**11**	**12**	**14**	**14**	**16**	**16**	**16**
	Acupuncture	**4**	**4**	**4**	**4**	**3**	**3**	**3**
	Year	**2022**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**
	Quarter	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
	% of PCPs Accepting New Patients - Goal (85%)	**95%**	**92%**	**97%**	**97%**	**97%**	**98%**	**96%**
	% Of Specialists Accepting New Patients - Goal (85%)	**98%**	**97%**	**97%**	**98%**	**98%**	**98%**	**98%**
	% Of Behavioral Health Providers Accepting New Patients - Goal (85%)	**97%**	**97%**	**96%**	**96%**	**97%**	**96%**	**93%**
	Year	**2023**	**2023**	**2023**	**2023**	**2024**	**2024**	**2024**
	Month	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Providers Touched by Provider Relations	**439**	**560**	**507**	**480**	**597**	**519**	**428**
	Provider Trainings by Provider Relations	**986**	**1,195**	**1,698**	**1,028**	**821**	**970**	**1154**
	Year	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
	Total Providers Touched	**2,552**	**1,932**	**3,354**	**1,952**	**1,530**	**5,554**	**1,544**
	Total Trainings Conducted	**808**	**1,353**	**257**	**3,376**	**5,754**	**11,238**	**2,945**
Message From the CEO	At present time, there are no significant issues or concerns as it pertains to the Plan's Provider Network & Engagement Activities.							

Claims Processing	**Year**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Medical Claims Timeliness (30 days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99% / 99% NO	95% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO	99% / 99% NO
	Behavioral Health Claims Timeliness (30 Days / 45 days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% N/A	99% / 99% N/A	94% / 95% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A	99% / 99% N/A
	Acupuncture Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Vision Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / NA NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	Transportation Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO
	PPG 1 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	96% / 99% NO	99% / 100% NO	99% / 99% NO	100% / 100% NO	87% / 100% NO	76% / 100% NO	1% / 93% NO
	PPG 2 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	81% / 89% YES	90% / 94% YES	82% / 91% YES	91% / 97% NO	95% / 98% NO	99% / 99% NO	94% / 97% YES
	PPG 3 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	55% / 89% NO	95% / 100% YES	90% / 100% YES	83% / 98% YES	68% / 92% NO	47% / 89% YES	79% / 93% YES
	PPG 4 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	98% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 5 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	100% / 100% NO	98% / 100% NO	100% / 100% NO	100% / 100% NO	99% / 100% NO	99% / 100% NO	99% / 100% NO
	PPG 6 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% YES	98% / 100% NO	99% / 100% NO	99% / 100% NO	98% / 100% NO	98% / 99% NO	100% / 100% NO
	PPG 7 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 99% NO	99%/100% NO	99%/100% NO	99% / 100% NO	100% / 100% YES	99% / 100% YES	98% / 100% NO
	PPG 8 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure	99% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	100% / 100% NO	64% / 100% NO	95% / 100% NO
	PPG 9 Claims Timeliness (30 Days / 45 Days) Goal (90% / 95%) - Deficiency Disclosure						100% / 100% NO	100% / 100% NO
Message from the CEO	Q1 2024 numbers are available. PPG 1 is no longer a contracted provider as of 12/31/2023. Q1 2024 represents run off data. Management is monitoring PPG 1, 2 and PPG 3 performance. All other areas met goal.							

Provider Disputes	**Year**	**2022**	**2022**	**2023**	**2023**	**2023**	**2023**	**2024**
	Quarter	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
	Medical Provider Disputes Timeliness (45 days) Goal (95%)	97%	96%	98%	99%	99%	99%	98%
	Behavioral Health Provider Disputes Timeliness (45 days) Goal (95%)	100%	100%	100%	100%	100%	100%	100%
	Acupuncture Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Vision Provider Dispute Timeliness (45 Days) Goal (95%)	100%	N/A	100%	100%	100%	100%	100%
	Transportation Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	PPG 1 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	78%	98%	89%
	PPG 2 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	84%	11%	31%	81%	100%
	PPG 3 Provider Dispute Timeliness (45 Days) Goal (95%)	45%	85%	71%	40%	66%	65%	70%
	PPG 4 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	99%	41%	55%	90%	97%
	PPG 5 Provider Dispute Timeliness (45 Days) Goal (95%)	86%	98%	100%	43%	65%	85%	98%
	PPG 6 Provider Dispute Timeliness (45 Days) Goal (95%)	N/A	100%	100%	47%	63%	97%	100%
	PPG 7 Provider Dispute Timeliness (45 Days) Goal (95%)	96%	98%	N/A	100%	67%	95%	100%
	PPG 8 Provider Dispute Timeliness (45 Days) Goal (95%)	100%	100%	100%	100%	99%	99%	100%
	PPG 9 Provider Dispute Timeliness (45 Days) Goal (95%)						N/A	100%
Message from the CEO	Q1 2024 numbers are available. PPG 1 is no longer a contracted provider as of 12/31/2023. Q1 2024 represents run off data. Management is monitoring PPG 1 and PPG 3 performance. All other areas met goal.							